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Personality Disorder: The Patients Psychiatrists Dislike

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A sample of psychiatrists was asked to read a case vignette and indicate likely management and attitudes to the patient on a number of semantic-differential scales. Patients given a previous diagnosis of personality disorder (PD) were seen as more difficult and less deserving of care compared with control subjects who were not. The PD cases were regarded as manipulative, attention-seeking, annoying, and in control of their suicidal urges and debts. PD therefore appears to be an enduring pejorative judgement rather than a clinical diagnosis. It is proposed that the concept be abandoned.

Personality disorder is an established clinical diagnosis, surviving in both ICD-9 (World Health Organization, 1978) and DSM-III (American Psychiatric Association, 1980). In 1974, Shepherd & Sartorius concluded: "Despite diagnostic imprecision and terminological confusion it is indisputable that some working concept of psychopathic personality is essential for the practice of clinical psychiatry".

A number of criticisms have been made of the concept of personality disorder (PD). Firstly, it is an unreliable diagnosis, in part due to rather vague definitions (e.g. Kreitman *et al*, 1961; Walton & Presly, 1973; Lewis, 1974), and remains so, despite attempts at greater precision, for instance in DSM-III (American Psychiatric Association, 1980; Mellsop *et al*, 1982). Secondly, the concept of personality that underlies this clinical term has been increasingly abandoned by most social psychologists (e.g. Mischel, 1968), who cite evidence showing that people do not behave similarly in different situations.

But there is a more serious criticism in the literature, that personality disorder is a derogatory label that may result in therapeutic neglect (Gunn & Robertson, 1976). Kendell (1975*a*), in his influential monograph on diagnosis, says "it is true that several of our diagnostic terms, like hysteric and psychopath, have acquired pejorative connotations even among psychiatrists". Although this argument is usually applied to antisocial PD, it is relevant to many of the other categories. For instance, Parry (1978) writes of alcoholics with personality disorder "they are of course, totally unreliable and their protestations are rapidly shown to be shallow insincerities". Hysterical PD in some accounts is a parody of supposed feminine characteristics (Chodoff & Lyons, 1958). Inadequate personality disorder, the term itself a critical judgement, has been described as an "addiction to help", and further that "young inadequate women may become prolific producers of children with whom they seek unsuccessfully the kind of intimacy they cannot achieve elsewhere" (Howard, 1985). Although ICD-9 (World Health Organization, 1978) has changed the name to asthenic, the concept of inadequate PD remains unchanged: "a weak inadequate response to the demands of daily life" (World Health Organization, 1978).

Among all this controversy, there is, surprisingly, one area of relative agreement; that personality disorder is not a mental illness (Lewis, 1974). Although Henderson (1939) and Cleckley (1976) regard PD as an illness, there has recently been an increasing consensus distinguishing PD from illness. Even Walton (1978), who has criticised PD, wrote "The Personality Disorders . . . take the form of recurrent disturbance in relationships with other people and is not a form of illness".

Many authorities have found mental illness difficult to define (Lewis, 1953; Wootton, 1959; Kendell, 1975*b*; Farrell, 1979). However, one aspect of the concept is that the mentally ill are seen as less responsible and less in control of their actions. Weiner (1980) has argued that the inference that someone is 'in control' is an important determinant in whether that person is given help. His subjects were more likely to help, and were more sympathetic to, someone who appeared ill (uncontrollable) than someone who appeared drunk (controllable). Thus, distinguishing PD patients from those with mental illness could lead to lack of sympathy and blame because of judgements that their actions are under control.

This study was both an empirical test of whether PD is a pejorative term, and an examination of the hypothesis that patients labelled as PD are thought to be more in control of their actions. A sample of psychiatrists was given different short case vignettes and then asked to complete a questionnaire assessing their attitudes towards the case. Using vignettes in this way allowed us to control for possible confounding variables, and forced the psychiatrists to use their stereotypes of PD to complete the questionnaire.

