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WHO/ADAMHA PROJECT ON DIAGNOSIS AND
CLASSIFICATION OF MENTAL DISORDERS
AND ALCOHOL- AND DRUG-RELATED PROBLEMS

INFORMAL CONSULTATION ON ASSESSMENT
AND DIAGNOSIS OF PERSONALITY DISORDERS
Leiden, 5-7 March 1986



# MINUTES OF THE CONSULTATION

## Introduction

After the opening of the meeting by Dr Ph. Holzman (Chairman of Task Force on Personality Disorders) and a welcome by the host Dr Diekstra, Dr Hirschfeld and Dr Jablensky stated, on behalf of the WHO/ADAHMA Steering Committee, the objectives of the meeting. Reference was made to the International Conference on Diagnosis and Classification of Mental Disorders and Alcohol- and Drug-Related Problems, held in Copenhagen in April 1982, where intensified research into the assessment and classification of personality disorders was recommended. In subsequent meetings of the Task Force on Assessment of Personality Disorders, it was decided to further develop and test a new diagnostic instrument, the Personality Disorder Examination (PDE). The PDE, which was originally developed by Dr Loranger to diagnose personality disorders according to DSM-III, will be adapted for international use by adding ICD-10 criteria, so that it can be used with both DSM-III(R) and ICD-10.

## Objectives of the consultation

The present meeting had the following objectives:

1. a) to review the need for further modification of the PDE and especially its adaptation to the draft ICD-10 criteria;
   b) to discuss the field trials of the instrument and agree on an outline of a research protocol;
   c) to develop a plan of work and a time table for the future activities of the Task Force;
2. to review the draft sections on personality disorders in ICD-10 and DSM-IIIR.

Dr Jablensky pointed out that many of the problems identified by the Seventh WHO Seminar on Standardization of Psychiatric Diagnosis, Classification and Statistics of Personality Disorders, held in 1971, were still unresolved, and that in the field of diagnosis of personality disorders relatively little progress was made since that time. For this reason, the instrument and the research proposals to be discussed in this meeting were of major importance.

## Progress since the 1985 consultation

Progress reports on preliminary experience with the PDE were given by the centres that had already used the schedule:

Cornell Medical Centre (Dr Loranger): While the study was going on it was found necessary to adjust the wording of some items. Some questions were deleted and others had to be substituted. There was also concern about the possible impact

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of the mental state of the patient (e.g. depression or anxiety) at the time of the interview on the assessment of personality traits. The Hamilton Depression Scale was used to identify depressive symptomatology. Two people were rating the PDE at the same time, one interviewing the respondent, the other rating passively, followed by the application of the Hamilton scale. Each patient was interviewed twice with an interval of not less than two weeks. The majority of patients selected for study were between 18-55 years of age, although the schedule has also been used on older people. The series of patients represented a mixture of inpatients and outpatients. History of a psychotic episode in the past, lasting for over two weeks, was an exclusion criterion. No forensic cases were included. In general it was found that the respondents accepted the interview well. In a proportion of cases a key informant was also used (with an interviewer who had no prior knowledge of the patient).

Department of Psychology, Leiden University (Dr Diekstra; Dr Heuves): The PDE has been translated into Dutch by Dr Heuves; it was found that the wording of some questions presented difficulties with Dutch respondents and had to be adjusted in some cases. The schedule will undergo a backtranslation(as a standard procedure) in the near future.

District Hospital, Kaufbeuren (Dr Cranach): The schedule has been translated into German. No backtranslation has yet been done, but the psychiatrists and psychologists working with the schedule were generally satisfied with it. However, there were some important problems, that emerged in testing the schedule:

(i) Transcultural applicability. The PDE questions and the order in which they are asked, appear to be culture bound, e.g. the assumptions underlying the section on dysfunction concerning work reflect North American attitudes and cultural norms which may not be valid elsewhere.

(ii) There is uncertainty as to whether the instrument is measuring personality traits or personality disorders.

(iii) The schedule is too complex and sophisticated. Numerous additional questions had to be asked before the patient understood which were the behaviours and subjective experiences that were asked for.

In clarification of this issue, Dr Loranger remarked that the schedule had been designed for use primarily with persons with completed high school education.

Department of Psychiatry, Nottingham University Medical School (Dr Tyrer): The schedule was used on 21 patients, 15 of whom were forensic cases. This series included some quite disturbed patients. The problems encountered were as follows:

(i) It was difficult to separate traits from disorders.

(ii) The interview was found too long by the patients and had to be split in half and administered in two sessions. Some questions seem repetitive.

(iii) There were idiomatic difficulties in the wording of some items.

(iv) Too many questions inquire about negatively valued traits or behaviours. This raises the problem of social desirability influencing the responses. In this context it was important to know if, and to what extent, open-ended questions could be added to clarify the items when necessary.

