British Journal of Psychiatry (1993), **162**, 265–277

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Editor: Ian Pullen

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Personality disorder and self-report questionnaire

SIR: Dowson (*Journal*, September 1992, **161**, 344–352) has provided further important evidence that the assessment of DSM–III–R personality disorder by self-report instruments such as the Personality Diagnostic Questionnaire (PDQ; or a modified version of the instrument) is invalid and that such instruments should not be employed in future studies. Unfortunately, he did not make this interpretation from his findings and encourages further use of the PDQ in clinical settings. His encouragement to use the screening test for comorbid personality disorders when patients are not able or willing to complete a questionnaire was puzzling after so clearly demonstrating that self-report and informant scores show so little resemblance.

His reference to the previous worrying findings of overdiagnosis by the PDQ was not as clear as it should have been. For the record, Hyler *et al* (1989) administered the instrument to 552 patients and compared the findings with clinicians' diagnoses. Those found by PDQ to have a personality disorder showed a mean of 3.0 Axis-II categories per patient compared with only 1.2 when diagnosed by a clinician. More importantly, the PDQ continued to diagnose a mean of 1.7 categories in subjects where clinicians diagnosed none.

Dowson is not correct in assuming that current interviewing instruments for Axis-II disorders are too long for routine clinical use. In-patients admitted to the East London Forensic Psychiatry Services are regularly diagnosed with the SCID-II administered by junior medical staff who are trained in its use at the beginning of each rotational placement in forensic psychiatry. Encouragement is given to supplement information obtained at interview with observations by patients' relatives and nursing staff. It is essential to improve training in the diagnosis of personality disorders in a service where 25% of patients have one or more of these conditions as their primary diagnosis. Clinical experience in forensic psychiatry indicates that there should be no short cuts to obtaining accurate personality disorder diagnoses. Both treatment and long-term management of mentally abnormal offenders can have adverse consequences when wrongly influenced by overdiagnosis or the diagnosis of a non-existent condition based on poor quality diagnostic techniques.

No study of schizophrenia would be accepted for publication where the researchers had handed out a modified PSE or SADS-L to be completed by the subjects. Similarly, no such instrument would be adopted by other researchers if clinicians could find the condition in only half the cases so diagnosed. Caron & Rutter (1991) have argued that future study of comorbidity is of major importance. The use of instruments that grossly overdiagnose Axis-II psychopathology will lead to few developments in this area.

CARON, C. & RUTTER, M. (1991) Co-morbidity in child psychopathology: concepts, issues and research strategies. *Journal of Child Psychology and Psychiatry*, **32**, 1063–1080.

HYLER, S. E., RIEDER, R. O., WILLIAMS, J. B. W., *et al* (1989) A comparison of clinical and self-report diagnoses of DSM–III personality disorders in 552 patients. *Comprehensive Psychiatry*, **30**, 170–178.

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AUTHOR'S REPLY: The different versions of the PDQ self-report questionnaire for DSM–III–R personality disorder (PD) have face validity in respect of DSM–III–R and have shown various other types of

https://doi.org/10.1192/S0007125000180201 Published online by Cambridge University Press

validity (i.e. degrees of success in measurement), as shown by significant relationships between PDQ scores and other variables (Morley & Snaith, 1989).

(a) PDQ scores have been shown to have predictive validity; for example, in relation to symptoms and signs of depressive disorders (Pfohl *et al*, 1987).

(b) A degree of construct validity has been demonstrated by factor analysis of PDQ scores in relation to the three clusters of PDs described in DSM–III–R (Dowson & Berrios, 1991).

(c) PDQ scores have shown concurrent validity in several studies by demonstrating differences between various clinically defined groups; for example, in relation to subgroups of patients with a history of anorexia nervosa (Dowson, 1992).

However, there can be poor agreement between PD diagnosis by questionnaire and structured interview; Hunt & Andrews (1992) concluded "the PDQ–R may well be tapping some dimension of personality, but it is inappropriate for the assessment of specific personality diagnoses ...". There are certainly discrepancies between PDQ PD diagnoses and clinical concepts of the thresholds for the use of PD diagnoses, as PDQ PDs can be found in 'normal' samples and several studies in patient populations have shown that the PDQ–R has lower thresholds for diagnosis than interview data. But these findings do not necessarily invalidate questionnaire data; cut-off points for PD diagnoses can be modified (although any cut-off point is arbitrary and loses information), while structured interviews are also subject to methodological problems. Perhaps PD is often underdiagnosed by interview methods (i.e. maladaptive patterns of behaviour are missed), particularly in relation to those criteria which do not depend on readily-identified behaviour.

Dr Coid questions the value of an informant's questionnaire when the patient is not compliant. However, the generally poor correlation between patients' and informants' total scores, or between scores for individual PDs, can disguise satisfactory agreement for certain individual PD criteria. But I accept Dr Coid's point that there is no short cut in obtaining a detailed PD assessment in the individual patient and I did not claim that a self-report instrument can achieve this. However, I believe that this format has a research role in groups of patients and, in some respects, such as examining relationships between subtle emotional and attitudinal states, self-report questionnaires may be at least as good as other methods. But, for the individual patient, PDQ self-report data can identify areas for further exploration in the clinical interview, including any obvious discrepancy between the patient's and informant's scores.

The self-report format requires further development (perhaps with scaled ratings for selected items), but has a track record as a research instrument and can complement information from interview assessments. The Screening Test for Co-morbid Personality Disorders (STCPD) also encourages us to look for a range of psychopathology from more than one PD category, which appears to accord with clinical reality in most personality-disordered patients.

DOWSON, J. H. (1992) Associations between self-induced vomiting and personality disorder in patients with a history of anorexia nervosa. *Acta Psychiatrica Scandinavica* (in press).

— & BERRIOS, G. E. (1991) Factor structure of DSM–III–R personality disorders shown by self-report questionnaire: implications for classifying and assessing personality disorders. *Acta Psychiatrica Scandinavica*, **84**, 555–560.

HUNT, C. & ANDREWS, G. (1992) Measuring personality disorder: the use of self-report questionnaires. *Journal of Personality Disorders*, **6**, 125–133.

MORLEY, S. & SNAITH, P. (1989) Principles of psychological assessment. In *Research Methods in Psychiatry* (eds C. Freeman & P. Tyrer), pp. 133–147. London: Gaskell.

PFOHL, B., CORYELL, W., ZIMMERMAN, M., *et al* (1987) Prognostic validity of self-report and interview measures of personality disorder in depressed inpatients. *Journal of Clinical Psychiatry*, **48**, 468–472.

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Combination treatment of depression

SIR: The interesting paper by Seth *et al* (*Journal*, October 1992, **161**, 562–565) can be supplemented by three other investigations which have reported the benefit of combined treatment with selective 5-HT uptake blockers (SSRIs) and tricyclic antidepressants (TCAs) in depressed patients (Weilburg *et al*, 1989, 1991; Nelson *et al*, 1991). None of these investigations has been controlled, but effects of combination treatment in patients unresponsive to first-line antidepressant medication are likely to be observations of clinical significance.

For those who may intend to use this drug combination it is important to take note that SSRIs can produce striking increases in plasma concentrations of co-administered TCAs. There have, for example, been reports of severe adverse reactions, including seizures, when fluoxetine has been combined with TCAs (Aranow *et al*, 1989; Preskorn *et al*, 1990). It may be that other SSRIs, such as sertraline, would be less likely to increase plasma TCA levels, but until formal studies are available, caution is needed when SSRIs and TCAs are combined. In this respect, the low doses of nortriptyline used by Seth *et al* are

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