FERNANDO, S. J. M. (1973) Sociocultural factors in depressive illness: a comparative study of Jewish and non-Jewish patients in East London (MD thesis). Cambridge: University of Cambridge.
GREEN, M. (1984) The Jewish mother. In *Women: Cultural Perspectives* (a conference report). Transcultural Psychiatry Society.
HARRISON, P. (1983) *Inside the Inner City*. Harmondsworth: Penguin Books.
KIDORF, I. W. (1963) Jewish tradition and Freudian theory of mourning. *Journal of Religion and Health*, **2**, 248–252.

Diagnosis of personality disorder

SIR: I do not agree with the statement by Casey & Tyrer (*Journal*, February 1990, **156**, 261–265) that a long-standing clinical attitude towards personality disorder and mental illness is that the patient is presumed to have either one or the other. The ICD–9 (World Health Organization, 1978) allows more than one diagnosis to be made so that an illness and personality label can both be given to a patient if required. Also, with axis I and II of DSM–III (American Psychiatric Association, 1980), it is possible to make a diagnosis of psychiatric illness or personality disorder alone, or to make both diagnoses in the same patient.

It is not surprising that distinguishing between neurotic disorder and personality disorder in the presence of chronic neurotic traits is extremely complicated. The ICD–9 does not give guidance on how to distinguish personality disorder from neurosis or from normal personality. In the light of such ambiguities, I found the final suggestion that general practitioners, when referring, should convey their personality assessments concisely and precisely, although laudable, rather naïve.

The main finding, that of the unexpectedly higher occurrence of personality disorder in general practice patients with conspicuous psychiatric morbidity, is alarming. However, I wonder if this could be because of the instrument used. The Personality Assessment Schedule (PAS) differs from all other instruments for assessing personality disorder in deriving the classification primarily from a computer program and adopting a dimensional approach rather than a categorical one for diagnosis. Its hierarchical structure may have lost information important in the general practice setting of the study, and its dimensional approach makes the question of caseness difficult.

Finally, the authors argue that their figure of 28% of all patients having a diagnosis of personality disorder is a true finding, since there was significantly greater social dysfunction in these patients. The PAS only refers to social adjustment. If their patients' sense of subjective distress had been noted, would they all still have qualified for the diagnosis of personality disorder or would they have been included in the less damning category of personality traits of psychiatric significance?

RAY TRAVERS

Psychiatric Day Hospital
Halton General Hospital
Runcorn

References

AMERICAN PSYCHIATRIC ASSOCIATION (1980) *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn) (DSM–III). Washington, DC: APA.
WORLD HEALTH ORGANIZATION (1978) *Mental Disorders: Glossary and Guide to their Classification in Accordance with the Ninth Revision of the International Classification of Disease* (ICD–9). Geneva: WHO.

SIR: Dr Travers fails to appreciate the gap between the ideal and the real world of clinical psychiatry. We agree that ICD–9 and DSM–III do allow for more than one diagnosis but this is rarely adhered to in practice. Even case registers, the bastions of epidemiological information, only cater for single diagnoses and the Department of Health has adhered to this approach also in national statistics.

In pointing to our naïve belief that general practitioners (GPs) should be encouraged to provide information on the patient's personality, Dr Travers is succumbing to clinical nihilism. If the family practitioner is not in a position to give details of the patient's pre-morbid traits and functioning, then who is? To suggest otherwise is to undermine the collaboration suggested as necessary by the World Health Organization (1973) between GPs and psychiatrists. Personality assessment is less of a sophisticated academic exercise than a skill that can be taught, and is grounded in the recognition of the separation between mental-state diagnosis and personality status (axis I and axis II).

Dr Travers' more substantive worries about the PAS have already been covered in the original paper. The suggestion that the cut-off for deciding on personality disorder in this population is too high and allows both categorical and dimensional diagnoses, is erroneous. The PAS adopts the approach used in clinical practice (i.e. that of diagnosing personality disorder only when it impinges on others). Within the PAS it is possible to measure personal distress, but to make a diagnosis of abnormal personality at this level would be over-inclusive and probably most people would meet these broad criteria. Setting it at the level used in our study has found constructive and predictive validity – those with personality disorder are significantly more socially dysfunctional (Casey *et al*, 1985), and have more frequent contact with

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