Institute of Psychiatry, London (Dr Williams): The PDE was found easy to administer. The major problems were:

(i) For about one-third of the patients the schedule had to be administered in two sessions (these were all outpatients).

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(ii) Some questions were repetitive.

(iii) The section on work proved to be difficult, in view of the many chronically unemployed people in UK at the present time.

(iv) For the above reasons it was sometimes difficult for the interviewer to establish rapport with the respondent.

(v) Many of the ratings presuppose a middle class scale of values, i.e. the assessment may have an inherent cultural and social class bias.

However, on the positive side, it seems that one of the reasons many patients like the interview is that it allows them to talk about themselves for some length of time.

Department of Psychiatry, University of Pisa (Dr Deltito, Dr Mauro) The schedule was used on in-patients in a psychiatric hospital. Each patient was given the PDE twice by two teams of interviewers, separated in time by at least one day. The same patients were also interviewed with the SCID. Problems that were observed:

(i) The schedule gave rise to difficulties in questions regarding career choice and work environment. The work section was especially problematic because of widespread unemployment.

(ii) It may be difficult to detect false responses, the general rule being the respondent's to accept "yes" or "no", unless there is clear doubt.

Further remarks about the PDE made in the course of the discussion

One should be careful with the introduction of additional probes and clarifying questions, because there may be serious differences among the interviewers in the way of undertaking such supplementary inquiries.

In relation to the general question about the intended output of the PDE, it was reiterated that the instrument aims to provide personality disorder diagnosis, which should be regarded as a probability statement.

Since some patients tend to answer "yes" to most questions, it was discussed whether the threshold for rating the presence of an item should be made higher. In the present version of the schedule the formulation of questions is close to matching the DSM-III criteria. However, the draft ICD-10 criteria have a higher threshold for diagnosing personality disorders than DSM-III and DSM-IIIR, and this fact will have a bearing upon further editions of the instument.

Various problems regarding the use of the schedule in different cultures were discussed, such as the influence of different value systems existing in cultures on the concepts built into the schedule, and the need for differential weighting of scores that may arise when the PDE is used in very different or contrasting settings.

Agreements regarding further "tidying up" of the PDE

(1) Dr Jablensky will send Dr Loranger the draft ICD-10 criteria for personality disorders as soon as they are available in a more advanced form, so that additional changes in the PDE can be made as necessary (end of May 1986).

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(2) Dr Loranger will provide WHO Headquarters with an updated version of the PDE for translation and backtranslation in the centres by the end of June 1986.

(3) Translation and backtranslation of the interview should be completed by the centres by the end of August 1986.

Proposal for an International Pilot Study of Personality Disorders

A draft protocol, which had been developed prior to the meeting, was extensively discussed and revised in the following areas:

1. Objective of the study:

- To determine the feasibility of using a standardized instrument and explicit diagnostic criteria, such as the PDE to detect and classify personality disorders in different cultures.

- To determine the interrater agreement based on the PDE, in determining the presence or absence of personality disorders in patients series at the various participating centres.

- To determine the interrater reliability of the specific criteria and dimensional scores on the PDE at the various participating centres.

- To determine the agreement between the patient and informant versions of the PDE criteria and dimensional scores at the various centres.

2. Design

At each participating centre a series of 40 or more subjects aged 18-55 years will be selected according to the protocol criteria. The subjects will be identified among consecutive attendances or admissions on the strength of the criterion that their behaviour and symptomatology meet the locally and culturally relevant concept of personality disorder. The individuals so selected will be interviewed with the local translation of the PDE. Additional instruments (e.g. the PAS) may be used on subsamples of cases, or in some of the centres. Each centre will have at least two qualified interviewers. Training of the interviewers will be carried out by Dr Loranger.

3. Tentative commitments concerning the participation of centres.

The pilot study will be carried out in 5 or 6 centres in Europe and North America and at least 2 in developing countries (A draft protocol is attached in Annex 3).

Kaufbeuren (Federal Republic of Germany), Dr von Cranach: Submitting a grant application to national or local agencies for participation in the study, may be possible. However, funds for travel and backtranslation of the schedule would have to be provided from elsewhere.

Pisa (Italy), Dr Deltito, Dr Mauro: Trained manpower for such a study is available. In addition, the centre has good computer facilities, including software, which may be offered for data analysis in the project.

Luxembourg, Dr Pull: The centre is willing to participate; an invitation letter from WHO would be helpful in local fund raising for the study.

Leiden (Netherlands), Dr Diekstra, Dr Heuves: Work with PDE is already an ongoing project and translation of the schedule is completed. Extra funds are necessary

for backtranslation. It is important for fieldwork to commence soon, in order to make use of manpower and other resources available now.