Method

Sample

Psychiatrists (240), who lived in England, Wales, or Scotland, were randomly selected from the membership list of the Royal College of Psychiatrists (approximately 12% of total; Department of Health and Social Security, 1987). Those who were described as registrars, who were retired, or were listed as being child psychiatrists, were excluded from the sample (but several child psychiatrists were included in the sample because they were not listed as such). Subjects were randomly allocated one of the six brief case histories, which they were asked to read before completing and returning an accompanying questionnaire. They were told that we were interested in how experience influenced the practice of psychiatrists, and were asked to provide details about previous qualifications and experience in psychiatry and in other specialties. The real purpose of the study was explained only to those receiving case 4 (see below).

Case histories

The six case histories differed from each other in only one or two particulars. Each history contained the information which a general practitioner's (GP's) letter might provide about a depressed patient. The amount of information was deliberately restricted, to encourage subjects to draw inferences based on pre-existing attitudes.

The first case history was as follows:

"A 34-year-old man is seen in out-patients. He complains of feeling depressed, and says he has been crying on his own at home. He is worried about whether he is having a nervous breakdown, and is requesting admission. He has thought of killing himself by taking an overdose of some tablets he has at home. He has taken one previous overdose, 2 years ago, and at that time he saw a psychiatrist who gave him a diagnosis of personality disorder. He has recently gone into debt and is concerned about how he will repay the money. He is finding it difficult to sleep and his GP has given him some nitrazepam. He thinks these have helped a little and is reluctant to give them up."

The other cases were modified from the first as follows:

Case 2

No previous diagnosis was mentioned.

Case 3

Previous diagnosis was given as depression.

Case 4

Information as for case 1 was given, but the subjects were told that we were interested in the labelling effect of certain psychiatric diagnoses and were asked not to let themselves be influenced by previous labels.

Case 5

Information as for case 2 was given, except that the patient was female.

Case 6

Information as for case 2 was given, except that the word "man" in the opening sentence was changed to "solicitor".

Questionnaire

The questionnaire consisted of 22 semantic differentials, with a 6-point scale, designed to elicit one aspect of the assessment or management of the case. Some of the items placed more emphasis on practical management issues (e.g. antidepressant prescription, psychotherapy referral), but most asked directly about attitudes to the patient (e.g. likely to annoy, attention-seeking, etc.). A full list is given in Table I. The semantic differentials were scored so that a higher score represented responses that were more rejecting or that indicated lack of active treatment. For instance, a response at the end of the scale "overdose would be an attention-seeking act" scored 6 and a response at the end "overdose would be a genuine suicidal act" was scored 1. Each subject was asked to complete the questionnaire and then choose a diagnosis from a list of depression, anxiety, adjustment reaction, drug dependence, personality disorder, and neurasthenia.

Results

Characteristics of the sample

Of the sample, 72% (173 of 240) returned completed questionnaires and a further 9% (22) refused to participate, usually complaining that there was insufficient clinical information on which to base judgements. Overall it was a very experienced sample, with a mean of 16.5 years psychiatric practice.

Previous diagnosis of personality disorder

The principal experimental concern was to see whether the previous diagnosis of personality disorder affected the psychiatrists' attitudes. Preliminary analysis illustrated that all statistically significant differences between the cases depended on the presence or absence of the PD diagnosis, so cases 1 and 4 were combined as group PD ($n = 58$) and the remainder, receiving cases 2, 3, 5, and 6 were combined as group NoPD ($n = 115$).

The means of group PD were higher (i.e. more critical) than those of NoPD on all but 1 of the 22 items as shown in the first two columns of Table I. Individual one-way analyses of variance showed a significant difference between groups PD and NoPD on 16 of the 22 semantic differentials. The F ratios of these one-way analyses are in column 3 of Table I.

These results confirm the hypothesis: when psychiatrists were given a previous diagnosis of personality disorder, their attitudes to the patient were less favourable. This occurred irrespective of whether they were informed of our interest in unfavourable attitudes towards PD (case 4). Furthermore, PD had a much more powerful effect on these attitudes than did sex and class.

