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Abnormal Personality

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PART 1: DIAGNOSIS

Introduction

A distinction has to be made between psychiatric illnesses on the one hand and the various forms of abnormal personality on the other hand.

The two main classes of psychiatric illness are clearly defined and firmly placed within the context of clinical psychiatry. The major illnesses—the organic and functional psychoses—were already familiar to early mental hospital physicians. The minor illnesses—the psychoneuroses—were differentiated much later, but Sydenham by 1680 and Cheyne by 1733 were describing psychoneuroses as commonplace among medical patients, and Charcot's studies of hysteria in the 1870s resulted in widespread clinical recognition of this illness. Both psychoses and psychoneuroses are defined in terms of symptoms and signs, as is customary in medicine generally.

In contrast, the abnormal personalities began to receive attention only much later (Kavka, 1949), and isolated polemicists can still be found who dispute that the study and treatment of abnormal personality is properly the concern of psychiatrists.

The debate has grown as the out-patient responsibilities of psychiatrists have extended, some psychiatrists contending that patients with marital problems, suicidal behaviour, alcoholism, etc., are more properly the conconcern of social workers and non-professional helping agencies such as the Samaritans, the Marriage Guidance Council, etc. In such debate the question why some people become disorganized by their marriage problems or social setbacks, while others do not tends to be neglected.

In many instances the person suffering from abnormal personality does not come to direct attention, but is noticed from the repercussions of his social ineffectiveness or disturbed personal relationships. Wolff and Acton (1968) found that many more of the mothers of children attending a child psychiatric clinic had hysterical and sociopathic disorders than mothers in a control group; fathers of clinic children were more often sociopathic than control fathers.

Psychiatrists who are interested in the problems of abnormal personality are hampered by the unsettled state of the terminology for describing these states. In recent decades, to remove the stigma attaching to the label of psychopathy, the term 'sociopath' has been advocated to designate the most gross forms (Partridge, 1930). This term replaced 'psychopathic personality' in the official U.S. nomenclature (American Psychiatric Association, 1952), but it in turn has lately been dropped in favour of the term 'antisocial personality' (American Psychiatric Association, 1968). Section V in the International Classification of Disease of the World Health Organization, which deals with personality disorders, is to be reviewed in 1970 (Shepherd *et al.*, 1968).

Psychopathic personality, not surprisingly, therefore, continues to be 'a notoriously unsatisfactory diagnostic category' (Lewis, 1953). *Severe* abnormality of personality is found in those who harm society by aggressive acts or are a gross liability because of their fecklessness.

Abnormal personality of *moderate* degree (e.g. hysterical, schizoid, obsessional, etc.) is usually identified clinically, often when the affected person presents with accompanying physical or psychiatric illness.

The person with a *mild* degree of abnormality may subjectively identify impairment in his sense of well-being or in the proper expression of his impulses, and if sophisticated may spontaneously seek psychotherapeutic help; the development of general hospital psychiatry has

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also fostered clinical awareness of mild degrees of abnormal personality.

To initiate the present investigation, the following preliminary classification of abnormal personality, related to the A.P.A. (1952) classification, was adopted:

1. MILD—*Character disorder* (usually complained of by the patient himself):
   (a) Dependent type.
   (b) Detached type.
   (c) Assertive type.
2. MODERATE—*Personality disorder* (usually identified clinically):
   (a) Obsessional type.
   (b) Hysterical type.
   (c) Schizoid type.
   (d) Paranoid type.
   (e) Cyclothymic type.
3. SEVERE—*Sociopathy* (usually identified socially):
   (a) Aggressive type
   (b) Inadequate type.

Major defects are present in this system, both in its logical basis and in its clinical application. 1. The mild and the serious forms are described in terms of predominant impairment in relationships with other people, while the intermediate class bears classical labels signifying well-known personality dispositions resembling qualitatively the psychiatric illnesses for which similar terms are employed. 2. A second objection is that while classes are differentiated according to severity, patients in the intermediate class may be mildly, moderately or severely impaired. 3. The system is of unknown reliability, the suspicion being that clinicians, even when working in the same setting and agreed on the need for uniformity in use of terminology, may assign the same patient to different personality diagnoses.

AIMS OF THE INVESTIGATION

The present report describes the first stage in a long-term project to study the different forms of abnormal personality encountered clinically.

The three aims were:

1. To find out which types of abnormal personality are clinically differentiated, by analysing the judgements made by a number of psychiatrists about in-patients with recognized abnormal personality.

2. To test how psychiatrists employ diagnostic and descriptive terms pertaining to abnormal personality.

3. The development of a psychological test with which to measure abnormal personality (reported in a separate publication).

METHOD

A. *Sampling*

Patients who were being treated in the same in-patient unit at the Royal Edinburgh Hospital were selected to provide a range of recognized abnormal personalities. The 40 patients chosen for study were not taken to be a representative sample of abnormal personalities, but were chosen to serve as the basis for a pilot study.

B. *Psychiatrists' ratings*

Six psychiatrists, all of them male, took part in rating the sample of patients.

1. Forty patients (20 male, 20 female), all but a few known to all the psychiatrists, were assigned one of the 10 diagnostic labels shown above by each of the psychiatrists.

2. The forty patients were rated on a six-point scale for each of 18 descriptive items (see Table II), such as likeability, egocentricity, aggressive acting-out, etc., related to personality and behaviour (the items did not include descriptions of symptoms). The descriptive terms were selected to characterize chiefly the more gross forms of abnormal personality.

C. *Psychological testing*

The following tests were administered to the patients: the 16 P.F.; the Symptom-sign Inventory; and the Hostility-Direction of Hostility Questionnaire.

RESULTS

1. *Diagnostic agreement*

The diagnoses applied by the psychiatrists to the 20 male and to the 20 female patients were analysed. Five conclusions emerged from

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the use made by the psychiatrists of the diagnostic classification:

i. *Sex differences:* The most severe form of disorder (sociopathy) is diagnosed much more frequently in the case of men than for women (Table I).

TABLE I

Personality disorder diagnoses assigned by psychiatrists to male (N = 20) and female patients (N = 20)

	Male patients	Female patients	Total diagnostic decisions
Mild:			
Character disorder ..	30	24	54
Moderate:			
Personality disorder ..	43	68	111
Severe:			
Sociopathy	29	14	43
Total	102	106	208*

$\chi^2 = 11{\cdot}45$; $p < {\cdot}005$

* If all psychiatrists had made a personality diagnosis in the case of every patient, there would have been 220 decisions.

