beyond the four- to eight-week designs that are usual. This will probably only happen when the CSM and FDA insist on chronic studies to justify chronic prescription for chronic disorders.

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Near-death experience

SIR: The article by Roberts & Owen (*Journal*, November 1988, **153**, 607–617) called to mind a recent article by the philosopher Sir Alfred Ayer (1988), entitled "What I saw when I was dead". Sir Alfred's heart evidently stopped beating for four minutes after he choked on a slice of smoked salmon. On recovering he described the experience to a French friend: "Did you know that I was dead? The first time I tried to cross the river I was frustrated, but my second attempt succeeded. It was most extraordinary. My thoughts became persons." He says further, "I was confronted by a red light, exceedingly bright and also very painful even when I turned away from it. I was aware that this light was responsible for the government of the universe. Amongst its ministers were two creatures who had been put in charge of space."

In analysing the experience, Sir Alfred says it "could well have been delusive. A slight indication that it might have been veridical has been supplied by my French friend, or rather by her mother, who also underwent a heart arrest many years ago. When her daughter asked her what it had been like she replied that all she remembered was that she must stay close to the red light."

Sir Alfred's experience corresponds significantly to the description of NDE provided by Greyson (1985), incorporating parts of the 'transcendental component', i.e. encountering guides, coming to a border of no return (in this case the river), and parts of the affective component, i.e. being surrounded by a brilliant, warm (in this case, red) light. His recollection, "my thoughts became people" is reminiscent of the experience that we, as psychiatrists, have with psychotic patients; i.e. there is a correspondence between their thoughts and the verbal productions/forms of their hallucinated objects.

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Teenage depressive stupor

SIR: We read with interest Powell *et al's* report of depressive stupor in a 13-year-old boy (*Journal*, November 1988, **153**, 689–692). The authors' claim that there are no published descriptions of stupor in this age group is, however, incorrect, as case 4 of our series of ten cases of adolescent bipolar psychosis also presented with stupor at the age of 13 years (Hassanyeh & Davison, 1980).

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Defining personality disorder

SIR: The validity of personality disorder (PD) as a mental illness has recently been the subject of several articles and letters (Blackburn, 1988; Chaloner, 1988; Cook, 1988; Gunn, 1988; Lewis & Appleby, 1988), with the majority favouring its rejection. While statistical cluster techniques and reliable personality-trait inventories support the existence of fixed deviant personalities, they cannot address the question of whether or not they are illness *per se*, as any such conclusion relies on the prior definition of mental illness. In the introduction to their study on the pejorative implications of the label 'personality

disorder', Lewis & Appleby (1988) comment on the difficulty inherent in defining mental illness. Indeed, this issue is crucial as regards the nosological status of personality disorder. DSM–III (American Psychiatric Association, 1980) does not offer a concise definition of mental illness, but the "conceptualisation" offered in the Glossary of Technical Terms makes it difficult to exclude PD if that diagnostic and classification system is used, viz.: "A mental disorder is conceptulised as a clinically significant behavioural or psychologic syndrome [Parameter 1] ... associated with ... impairment in one or more areas of functioning [Parameter 2] ... not only in the relationship between the individual and society [Parameter 3]." Trait cluster techniques satisfy the first parameter, and impaired interpersonal relationships, the second. Parameter 3 is an expedient rider that permits the exclusion of "voluntary" criminality and political agitation. The classic concept of psychopathy (DSM–III category 301.7, Antisocial personality disorder) qualifies as a mental disorder on these grounds.

The key to possible solution is referred to by Blackburn (1988) in his review of the moral implications of the psychopathy concept. He notes that the DSM–III requirement that clinicians make diagnoses on both Axis I (clinical syndromes) and Axis II (personality disorders) makes it explicit that different criteria are involved in these two sets of disorders, and that symptoms of major syndromes differ in kind rather than degree from the traits that define personality disorders. However, DSM–III makes no allowance for this, as only one tentative definition of mental disorder is offered. Criteria that are arguably appropriate for the definition of *intra*personal mental disorders, as per the traditional medical model, inappropriately subsume *inter*personal disorders, better understood using a bio-psycho-social model. Personality disorder is a diagnosis given to an individual, yet it relies on external referents (other persons) to become manifest. A mental disorder should result in distress or disability in an affected individual when he/she is observed in social isolation. One possible discriminator would be the 'Desert Island Test', i.e. a statistically valid syndrome must reliably result in distress or disability if a putatively affected individual were to be marooned alone on a desert island. This test would exclude PD from being classified as a mental disorder. Were he a candidate for the PD label, Robinson Crusoe would have only shown signs of disturbance once Man Friday appeared. In keeping with the empiricism underpinning DSM–III, PDs should be relabelled 'Interpersonal disorders', and their nosological status considered more akin to the V Codes (conditions not attributable to mental disorders that are a focus of attention or treatment) than to the clinical syndromes.

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LEWIS, G. & APPLEBY, L. (1988) Personality disorder: the patients psychiatrists dislike. *British Journal of Psychiatry*, **153,** 44–49.

SIR: Blackburn (*Journal*, October 1988, **153,** 505–512) contends that "the current concept of psychopathic or antisocial personality remains 'a mythical entity'." Although I find myself in agreement with the author's assertion that a psychiatric syndrome defined largely or entirely on the basis of social deviance (e.g. DSM–III antisocial personality disorder) is likely to be aetiologically heterogeneous, I find the empirical basis for several of his arguments concerning the nosological status of primary (i.e. Cleckley) psychopathy wanting.

Blackburn asserts that: (a) the evidence for the construct validity of Cleckley's (1976) criteria for psychopathic personality is relatively weak and inconsistent, (b) Cleckley's criteria include items tapping both personal and social deviance, and thus define a 'hybrid' construct; and (c) Cleckley's criteria do not identify a homogeneous group of individuals. Below I address each of these points in turn.

(a) Despite Blackburn's contention that the accumulated research suggests that Cleckley's psychopathic personality "remains a speculative construct" (p. 505), it could be argued that the laboratory findings concerning primary psychopathy are as replicable and coherent as that for any psychiatric disorder. For example, primary psychopaths have consistently been found to exhibit poor passive avoidance learning, diminished spontaneous skin conductance fluctuations, a slow recovery rate of the electrodermal response, slow electrodermal classic conditioning to aversive stimuli, diminished electrodermal and augmented cardiovascular activity to impending aversive stimuli, and excess theta waves during resting EEG (Hare, 1978; Lykken, 1984).