Groningen (Netherlands), Dr Slooff: The WHO Collaborating Centre could possibly participate; a request from WHO should be sent to the Department of Social Psychiatry.

Oslo (Norway), Dr A. Dahl: Could apply for a local grant but would need invitation from WHO before 1 May 1986.

Dar es Salaam (Tanzania), Dr Mbatia: Funds for participation of a Tanzanian team will have to be provided. A translation of the PDE into kiswahili will be soon available.

Nottingham (United Kingdom), Dr Tyrer: Participation can be regarded as possible. The centre has adequate funds for implementing the proposed study design.

London (United Kingdom), Dr Williams: The MRC General Practice Research Unit has the possibility of involving interested residents to take part in the project. It will be important to establish early on rules concerning authorship of publications. Data processing facilities are available at the Institute.

New York (United States of America), Dr Frances: Participation is possible.

Boston (United States of America), Dr Holzman: Participation very likely

White Plains, New York (United States of America), Dr Loranger: The centre will participate and can provide data analysis and will train interviewers. Additional funds will be needed for the latter activity.

WHO (Geneva), Dr Jablensky: Certain amendments to the draft research protocol will be made at WHO Headquarters within the next six weeks and circulated among prospective participants. Additional study sites may be proposed by WHO in the course of the current year.

Discussion of the Personality Assessment Schedule (PAS)

As an instrument based on a different approach to the assessment of personality disorders than the one of the PDE, the Personality Assessment Schedule(PAS) was discussed with a view to its possible use in the study as a complementary tool. The PAS is a well proven instrument, in existence since 1971 and published in 1979 (Dr Tyrer, Nottingham). It was developed for the needs of research based on clinical practice. By now it has been used with over 1600 respondents and informants. As time went by, the informant version proved to be more useful than the patient version and in most cases now only the informant version is applied. The interview takes about one half hour. The classification used is empirical, statistically derived, and it does not match either DSM-III or ICD criteria. However, the expected differences from the ICD-10 criteria are small. A 9-point rating scale is used. A training video tape for interviewers was shown at the meeting; several such tapes are available to centres on request.

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Review of the draft ICD-10 criteria and classification of abnormalities of adult personality and behaviour

In the discussion of the draft Section F6 (Abnormalities of Adult Personality and Behaviour) for ICD-10, the four main questions were:

(a) Can the proposed distinction between personality disorder and personality trait accentuation be made sharper?

(b) Is it possible to introduce in the preface to that section a clear statement as to what is to be regarded as personality, character, trait?

(c) Can better instructions be formulated regarding the rules of diagnosis and coding when personality disorder and psychiatric illness coexist?

(d) What are the minimum requirements and sources of information necessary for diagnosing a personality disorder or personality trait accentuation?

The term "personality accentuation" has been proposed because of the need to close the gap between "normality" and personality disorder, a gap which will result from the intended raising of the threshold for the diagnosis of personality disorder. However, the preliminary definitions and criteria for personality trait accentuation have been based on the unproven assumption that the latter is merely a mild form of personality disorder. There is at present no research instrument in existence to enable the collection of data necessary to establish whether there is, or not, a qualitative difference between personality accentuation and personality disorder. Provisionally, the scale of diagnosis in the draft IC-10 is a sliding one, assuming that there is a continuum from one to the other rather than a qualitative difference.

The concept of personality accentuation has been found useful in clinical practice e.g. for assessing traits that may affect the prognosis of a mental disorder or for describing the premorbid personality of the patient. However, it will be important to point out very clearly in the ICD-10 draft that personality trait accentuation is not itself a disorder.

The participants in the consultation reviewed in some detail the proposed classification and criteria for personality disorders in ICD-10. A number of specific suggestions were made, and these have since been taken into account in the subsequent revision of the section (Appendix).

Comparisons were made between the relevant sections of the draft ICD-10 and DSM-IIIR. The conspicuous absence from ICD-10 of the category "borderline" personality disorder was noted in particular, as well as that of other concepts such as "narcissistic" and "sadomasochistic" personality disorders. It was pointed out that while the "borderline" is probably a heterogeneous group of behaviour patterns, with no single underlying disorder, the remaining two categories, if at all valid, were of limited relevance outside the culture in which they had been developed.

In conclusion, it was agreed that:

(i) Dr Holzman would provide WHO with an updated list of descriptive personality traits for use in further revisions of the ICD-10 draft;

(ii) all participants would send their comments and annotations on section F6 (Abnormalities of Adult Personality and Behaviour) to Geneva.

Annex 1: List of participants

Annex 2: Agenda

Annex 3: Draft research protocol for an International Pilot Study of Personality Disorders.

Appendix: Revised draft of ICD-10 Section F6 (Abnormalities of Adult Personality and Behaviour).