The clinicians more frequently assigned male patients to the mild and severe categories, while women were most often considered moderate in their degree of disorder.

Various explanations are possible for the finding that different decisions regarding degree of abnormality are made according to the sex of the patient: (a) Clinicians may be influenced by the sex of the patient when evaluating the personality; (b) abnormal personality may present differently according to the sex of the patient; (c) the sample may be biased, due to ward intake procedure or selection policy for this investigation.

ii. *Greater clinical agreement regarding women:* Psychiatrists agree more in diagnosing abnormal personality in women than they do about the diagnostic labels they apply to male patients. However, the greater diagnostic agreement for women is accounted for by the frequency with which women are diagnosed as 'personality disorder, hysterical type'. This diagnosis alone accounted for two-thirds of the diagnostic decisions in the female group of patients. Any study of abnormal personality in women is thus likely to be hampered by possible overusage of this diagnostic category.

iii. *Relative rarity of some categories:* Several diagnostic categories were not used at all or only rarely. The following labels were each applied only once: character disorder, assertive type; personality disorder, cyclothymic type; personality disorder, paranoid type. The last two labels were not applied at all in the case of women patients.

iv. *Good agreement regarding certain patients:* Certain types of abnormal personality are readily diagnosed. The psychiatrists were unanimous in their diagnostic decisions regarding seven out of 40 patients. Five women were diagnosed by all psychiatrists without exception as personality disorder, hysterical type; one man was uniformly diagnosed as personality disorder, schizoid type; and one man was diagnosed by all psychiatrists as a sociopath, aggressive type.

v. *Wide disagreement about certain other patients:* The considerable variation in application of diagnostic terms was demonstrated by the finding that four women and five men were assigned diagnoses from all three major categories, i.e. each of the nine was labelled mild, or moderate, or severe by different clinicians.

2. *Descriptive agreement*

The inter-rater agreement (five psychiatrists) for the 18 qualitative ratings regarding abnormal behaviour is shown in Table II. All coefficients are statistically significant for men, and all but three for female patients. It can be concluded that these descriptive items provide reliable data and may be a useful basis in future investigations.

It is of interest that the male patients were reliably assessed on all 18 items, but the women patients only on 15 items. The clinicians, all of them men, did not agree to any significant extent about the presence or absence in women patients of sexual deviation, conscience deficiency, or the capacity of the patient to conform with the expectations of the social milieu.

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TABLE II

Inter-rater agreement (5 psychiatrists) on 18 qualitative behaviour dimensions

i. *Items for which there is agreement beyond the ·001 level for both men and women patients*

1. Personality disorder dominant over illness
2. Disturbance in interpersonal relationships
3. Alcoholism
4. Antisocial acts
5. Evasion of obligations
6. Lack of regard for possible consequences of acts
7. Inability to profit from experience

ii. *Items for which there is agreement beyond the ·005 level for both men and women patients*

8. Autonomy
9. Likeability
10. Faulty control of impulses

iii. *Items for which there is agreement beyond the ·01 level for both men and women patients*

11. Drug addiction (less well-judged in men)
12. Associated psychiatric illness (less well-judged in women)
13. Aggressive acting-out—physical violence (less well-judged in women)

iv. *Items for which there is agreement beyond the ·05 level for both men and women*

14. Egocentricity (less well-judged in men)
15. Low anxiety, remorse, guilt (less well-judged in women)

v. *Items for which there is agreement beyond the ·001 level regarding men but no significant agreement regarding women*

16. Sexual deviation
17. Conscience defect
18. Inability to fit into the social group

PART 2: CLINICAL PRESENTATION

INTRODUCTION

Abnormal personalities 'represent dispositions which deviate from average and appear as extreme variations of human nature' (Jaspers). They are distinct from illness, which is essentially a change in the person resulting from a supervening process.

In the best known descriptive work on the subject (Schneider, 1950) abnormal personality is subdivided into ten types, which are not closely related to specific psychiatric illnesses and do not tend to pass over into them. In this system a cyclothymic type is not described nor do the obsessional or schizoid personalities feature as such in the classification. Schneider's system of abnormal personalities comprises distinct deviations which are different from the formal illnesses and do not produce them.

In everyday practice, however, psychiatric illnesses often present in association with personality deviations of more or less severity. The concurrence of psychiatric illness and abnormal personality has long been recognized (Henderson, 1939). When discussing drug treatment of psychiatric disorder, for example, some clinicians give particular emphasis to evaluation of the patient's personality state. 'To begin with, we must always try to distinguish . . . those with previously adequate personalities . . .' (Sargant, 1969); such well-endowed patients are differentiated from 'chronic inadequate people', who show disappointing responses to treatments which benefit the former.

The central feature of abnormal personality is some degree of persistent abnormality of character which is frequently, but not necessarily, antisocial in its manifestations. Degree of abnormality varies considerably, ranging from schizoid people who are valuable if somewhat unstable members of the community, through cyclothymics who have useful lives between their phases of disturbance, to psychopaths who are socially destructive (Bullard, 1941).

In one study, 6·8 per cent of the population was found to have major personality deviations (Essen-Möller, 1956). People can be abnormal in personality without being psychiatrically ill. These cases of abnormal personality without illness customarily escape the notice of psychiatrists. When the whole population is surveyed, as in an epidemiological investigation, they come to attention. This happens also in wartime: when the population has to be screened for military service, psychiatric interest in abnormal personality inevitably rises (Petrie, 1942; Goldstein, 1942).

In a German investigation during the first World War men with abnormal personality were classified with particular attention to their efficiency for military service, into: i. Disturbers ('Störer'), and ii. Failures ('Versager'). The former group were considered

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disruptive of military discipline and therefore useless for army purposes. The latter group were, to a certain degree, found usable (Wollenberg, 1917).

Among Swedish naval conscripts 33 per cent of the men were considered to have abnormal personalities (Ekblad, 1948), taking into account their capacity for social adjustment and their reaction when under stress. Two types were differentiated: i. *Asthenic* types, who paid too much attention to their bodies, and when under stress showed psychoneuroses, psychosomatic symptoms, poor concentration, etc.—they corresponded to Wollenberg's 'failure' types; ii. The *non-asthenic* group included all other types, and resembled the 'disturber' type of the earlier study—these men had shown asocial tendencies and, although self-assured, were swayed by temporary emotions and outside influences, and were also emotionally cold.