TABLE I
Means and results of analysis of variance

Statement about patient	Group/means PD	Group/means NoPD	One-way anova (F ratios) Group	Two-way anova (F ratios) Diagnosis
Manipulating admission	3.41	2.75	14.2***	4.6***
Unlikely to arouse sympathy	3.50	2.61	15.0***	2.8*
Taking an overdose would be attention-seeking	3.67	3.18	7.1**	6.4***
Should be discharged from out-patient follow-up	2.05	1.65	7.0**	1.5
Would not like to have in one's clinic	2.96	2.45	7.2**	2.0
Poses difficult management problem	3.89	2.95	19.2***	2.0
Likely to annoy	3.14	2.59	7.0**	2.9*
Unlikely to improve	2.54	2.00	13.7***	3.6**
Cause of debts under patient's control	4.36	4.04	3.9*	1.4
Not mentally ill	3.67	2.96	9.8**	9.4***
Case does not merit NHS time	3.00	2.67	5.3*	2.7*
Unlikely to complete treatment	3.76	2.61	42.9***	3.8**
Unlikely to comply with advice/treatment	3.45	2.69	21.6***	3.8**
Suicidal urges under patient's control	3.48	3.18	2.7	3.1*
Likely to become dependent on one	4.09	3.94	0.2	1.0
Condition not severe	3.60	3.12	10.3**	4.5***
Admission not indicated	4.03	3.41	3.6	2.2
Not a suicide risk	3.44	3.07	4.3*	4.1**
Does not require sickness certificate	3.00	2.44	3.8	3.6**
Dependent on benzodiazepines	3.26	3.14	0.9	1.9
Psychotherapy referral not indicated	3.54	3.55	0.0	1.5
Antidepressants not indicated	3.77	3.12	6.6*	5.8***

*$P<0.05$; **$P<0.01$; ***$P<0.001$.
ANOVA = analysis of variance; PD = personality disorder; NoPD = no personality disorder.
Higher values indicate greater agreement with Statement; there was a 6-point scale between the two statements of the semantic differential.

Diagnosis made by respondents: its relationship to attitudes

At the end of the semantic differential, the psychiatrists were asked to make a provisional diagnosis. Sixty-three per cent made a diagnosis of depression. The respondents in Group PD were more likely than those in Group NoPD to make the diagnosis of adjustment reaction ($\chi^2 = 14.4$; d.f. = 3; $P<0.001$; Table II). Because of this relationship, two-way analyses of variance were performed, entering the group effect first. This allowed us to examine the effects of diagnosis independent of the group effect. The results are shown in the fourth column of Table I.

The mean values (Table II) show that the diagnosis of depression was associated with the least-critical attitudes. Personality disorder, adjustment reaction, and anxiety had

TABLE II
The relationship between the diagnosis made by the psychiatrists and their attitudes to the case

	Group PD		Group NoPD	
	Number of cases	Mean of variables (s.e.m.)	Number of cases	Mean of variables (s.e.m.)
Depression	25	3.03 (0.11)	64	2.59 (0.07)
Personality disorder	7	3.48 (0.18)	4	3.30 (0.37)
Anxiety state	3	3.88 (0.30)	8	3.27 (0.09)
Adjustment reaction	16	3.76 (0.36)	9	3.09 (0.18)
Neurasthenia	2	3.07 (0.36)	2	3.61 (0.97)
Drug dependence	0	—	1	3.0

The significant semantic differential items have been summed for each subject and the means for each diagnostic group are given here. Higher values indicate more critical attitudes (see Table I).

higher scores than depression, but the small sample size makes it impossible to say whether there were any real differences between these diagnoses. Table II gives an overall picture of the results, obtained by calculating the means of the sum of the significant variables in each diagnostic category.

