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Editorial

Finding the "Person" in Personality Disorders

In 1874 Hughlings Jackson endorsed a two-pronged diagnostic system—one for clinicians and another for researchers (1). The report by Drew Westen in this issue of the *Journal* suggests that at least with regard to personality disorders, Jackson's wish may have been granted unintentionally. In a small study of his colleagues at the Cambridge Hospital and in a larger survey of a randomly selected national sample of experienced psychiatrists and psychologists, Westen found that clinicians approach the diagnosis of patients with personality disorders in ways that diverge substantially from standard research instruments geared to DSM-IV classification. Direct questions based on criteria from DSM-IV were regarded as only minimally useful in making the diagnosis of a particular personality disorder. Instead, clinicians emphasized observation of the patient's behavior during the interview and descriptions of the patient's interactions with significant others. Westen also found that clinicians tend to apply only one axis II diagnosis, while the use of currently popular research instruments based on the DSM-IV system typically results in somewhere between three and six personality disorder diagnoses if subjects are thought to have any pathology at all on axis II.

Research instruments using direct questions about personality traits are fraught with problems. The core of such questions is, "What kind of person are you?" These sorts of inquiries are bound to heighten defensiveness in a patient. Most of us are much better at observing traits in others than at describing ourselves. What we refer to as personality is a complex mixture of biologically based temperament, the internalized record of the ravages of experience, including internal representations of self and others, conflicts involving wishes and defenses against those wishes, and a variety of vulnerabilities and aspirations. Character traits tend to be unconscious and ego syntonic. Many patients with personality disorders create much more distress in others than in themselves. As Westen points out, the psychoanalytic construct of the unconscious dimensions of personality has now been legitimized by empirical research on implicit or nondeclarative memory and a host of studies showing that unconscious motivations influence our behavior.

In the rest of medicine, much more is made of the distinction between signs and symptoms than in psychiatry. Classically, signs refer to phenomena observed by the physician in the course of a physical examination, while symptoms are subjective reports from the patient. The diagnosis of pathology on axis II depends much more on the observation of signs by the clinician than on the patient's highly defended answers to direct questions about traits. Clinicians have long known this, and Westen's findings confirm it.

A host of criticisms have been levied against the categorical approach to the diagnosis of personality disorders (2–6). This model, based on a disease-oriented/medical model approach, makes a basic assumption that a disorder is either present or absent, even though most personality features occur on a continuum without a clear demarcation of what is normal from what is abnormal (7). These categorical distinctions between personality disorders do not hold up and result in high degrees of comorbidity, as Westen suggests. He offers three explanations for why clinicians are much more likely than researchers to diagnose only one person-

ality disorder: the failure to recognize comorbidity, the questions they ask do not allow for discrimination among disorders, and research instruments tend to diagnose multiple disorders because they cannot prioritize diagnoses the way clinicians can. I would add a fourth possibility, namely, that clinicians inherently approach diagnosis with treatment in mind. Analogous to a medical officer on a battlefield, who assesses the nature and extent of injuries in order to know what wound to treat first, the clinician assesses the predominant character difficulties to develop strategies in planning a treatment approach.

A related issue involves theory. The DSM-IV system of classification is explicitly atheoretical. Clinicians, on the other hand, must approach personality with a theory at their side. Negotiating the complexity of another person's character frequently dissolves into chaos without the anchoring of some form of theoretical understanding. As Francis Bacon is alleged to have quipped, "Even wrong theories are better than chaos." Guided by theory, clinicians, and in particular psychotherapists, may "lock in" to a predominant personality constellation that is a good fit with the theory. From a theoretical or, for that matter, *any* clinical perspective, it is not very helpful to think of the patient as suffering from four or five different personality disorders. The clinician is more likely to diagnose a predominant personality disorder and speak of "features" of other axis II diagnoses.

Another finding worth mentioning in Westen's survey is the fact that clinicians who work with personality disorders also treat a wide range of patients who fall short of meeting the criteria for standard categories in the DSM-IV system. One of the distressing consequences stemming from the deletion of the neuroses from the diagnostic nomenclature with the arrival of DSM-III in 1980 was the accompanying loss of the time-honored notion of "character neuroses." This term was necessary historically to describe the shift from clinical presentations involving neurotic symptoms to more generalized problems of intimate relationships, quiet desperation, and problems in the workplace. The individual's character structure often plays a key role in the generation of these difficulties, and treatment may be imperative to interrupt the suffering of the patient and others. We know from systematic research on subsyndromal states, such as depressive symptoms falling short of the threshold for the diagnosis of affective disorder, that costly disability and considerable distress can be associated with problems that do not meet criteria for a mental illness (8).

As we slouch toward the end of the millennium and the inevitability of DSM-V, let us hope that clinicians and researchers can converge on a classification system that is useful to both groups. There are a variety of models based on the dimensional approach, many of which are gaining empirical support and should be actively considered as the work group sits down to contemplate changes (6, 9). Westen proposes a method of comparing the pattern of personality attributes of a given patient with patterns found among particular groups of patients. Others (10) have proposed a return to a classical model that focuses on ideal types or prototypes not in which categories are defined by meeting a specified number of attributes required for the diagnosis, but, rather, in which an individual is included in a category on the basis of *degree*. In other words, an individual who possesses more features of the prototype is a better fit than someone with fewer features. Space considerations preclude a thorough discussion of the advantages and disadvantages of each of these approaches.

Finally, when we speak of personality disorders, we are in a realm of high stakes. Although some third- and fourth-party payers limit their coverage to axis I disorders, there is a high degree of morbidity associated with personality disorders, including suicide, violent aggression, self-destructive behavior, high utilization of medical resources, wrecked lives, "dead" marriages, and painful isolation. The diagnosis may not be immediately apparent, and sometimes "tincture of time" is necessary to allow a personality disorder to blossom into its fullest manifestation. In the current economic climate, that time is not always available, and many patients are diagnosed

retrospectively. Patients with personality disorders repeat their characteristic mode of relatedness in their relationship with the clinician, and it is often through the clinician's own observation about his or her reactions that the impact the patient has on others becomes apparent. It may take awhile before the clinician recognizes the particular "dance" that the patient has introduced. Indeed, when the music starts, clinicians may have to join in the dance before they recognize that they have become an unwitting partner in the patient's inner world. As John Nemiah said many years ago, "To see into the mind of another, we must repeatedly immerse ourselves in the flood of his associations and feelings; we must be ourselves the instrument that sounds him" (11, p. 4).

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