In a United States review which received much attention (Partridge, 1930), three groups of abnormal personality were suggested. i. The inadequate personality, more nondescript than the remaining pair, is insecure and unstable. ii. Another band of the spectrum includes the egocentric, the contentious, the paranoid, the explosive and the excitable. iii. The third group are the antisocial, including the liars, swindlers, vagabonds and the sexually perverse.

The association between illness and personality emerges more clearly when the individuals are studied not in a military or induction setting but in a hospital context. Then it becomes essential to evaluate each patient, first for the presence of illness, and second regarding the type of the personality (Foulds, 1965). Often the two occur concurrently in the same person. In a general population a very marked association was found (Hare and Shaw, 1965) between abnormal personality and psychoneurotic illness ('nervous disturbance').

An experimental study of psychiatric diagnosis (Shepherd *et al.*, 1968) showed that psychiatrists consider more than one diagnostic term necessary for adequate description of some cases, e.g. by adding a personality disorder to qualify the principal psychiatric diagnosis. Most psychiatrists taking part in the study regarded the patient's previous personality as an important factor in making a diagnosis. With the psychoneurotic illnesses particularly, psychiatrists may want to specify the associated personality disorder; the investigators state that the clinical association of certain personality types with certain psychoses may lead psychiatrists to the view that the personality disorder is integrated into the concept of the psychotic diagnosis and does not need to be expressed separately.

Some clinicians who separately evaluate the illness state and the personality type do so somewhat apologetically, in spite of the evidence to support their position. The investigators who described men admitted to psychiatric wards in Oslo general hospitals comment that their procedure of diagnosing separately disease reaction and personality type 'may seem artificial . . .' (Sundby and Nyhus, 1963). They differentiate three degrees of personality deviation: i. Normals with good general adaptability and vitality (21 per cent); ii. Vulnerable personalities (including schizoid, cycloid and obsessional personalities) who are liable to neurotic and minor maladaption under stress (62 per cent); iii. Definitely unusual and abnormal personalities or psychopaths (17 per cent). In agreement with Henderson's belief (1939), the prevalence of severe deviations was found to decrease with age.

In a British classification which proposed that three classes of abnormal personality should be differentiated (Curran and Mallinson, 1944), one type of individual was regarded as characteristically at risk of psychiatric illness: *Vulnerable* personalities: potentially unstable individuals who are bad psychiatric risks; they have a small margin of reserve, and when pinched by circumstances are liable to develop neurotic and psychotic illness. In a study of 88 depressive patients, 15 were considered to have vulnerable personalities (Curran and Mallinson, 1941).

The second type in this classification were: *Unusual or abnormal* personalities who have a greater degree of disorder. They are not necessarily potentially unstable or bad psychiatric risks. They are commonly called cyclothymic, schizoid, hysterical, obsessional, etc. The third type were: *Psychopathic* personalities,

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those who indulge repeatedly in antisocial acts, e.g. family black sheep or certain types of criminal. They are (a) predominantly aggressive or (b) predominantly inadequate.

The association between the different types of psychiatric illness and the various forms of abnormal personality is now recognized as a more complicated problem than this earlier statement of the position suggests. Little systematic research to explore the various relationships has yet been carried out.

Aim

The present report describes the associations found between the illness suffered by a patient and the degree and type of the related abnormality of personality.

Method

A. *Sampling*

Patients who were being treated in the same in-patient unit at the Royal Edinburgh Hospital were selected to provide a range of recognized abnormal personalities. That the 40 patients, 20 men and 20 women, constituted an incomplete sample was recognized. The patients included in the study enabled a pilot investigation to be carried out as a preliminary to a long-term project now in process.

B. *Psychiatrists' ratings*

Six psychiatrists took part. They rated each patient in terms of: i. a diagnostic classification system for abnormal personality; ii. a list of 18 descriptive items categorizing personality and behaviour characteristic chiefly of the grosser forms of abnormal personality (see Part 1).

Each psychiatrist rated the 40 patients on a six-point scale regarding all of the 18 descriptive items.

C. *Linkage analysis*

To discover whether any distinct types of patient emerged in terms of the behaviour ratings, correlations were calculated between the psychiatrists' mean ratings on the descriptive items for each patient and those of other patients of the same sex. (Five psychiatrists had rated half of the male and female patients, and six psychiatrists the other 20 patients.) On the association matrix obtained an elementary linkage analysis (McQuitty, 1957, 1961) was carried out.

The procedure is a typal method of demonstrating associations between variables (symptoms, test items or people). It defines the linkage between two items as being the largest index of association which a variable has with any of the other variables. Every variable is assigned to a cluster in terms of its highest index of association, usually a form of correlation coefficient.

Cluster methods are related to typal theory, which in general states that every member in a cluster is more like some other member of that cluster than it is like any member of any other cluster.

Results

For men and also for women four clusters emerge, as shown in Figs. 1 and 2.* Each cluster represents a different category of abnormal personality. Reciprocal pairs denoted by ⇌ are the key elements in each cluster. Members linked most directly to these are the next most typical, and the greater the number of intervening links between a member and the reciprocal pair the less that member will be typical of the cluster as a whole.

Descriptive Classification of Male Patients

i. *Type 1 male patient*

The features of this type of patient are his low scores on the behaviour attributes 7–18 in Table III, which classically are viewed as characteristic of sociopathy. Indeed, this type of man has marked personality assets: he is notably autonomous, likeable, well able to fit into his social group, responsible and conscientious, with firm control over his impulses; he is not at all antisocial, and is capable of foresight; he meets his obligations and learns from his experiences.

He is more ill psychiatrically than the sociopathic Types 3 and 4 males (see below), but not as ill as the Type 2 male.

* These types are not in the order in which they appeared in the statistical analysis, but were re-arranged for clarity of presentation.