Although the diagnosis of depression was associated with more favourable attitudes overall, a previous diagnosis of PD (Group PD) still resulted in more critical attitudes, even when the psychiatrists' own diagnosis was depression (Table II). This result was confirmed by the analysis of variance, for there was only one semantic differential that showed a significant group by diagnosis interaction, the item "manipulating admission" ($F=2.89$; $P<0.05$) and even here, the mean of subjects who diagnosed depression in group PD (mean = 3.00) was still higher than those in group NoPD (mean = 2.55; $t=2.74$; $P<0.01$). The vast majority of the attitudes showed no such interaction and it is clear that the group effect of previous diagnosis was independent of the effect of the 'current' diagnosis made by the psychiatrists. It indicates that PD still had an effect on attitudes even though it was not the psychiatrists' own diagnosis.

The diagnosis of adjustment reaction was commoner in the group that had been given a previous diagnosis of PD, and adjustment reaction was associated with more critical attitudes. This suggests that adjustment reaction could be a diagnosis applied to depressive symptoms in those whose fundamental disturbance is seen as of the personality rather than due to illness.

The more-experienced psychiatrists had less-critical attitudes on a number of items, e.g. "annoying", "not mentally ill", "condition not severe". Such cross-sectional data though, could reflect changes in medical education rather than experience.

Perception of control and personality disorder

The correlations between individual items provide some confirmation of the suggested link between mental illness and control (Table III). "Not mentally ill" was correlated with items implying the patient had control over his or her behaviour (items 2–5 in Table III). Weiner's (1980) model also predicts that perceived control should be associated with lack of sympathy (items 8 and 9) and so make it less likely that the psychiatrist would consider helping (items 6 and 7). Of the correlation coefficients in Table III, 31 of 36 are significant at the 5% level.

Discussion

This study supports the view that psychiatrists form pejorative, judgemental, and rejecting attitudes towards those who have been given a diagnosis of personality disorder. Patients previously labelled as personality disordered were seen as manipulative, difficult to manage, unlikely to arouse sympathy, annoying, and not deserving NHS resources. Psychiatrists viewed them as uncompliant, not accepting advice, and having a poor prognosis. They were more likely to be discharged from follow-up examination, and suicide attempts were seen as attention-seeking rather than 'genuine'. Requests for admission were thought to be manipulative, and the patients were judged less mentally ill, and their problems less severe.

At the end of the questionnaire, the subjects were asked to make their own diagnosis; analysis of the results indicated that these attitudes to PD were

TABLE III
Correlations between selected items

Item	*Correlation (r)*[1]							
	2	*3*	*4*	*5*	*6*	*7*	*8*	*9*
1. Not mentally ill	0.40	0.35	0.19	0.40	0.23	0.27	0.25	0.28
2. Taking an overdose would be attention seeking		0.51	0.28	0.39	0.31	0.31	0.41	0.30
3. Manipulating admission			0.27	0.37	0.36	0.36	0.23	0.10
4. Cause of debts under patient's control				0.31	0.04	0.14	0.23	0.21
5. Suicidal urges under patient's control					0.12	0.29	0.17	0.19
6. Should be discharged from out-patient follow up						0.29	0.25	0.06
7. Case does not merit NHS time							0.25	0.24
8. Unlikely to arouse sympathy								0.37
9. Likely to annoy								

1. If $r>0.15$, then $P<0.05$; if $r>0.25$ then $P<0.001$.

apparent regardless of the psychiatrists' own diagnosis. One cannot argue therefore, that the features shown above are the real features of personality disorder.

The results show that the past diagnosis of PD was more important in determining these attitudes than sex, class, and giving a previous diagnosis of depression. Informing the respondents of our main experimental concerns did not affect attitudes.

Methodological issues

Case vignettes have been used in previous studies of decision-making by psychiatrists (Mayou, 1977) and physicians (O'Toole *et al*, 1983). This method allows a fully controlled experimental study, and usually produces results consistent with behavioural observations (e.g. Weiner, 1980). Although a case vignette does not provide as much information as a clinical interview, it cannot create attitudes that do not already exist.