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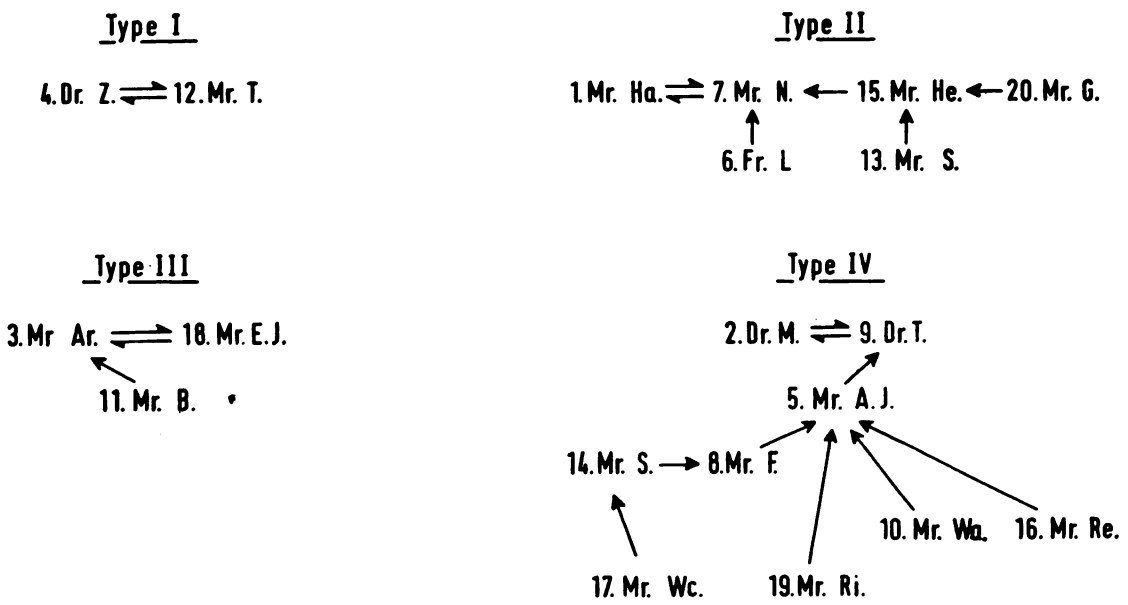


FIG. 1. Linkage analysis: men

He is characterized by his high anxiety, remorse and guilt, and his low level of social aggression or assertiveness. Fig. 1 points out the two patients, Nos. 4 and 12, who typify this category of abnormal personality. A clinical description of one follows:

4. *Dr. Z.*, aged 24, complained of panic attacks occurring in the general hospital wards where he worked, and in consequence of which he felt himself incompetent. His anxiety and sense of inadequacy used to improve whenever he left the ward after a period on duty.

He was the only child of a dominant and over-protective mother and a rather weak father. He had never lived away from home for any length of time. He did very well both at school and at University, always setting himself high standards. He had never been interested in sport and had few close friends. He planned his activities for years in advance; he had decided on his future specialty soon after his clinical work at medical school commenced.

Three years before his admission a less sexually inhibited man had taken from him a girl friend to whom he had been platonically attached for some years. In the ward he was painfully ashamed and reticent, not wanting to display any feeling. He was introspective, tidy and precise. He advocated self-control in ward meetings.

As his treatment progressed he developed a positive transference to his doctor, with marked dependency. He was then able to reveal strong hostility towards his dominant mother, and sympathy for his subservient father. He also conveyed his highly-charged phantasy life. He was interested in escapology, safebreaking being a particular preoccupation. He had a secret collection of pornography centering on large breasts. As treatment progressed further he became more spontaneous in social interactions and considerably more assertive, and he returned successfully to work, although many professional obstacles had to be faced.

The diagnoses clinicians give to the typical patients illustrating this type of abnormal personality are: personality disorder, schizoid (5 decisions); personality disorder, obsessional (3 decisions); personality disorder, hysterical (1 decision); and character disorder, withdrawn (1 decision).

Patients with Type 1 abnormal personality present clinically with superadded psychiatric illness. In the case of the characteristic patients the illness was a psychoneurosis.

ii. *Type 2 male patient*

The second type of presentation of abnormal personality among the men patients is also characterized by associated psychiatric illness, the superadded clinical symptomatology being a more gross aspect of the clinical picture than the abnormality of personality (item 5, Table III).

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TABLE III

Mean ratings of patients most representative of each type (males)

	Type 1 Nos. 4, 12	Type 2 Nos. 1, 7, 15	Type 3 Nos. 3, 18	Type 4 Nos. 2, 5, 9
1. Alcoholism	·2	·6	1·5	1·7
2. Drug addiction	7	·3	·5	2·4
3. Sexual deviation	·7	·7	1·6	·5
4. Associated psychiatric illness	3·5	4·5	1·7	3·3
5. Personality disorder dominant over illness (= 5)	3·4	2·4	4·9	4·2
6. Disturbance in interpersonal relationships	3·5	3·7	4·8	3·6
7. Autonomy (lack of = 5)	1·7	4·0	2·9	3·3
8. Likeable (not likeable = 5)	·9	1·7	3·0	2·6
9. Inability to fit in social group	2·2	2·9	4·2	2·7
10. Conscience-defect	1·5	1·9	4·5	3·1
11. Faulty control of impulses	·9	2·8	4·6	3·6
12. Antisocial acts	0	1·3	4·8	3·0
13. Lack of regard for consequences of acts	·5	2·1	4·7	3·2
14. Egocentricity	2·3	3·4	3·8	3·8
15. Evasion of obligations	1·3	3·2	4·7	3·7
16. Inability to profit from experience	1·2	2·9	4·9	4·0
17. Low anxiety, remorse, guilt (= 5)	·9	1·5	4·6	3·2
18. Aggressive acting-out	·3	1·0	4·5	3·1

Inspection of the clinical records shows that four men in cluster 2 suffered from psychotic illness, and two from severe obsessional illness. Item 4 also emphasizes the gravity of illness in this type.

In personality these men are markedly dependent (item 7) and almost as egocentric as the Type 3 and 4 males. They fail in meeting their obligations, but this is on the basis of omission and not antisocial commission, for they are conscientious men who tend to be anxious and unaggressive.

15. *Mr. H.*, came to Britain when aged six years. He was a bed-wetter until aged seven. Because of language difficulty and because his family was snobbish he was discouraged from mixing in the neighbourhood. He did well at grammar school and was made head boy. He liked to oppose authorities but at the same time to get his plans accepted. He came to Edinburgh and did well in his first two years of medicine but failed in the third and fourth. He was uncertain whether he was preparing for the right career. He found it shattering when he was assigned for a clerkship in a psychiatric hospital. He was intimate with a girl at the time, but he felt lonely and cut off from people.

His mother had died by suicide from gassing when he was 15 years old. He had been very close to her, and her death upset him extremely. He was her favourite; his brother was preferred by his father.

On admission he was very tense and depressed. He could not express words coherently to make a sentence. He was very indecisive. He was restless, and appeared acutely unhappy. He accused himself of exploiting his girl friend, of selfishness and of uselessness. He said he should have got over his illness himself. He would engage staff members in intense encounters, inarticulately straining to make himself understood. He thought people were watching him. He was guilty and frightened. A schizo-affective psychosis in a schizoid personality was diagnosed.

The personality diagnoses assigned by the clinicians to the three patients characteristic of this type are as follows: personality disorder, schizoid (11 decisions), hysterical (4 decisions), obsessional (1 decision); character disorder, dependent (12 decisions), withdrawn (1 decision), over-assertive (1 decision); sociopathy, passive type (1 decision). The two most common labels thus emphasize schizoid features with dependency.

iii. *Type 3 male patient*

The attributes characterizing the third type of patient are low scores on items 4, 7 and 8, and high scores on items 5, 6 and 9–18, as shown in Table III. The men typical of this

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cluster meet the descriptive criteria classical of the psychopath. They are not likeable; they cannot fit into the social group; they are defective in conscience; they control their impulses poorly; they behave antisocially; they lack foresight; they lack consideration for others; they evade obligations; they cannot profit from experience; they are guilt free; they act out aggressively.

They have little associated psychiatric illness (i.e. the personality disorder is far more gross a component of the presenting state than any accompanying symptomatology). They operate fairly independently of other people, and tend to some sexually deviant behaviour. The disturbance in their personal relationships is very gross.

Fig. 1 demonstrates that the patients representing the Type 3 patients are Nos. 3, 18 and 11. The former two resemble each other, and 11 has his main affinity with 3. The last presented clinically as follows:

3. *Mr. A.R.*, a 30-year-old truck driver, was referred because of headaches, moodiness and tension, and violent behaviour at home. He had assaulted his wife on a number of occasions, and was afraid that she might leave him.

The fifth child of unhappily married parents, who argued frequently (his father drank heavily), he sustained two head injuries (at 6 and 13 years) recovering without neurological sequelae. His school performance had been poor. He was popular, but often played truant. He was seldom punished at home. During his adolescence he broke windows, planned robberies, stole brass and copper, and broke into coin boxes. While in the army (17–20 years) he made few friends. He drank excessively and used stimulant drugs; he felt lonely and insecure. He began to get into fights. He got a girl pregnant and married her at 21 years; he has three children. He has had many jobs, mainly as a driver, and has had numerous accidents, at times when under the influence of drink. He killed dogs by riding them down. He often lost his jobs because of difficulties in relationships with work associates. He had taken part in adolescent homosexual play and retained a fear of being homosexual. He was promiscuous. He masturbated compulsively after marriage, sometimes stimulating himself anally. He had extramarital affairs unknown to his wife, and was distressed on occasion by impotence. He had attempted suicide three times. He had been convicted for car theft.

He had great difficulties in his personal relationships, partly because of his extreme suspiciousness and his high hostility, and also because of his poor self control and tendency to short-circuit reactions. His self-regard was low. He seldom enjoyed himself. He described himself as often exploiting other people. During his stay in the ward, he frequently left the ward on impulse to go out drinking. His relationships with fellow-patients and staff were superficial. He engaged in petting with women patients. When asked to help persuade a fellow-patient from going to the pub, he went to the pub himself. He reacted with anger when confronted or criticized. His dejected mood and social withdrawal had improved rapidly after admission, but shortly after his discharge from hospital he confessed at an out-patient visit that he had broken into a shop.

The psychiatrists without exception diagnosed this man (independently of the descriptive ratings) as a case of sociopathy, aggressive type, on the basis of their knowledge about him in the ward. For the three patients characteristic of this type the diagnoses were sociopathy, aggressive (12 decisions); personality disorder, schizoid (2 decisions), obsessional (1 decision).

iv. *Type 4 male patient*

The behavioural feature of this type of man can be seen from Table I. He also meets the criteria of psychopathy as classically described, but these features are less marked than in the Type 3 male.

This type is further characterized by the presence of dependency (item 7), and by the presence of addiction (item 2). This is probably the basis for the greater evidence of psychiatric illness than in the type 3 male (although the personality disorder predominates in the clinical picture over any associated symptomatology). Alcohol addiction and drug dependence both occur in the cluster.

Fig. 1 shows the men most representative of this type, Nos. 2, 9 and 5.

5. *Dr. M.* was first seen as a medical student aged 21 years. He had a head injury a year previously. He had outbursts of rage, when he shouted, broke things, flourished an iron bar, swallowed sleeping capsules. He was detached and self-condoning, and was considered an emotionally immature person without serious psychiatric illness.

He was subsequently seen for episodes of amnesia, irritability and violent behaviour, with anxiety and inability to concentrate. He was given much psychiatric support during his studies. Moody with his parents, childish in interviews, he was nevertheless able to graduate and to marry. He was re-admitted following excessive drinking, drug-taking and disturbed behaviour, including assaults on his wife and a conviction for drunken driving. His poor tolerance of any stress was evident, as was his dependency and great readiness to enlist help from others. His wife sought refuge in another relationship and became pregnant. The child was all too evidently not the patient's. He accepted the child only after a hospitalization, during much of which he presented himself with much moral indignation as the wronged husband.