Unambiguous semantic differentials are an accepted method of measuring attitudes. The validity of the scales is supported by the results, for instance, that psychotherapists were more likely to refer for psychotherapy, and biological psychiatrists were more likely to prescribe antidepressants. Attitudes are an important determinant of behaviour (e.g. Nisbett & Ross, 1980) and an important area of study in their own right, particularly in psychiatry, where rejecting and pejorative attitudes would be noted by patients because of non-verbal cues, although the psychiatrists' overt behaviour might be unchanged.

Categories of personality

The case vignette used here did not specify a category of PD nor provide any information that might support any particular PD diagnosis. This is consistent with the practice of many psychiatrists, who use the term without subdividing PD into categories.

The present study therefore extends Gunn & Robertson's (1976) assertion on the label 'psychopath' to the overall term of personality disorder that "what is conveyed . . . is that the patient is difficult and probably unpleasant"; although it does not exclude the possibility that some types of personality disorder are less damning than others.

Personality disorder and mental illness

How has a term, which appears at first sight to bring together a group of deviant types of behaviour, come to be a derogatory label? We argue here, with supportive evidence from the study, that the answer lies in the assumption that PD is not a mental illness, and the consequent attributions of control.

The PD patients were judged less mentally ill, and were seen as being in control of their debts and suicidal urges. They were thought to be manipulating and attention-seeking, both expressions implying control of behaviour. Perceived control and absence of 'illness' were also significantly correlated with lack of help-giving and sympathy, consistent with Weiner's (1980) model.

Sociologists (e.g. Scheff, 1963) usually think of mental illness as a stigmatising label, but for the psychiatrists in this study it was associated with favourable attitudes. This does not imply that there is no stigma to mental illness; rather that 'abnormal' behaviour may be relatively excused if attributed to mental illness. For a psychiatrist, someone who is mentally ill requires professional help, including the sympathy and acceptance that doctors are expected to provide.

Although mental illness is a concept without rigid boundaries (Farrell, 1979), doctors appear to distinguish between those that are ill and those that are not. Furthermore, the unreliability of the PD diagnosis suggests that the rules employed are arbitrary. This view would be ethically acceptable, although scientifically dubious, if its only consequence were a caring, sympathetic attitude to those whose behaviour fell within the illness boundary. However, this study demonstrates that patients receiving a non-illness, PD diagnosis may be rejected and viewed with therapeutic pessimism even when they have psychiatric symptoms. Those labelled as personality disordered appear to be denied the benefits of being regarded as ill, but also denied the privilege of being regarded as 'normal'.

In clinical practice, judgements are frequently made on whether a patient is in control of his or her actions, and so responsible for them. For example, if a patient considered ill breaks a window, his action may automatically be attributed to his illness; he is therefore not responsible and is not blamed. For the patient thought to have a PD, there may be an equivalent automatic assumption: he is responsible and deserves blame for his actions.

Each case vignette described the same symptoms and so the effect of the PD label on attitudes was seen to override the patient's complaints. It has been suggested that those diagnosed as personality disordered are less likely to receive treatment for depression despite having depressive symptoms (Slavney & McHugh, 1974; Thompson & Goldberg, 1987). Here, prescription of antidepressants and outpatient follow-up examination was less likely in group PD. The PD label appears to reduce the

importance attributed to symptoms, perhaps by providing alternative explanations: for instance, that the patient is attention-seeking or manipulative, that their symptoms are less genuine.

Conclusion

This study adds to the criticism of the personality-disorder diagnosis. We have suggested that because it is seen as distinct from mental illness, it implies control and responsibility, and encourages rejection. Most seriously, it leads to pejorative attitudes.

We suggest that the clinical diagnosis of personality disorder has no justification and should be abandoned. No physicist would claim that an electron was any more worthwhile than a positron, but psychiatrists appear to prefer one diagnosis to another. A scientific classification loses credibility if it contains value judgements or moral statements. A classification based on symptoms should be more reliable, and encourage a sympathetic approach to treatment.

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