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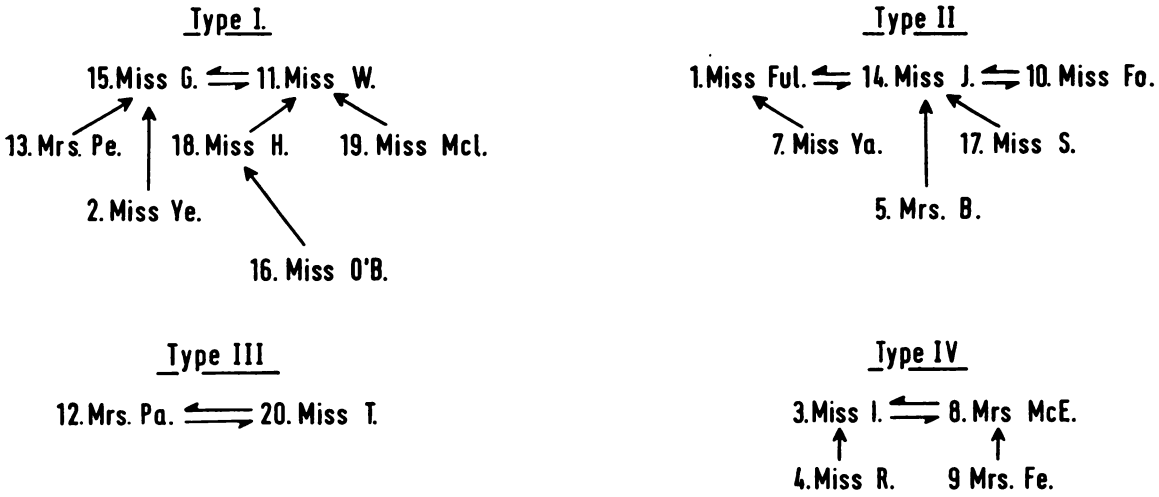


FIG. 2. Linkage analysis: women

He made limited use of psychotherapy. He had to be re-admitted to hospital when, using alcohol and barbiturates excessively, he set fire to his bed and hit his wife, who was forced to move out of the house with the children. He was agitated and restless when seen, self-justifying and unco-operative, disorientated to such a degree that delirium was diagnosed. The toxic psychosis resolved rapidly in hospital and his marriage rift was patched up.

The psychiatrists diagnosed men in this cluster as: sociopathy, passive (11 decisions), aggressive (3 decisions); personality disorder, schizoid (3 decisions), hysterical (3 decisions), paranoid, obsessional, cyclothymic (1 decision each); character disorder, dependent (9 decisions). The chief diagnosis is thus sociopathy, passive type, the next most common diagnosis also stressing dependency features. The descriptive items portraying the type give prominence to the frequent concurrence of an addictive state complicating the personality disorder.

Descriptive Classification of Women Patients

i. *Type 1 woman patient*

The typical women in this cluster (Fig. 2) seem to correspond to Type 1 males. They are characterized by low scores on items 7 and 8 and 11–18 in Table II.

This type of woman is thus highly likeable and autonomous, and conspicuously low in all attributes characteristic of sociopathy. She meets her obligations responsibly, aggressive acting-out is absent or nearly so, and anxiety, remorse and guilt are prominent. In addition, a relatively high degree of associated psychiatric illness characterizes the clinical presentation of this type.

As Fig. 2 shows, the patients most representative of this type are Nos. 11 and 15. A clinical description of the former will show that she resembles the Type 1 male both in positive personality potential and also in the active and secret phantasies characterizing her mental life.

11. *Miss W.*, a first-year student of English aged 20 years, was admitted as an emergency with depression. She had been about to kill herself by hanging, but changed her mind and removed the rope from her neck. She had ruminated for four months about being pregnant; she sent off urine by post for pregnancy tests and saved money from her student grant for an abortion. Never having missed a period and never having had intercourse, she recognized these actions as irrational. The only child of immigrant Jewish parents, she had gone at nine years of age to a Catholic school and had become a Catholic herself. She felt extremely lonely after arriving at university. She had always been excessively particular about her toilet and about cleanliness generally. She wrote notes to remind herself of tasks ahead. She idealized her mother. She planned to excel in examinations to please her mother. When her latent hostility towards her domineering and uncomprehending mother became overt, the patient became increasingly self-reproachful and also aware of

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resentment directed at her mother. She left the ward to attempt suicide with sleeping pills in a cinema. After this acting-out her illness improved rapidly.

When the 31 personality diagnoses assigned to this type were inspected, the majority (24) were of personality disorder: hysterical (16), schizoid (4) and obsessional (4). This also was the case with the Type 1 male of whom these women are clearly the female counterpart. In their case as well the associated psychiatric illness is usually of psychoneurotic type. However, this personality configuration in women unfortunately becomes obscured clinically by diagnostic over-use of the term 'hysterical personality disorder'.

ii. *Type 2 woman patient*

The woman patient of this type at first glance appears to lack a male counterpart. She is characterized by items 5, 7, 9, 14 and 17 in Table II. The patient shows marked lack of autonomy, marked inability to fit into the social group, and gross egocentricity; she is not antisocial. The abnormality of personality is more prominent than any associated psychiatric illness. The patient is remarkably free of anxiety.

Fig. 2 shows that the patients most representative are Nos. 1 and 14. The former appeared clinically as follows:

1. *Miss F.*, aged 29 years, was the only child of a highly successful self-made businessman. Her mother was a hypochondriac, and in youth the patient was made to feel responsible for the mother's many complaints of illness; the mother cried when the patient first went to school, and did not want her to grow up. The patient and her mother competed for the father's affections. The patient wet her bed until 6 and bit her nails until 8 years of age. When 10 she was attacked by a mastiff and she had had fourteen plastic surgical operations to her face by the time she was 15 years old. Her mother is said to have held that from the day she had the dog bite she changed from a nice little girl to 'a horrible spoilt, nasty bitch'.

She worked at a number of secretarial jobs, and tried dress-designing. Then she tried to work in Canada, leaving Britain partly to 'spite' a man to whom she was engaged. She had to return after an affair with a man in Canada; she was involved with a succession of other men, and made a suicide attempt. She lived with her father and bred dogs. A relationship with yet another man, whom her father planned to make his partner, ended when she became increasingly phobic.

She became afraid of travelling by bus, plane or train. She could not go to theatres, cinemas or dances. She entered psychoanalytic treatment, but a photograph of her therapist displayed in his consulting room of himself at a party drinking champagne angered her, and with her father's support she ended treatment. It was through his initiative that she was admitted to hospital. While an in-patient she formed intense attachments to male fellow-patients, and she had a stormy relationship with her doctor,

TABLE IV

Mean ratings of patients most representative of each type (females)

	Type 1 Nos. 11, 15	Type 2 Nos. 1, 14	Type 3 Nos. 12, 20	Type 4 Nos. 3, 8
1. Alcoholism	0	0·1	0	*3·6*
2. Drug addiction	0	0·1	0·1	*1·2*
3. Sexual deviation	0·2	0·8	0·2	0·9
4. Associated psychiatric illness	4·1	3·9	4·1	*3·5*
5. Personality disorder dominant over illness (= 5)	3·3	*4·0*	3·4	3·4
6. Disturbance in interpersonal relationships	3·8	4·2	*4·3*	3·1
7. Autonomy (lack of = 5)	*2·7*	*3·6*	3·1	3·1
8. Likeable (not likeable = 5)	*1·3*	1·8	*2·4*	2·1
9. Inability to fit into social group	2·1	*2·6*	1·8	1·9
10. Conscience defect	3·8	3·6	3·5	3·6
11. Faulty control of impulses	*2·0*	3·4	*4·5*	3·8
12. Antisocial acts	*0·1*	1·3	*2·6*	2·2
13. Lack of regard for consequences of acts	*0·9*	2·9	2·9	*3·3*
14. Egocentricity	*1·8*	3·9	4·0	3·1
15. Evasion of obligations	*0·7*	3·5	3·4	*3·7*
16. Inability to profit from experience	*1·7*	3·7	3·7	3·8
17. Low anxiety, remorse, guilt (= 5)	1·2	*2·5*	1·1	*2·9*
18. Aggressive acting-out	*0·8*	1·5	*3·3*	1·8

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frequently summoning her father to intervene on her behalf. After innumerable dramatic vicissitudes she was discharged to live in a hostel apart from her father, and began to work, while he at length remarried. Her treatment continued on an out-patient basis, achieving the two goals set initially: she separated from her father and herself married.

The question arises whether this Type—characteristically diagnosed by (male) psychiatrists as suffering from hysterical personality disorder—may be the female equivalent of the Type 2 male. She too is characterized by marked lack of autonomy. However, while the dependent Type 2 males are rated as conspicuously ill psychiatrically, their associated illness predominating over their abnormal personality, the Type 2 women have high ratings for inability to fit into their social group (item 9), and for disturbances in personal relationships (item 6).

The possibility exists that dependent males with personality disorder present clinically when they develop grave psychiatric illness, but correspondingly dependent women come to attention without such disabling superadded illness, their equivalent clinical presentation being conspicuous difficulty in personal relationships.

When the diagnostic labels assigned by psychiatrists to these patients are inspected, 23 decisions favour personality disorder (22 hysterical, 1 schizoid), 10 character disorder and 1 sociopathy.

There is suggestive evidence here that personality disorder of hysterical type in women may occur—in terms of clinical presentation—where men tend also to present with passivity and moderate-degree abnormal personality. However, the male Type 2 patient is often assessed clinically as schizoid or obsessional.

A helpful limitation of the over used term 'hysterical personality disorder' may be to require, in addition to the characteristic abnormality, that the person is not antisocial, is relatively likeable, but is grossly passive and dependent and unable to achieve a social adjustment. That Type 2 women are remarkably free of anxiety suggests the excessive utilization of denial as a mechanism of defence.

They are to be differentiated plainly from the Type 1 woman, for whom the label 'hysterical' is clearly not equally apposite, considering that she is more likeable, autonomous, controlled, and prudent, that she is not egocentric, and is also both highly responsible and capable of learning from experience.

iii. *Type 3 woman patient*

The third type of woman patient is characterized by items 8, 11, 12, 14 and 18 in Table II. She is conspicuous for being grossly aggressive in her behaviour, for her antisocial actions, for being highly impulsive and for not being likeable.

Fig. 2 shows that the women most representative of this type are Nos. 12 and 20. The latter presented clinically as follows:

Miss T., aged 20, was admitted, after a series of emergency admissions to various medical and surgical wards, with complaints of abdominal pain and blackouts. She suffered from conversion hysterical psychoneurosis, the symptoms apparently following the death of a boy friend. In the course of her treatment more and more disruptive personal experiences were progressively revealed. She gave forth initially that she was 'a poor girl who had been raped', but it rapidly became evident that she was promiscuous.

In the ward she behaved in an unpredictable, impetuous and childish way, extremely demanding of the staff's time and possessive towards her doctor. She flagrantly manipulated patients and staff alike, often by fainting when her wishes were not met, vomiting, developing aches and pains, threatening to kill herself, and running away on impulse from the ward. When her unacceptable behaviour was commented on, she would weep in an outburst of rage and remorse, but afterwards rapidly regained her composure.

The diagnostic label unanimously assigned to this patient by clinicians independently of the descriptive items was personality disorder, hysterical type.

On the basis of the descriptive items characterizing the cluster, the Type 3 woman to some extent resembles the Type 3 male, particularly similar in the attributes of unlikeability, antisocial acts and aggressive acting-out. Aggressive men are guilt-free, but women of this type are anxious and guilty.

Clinicians are liable to mask this grossly abnormal behaviour syndrome in women by use of the 'hysterical personality disorder' label, which is probably misused when applied to women who are grossly unlikeable, antisocial, and aggressive to other people.

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iv. *Type 4 woman patient*

The last type of presentation of abnormal personality in women patients has the features shown by items 1, 2, 13, 15 and 17 in Table II.

These women characteristically present with alcoholism and dependence on drugs, the two forms of addiction often combined. They have many of the impulsive and antisocial features of the Type 3 woman, but to a less marked extent. They are to be identified on the basis of their lack of regard for the consequences of their acts, their evasion of responsibilities, and their low anxiety, guilt and remorse.

Fig. 2 shows the cluster of women comprising this type. Most typical are Nos. 3 and 8. The former presented clinically as follows:

Miss I., aged 23 years, is the oldest child of a high-ranking official. Her mother has Korsakov's psychosis from chronic alcoholism.

The patient was admitted with phobic symptoms and a suspicion that she also was drinking excessively, which she denied.

As a child she had been afraid of the dark. She did not like secondary school as she found it 'above my head'. She became a salesgirl at 15 years, but her father made her change to a secretarial job. She had had a succession of jobs; one she gave up when her employer proposed marriage to her. She had had many boy friends, most of them for a short time. Although promiscuous and at the time of admission engaged for four years, she was afraid of marriage. She had taken part in the nursing of her demented mother, the severity of whose illness she minimized, on occasions secretly supplying her with drink. She often took her mother's place at official functions.

In the ward she was vague, casual, indifferent and superficial. She seemed below average in intelligence, but cognitive tests did not support this impression. She continued as an in-patient to rely emotionally in a passive, casual way on the boy friend who had ferried her to work. She occasionally drank secretly in the ward, as revealed by bottles found among her belongings. She allowed another patient to attempt intercourse with her. In drug-assisted abreactive sessions she expressed anger towards her mother and disappointment in her father, but she could not make progress with these themes during individual psychotherapy or in ward group meetings.

Women patients in this cluster resemble the Type 4 men, in the presence of addiction (alcoholism), evasion of obligations, low anxiety or guilt, and lack of regard for the consequences of their actions. The diagnostic labels assigned among the 23 diagnostic decisions to the women in this cluster included sociopathy, passive type (4 decisions) and personality disorder, hysterical type (10 decisions). This distinct personality type, therefore, once more tends to get obscured under the hysterical diagnostic label.

Summary

Part 1

1. This preliminary study of the clinical presentation of abnormal personality shows that psychiatrists more reliably categorize patients in descriptive terms than by use of diagnostic terminology. They do not agree about the nosological label to be applied to an individual patient's personality, but show better agreement in categorizing selected aspects of the patient's behaviour.

2. The considerable variation among psychiatrists in their use of the diagnostic classification occurred in spite of their regular working contact and their frequent discussions about the system of classification. The lack of reliability may be improved by more thorough briefing of the raters about diagnostic terms, or by ensuring that all clinicians have the same amount of personal knowledge about individual patients, which was known not to be the case in the present investigation.

Part 2

The investigation differentiates four types of abnormal personality, which may be designated as follows:

Type 1. *Inhibited personalities:* The patients have disturbed personal relationships and difficulty in fitting in socially. They are anxious and guilty and do not act aggressively. They have marked assets of personality, sociopathic features being absent.

Typ 2. *Personality disorders:* These patients have more marked disturbance in interpersonal relationships and grosser difficulty in adapting socially. Their main feature is their dependency. They fail to meet obligations, not because they are antisocial but because they are self-absorbed and lacking in aggression. They tend to present clinically as hysterical disorder in the case of women, and as schizoid or obsessional personality disorder in the case of men.

Type 3. *Aggressive sociopathy:* These patients are unlikeable, antisocial, highly impulsive, and aggressive.

Type 4. *Inadequate sociopathy with addiction:* These patients are dependent on drugs or

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alcohol, and are grossly egocentric; they evade obligations, lack regard for the consequences of their actions, and are free of guilt or anxiety.

The four types support the major categories of the original classification set out in Part 1 (i.e. the severity dimension), but descriptive labels were not reliably applied. There are important sex distinctions among the types, e.g. Type 2 males present when grossly ill, often with psychoses, while the equivalent type in women present clinically without serious illness but with major social complications. Type 3 men are guilt-free, but an aggressive sociopathic state in women is accompanied by anxiety and self-blame; the Type 3 male, moreover, may show sexually deviant behaviour, but this is not a feature of the women in that category.

One of the preliminaries to further exploration of the clinical manifestations of personality disorder is a clearer definition of hysterical disorder in women. On the basis of the present study we suggest that this personality diagnosis can usefully be confined to women whose relationships are grossly disturbed and who are both egocentric and also passive and dependent; the term loses its discriminating value when applied to women who are aggressive and antisocial.

These findings are derived from a relatively small sample of patients, and one moreover which is not representative of abnormal personalities in general. The results are being tested further in an investigation now in progress.

References

American Psychiatric Association. *Diagnostic and Statistical Manual, Mental Disorders*, 1st Ed. 1952; 2nd Ed. 1968. Washington, D.C.

Bullard, D. M. (1941). 'Mood disorders and psychopathic personalities.' *Psychiatry*, **4**, 231.

Curran, D., and Mallinson, W. P. (1941). 'Depressive states in wartime.' *Brit. med. J.*, *i*, 305.

Curran, D., Mallinson, W.P. (1944). 'Psychopathic personality.' *J. ment.Sci.*, **90**, 266.

Ekblad, M. (1948). *A Psychiatric and Sociologic Study of a Series of Swedish Naval Conscripts*. Copenhagen: Ejnar Munksgaard.

Essen-Möller, E. (1956). 'Individual traits and morbidity in a Swedish rural population.' *Acta psychiat. neurol. Scand.*, Suppl. 100.

Foulds, G. A. (1965). *Personality and Personal Illness*. London.

Goldstein, H. K. (1942). 'Neuropsychiatric evaluation of the potential soldier.' *Amer. J. Psychiat.*, **99**, 29.

Hare, E. H., and Shaw, G. K. (1965). *Mental Health on a New Housing Estate*. London: Oxford University Press.

Henderson, D. (1939). *Psychopathic States*. New York.

Jaspers, K. *General Psychopathology*. Engl. transl. 1963, by J. Hoenig and M. W. Hamilton. Manchester.

Kavka, J. (1949). 'Pinel's conception of the psychopathic state.' *Bull. Hist. Med.*, **23**, 461.

Lewis, A. J. (1953). 'Health as a social concept.' *Brit. J. Sociol.*, **4**, 109.

McQuitty, L. L. (1957). 'Elementary linkage analysis for isolating orthogonal and oblique types and typal relevancies.' *Educational and Psychological Measurement*, **17**, 207–29.

—— (1961). 'Elementary factor analysis.' *Psychological Reports*, 71–8.

Partridge, G. E. (1930). 'Current conceptions of psychopathic personality.' *Amer. J. Psychiat.*, **10**, 53.

Petrie, A. A. W. (1942). 'Types of psychopathic personality.' *J. ment. Sci.*, **88**, 491.

Sargant, W. (1969). 'Physical treatments of anxiety.' In *Studies of Anxiety*, ed. M. H. Lader. British Journal of Psychiatry Special Publication No. 3. London: Headley Brothers.

Schneider, K. (1950). *Die Psychopathischen Persönlichkeiten*, 9th edition. Vienna. Translated M. W. Hamilton, 1958. London: Cassell.

Shepherd, M., Brooke, E. M. Copper, J. E., and Lin, T. (1968). 'An experimental approach to psychiatric diagnosis.' *Acta psychiat. Scand.*, Supp. 201.

Sundby, P., and Nyhus, P. (1963). 'Major and minor psychiatric disorders in males in Oslo.' *Acta psychiat. Scand.*, **39** (2), 519.

Wolff, S., and Acton, W. P. (1968). 'Characteristics of parents of disturbed children.' *Brit. J. Psychiat.*, **114**, 593.

Wollenberg, R. (1917). In *Psychopathische Persönlichkeiten im Kriege*. ed. L. Jacobsohn. Berlin.

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