taining all the tablets for a particular time of day, and in this way even bi-weekly regimens could be included. The patient would in effect then be on a single daily regimen. Eshelman' states that in a pilot study this appeared to increase adherence significantly.

The author employed a simplified version of this, using four egg cups marked morning, afternoon, evening and night, with an elderly patient suffering from hypertension, cardiac failure and diabetes who was taking 6 tablets and was on a number of regimens. The egg cups were filled by a reliable domestic each morning, and this not only improved compliance markedly and led to better control of the patient but also prevented over-adherence. The unit dose pack should be investigated because improvement in patient compliance must improve the control of disease and reap economic benefits from the minimization of drug wastage and the possibility of decreasing hospitalization and bed occupation due to failure of therapy.

I would like to express my thanks to Mr S. P. M. Rosslee, Chief Pharmacist at the Johannesburg General Hospital, for making his data available to me for analysis and congratulate his research team on the amount of data collected. I would also like to thank Mrs S. Wilkins for secretarial assistance.

REFERENCES

Personality Disorder in Black Patients in Zimbabwe

T. BUCHAN, F. B. CHIKARA

SUMMARY

The complex inter-relationships between personal illness and personality disorder are discussed, and Foulds' model based on Venn diagrams is proposed as an adequate conceptual framework. A dimensional model is proposed for the classification of personality disorders. Three patients are discussed to illustrate some of the pitfalls in diagnosis and differential diagnosis. It is concluded that conventional concepts in psychopathology appear to be applicable to Black patients.


Psychiatric illness may be defined as a syndrome which disrupts the normal continuity of the personality. It consists of symptoms of behavioural events differing in quality from those presenting in health, and the temporary or episodic disruption of personal life.¹

In personality disorder, on the other hand, behaviour differs from the normal (i.e. modal) only quantitatively; such behaviour stems from an attribute or trait which is present in everybody but which is exaggerated in the subject to a degree which is abnormal for the culture. There is thus an enduring quality to the abnormal behaviour pattern.

Unfortunately, the differentiation between these two types of disorder is not so straightforward as the above definitions would imply. Firstly, even disordered personalities have resources of a sort, both internal coping mechanisms and external emotional supports. The imbalance between these resources and the stresses imposed by the environment may be recurrent but intermittent, resulting in abnormal behaviour of a deceptively episodic appearance. Secondly, it is often extremely difficult to assess when a particular fragment of behaviour has become socially abnormal. Although deeper psychological structures may be present in all cultures,² different cultures tend to produce different modal personalities.³ There is a real danger that the psychiatrist may allow his own cultural background and own frame of reference to influence his perception of social roles and their

Ingutsheni Hospital, Bulawayo, Zimbabwe

T. BUCHAN, M.A., M.B., B.CHIR., F.F. PSYCH. (S.A.), F.R.C. PSYCH., D.T.M. & H. (Present address: Department of Psychiatry, Godfrey Huggins School of Medicine, University of Zimbabwe, Salisbury, Zimbabwe)

F. B. CHIKARA, M.B. CH.B.

Date received: 8 August 1980.
relevance to psychiatric nosology when dealing with a culture other than his own.\(^5\)

Because of these difficulties in diagnosis, epidemiological studies in Africa are largely meaningless. For example, on the one hand, psychopathic disorder is extremely rare among Blacks in South Africa, with the exception of urbanized and westernized Blacks,\(^6\) but, on the other hand, an incidence of personality disorder of 6% is quoted for the Yoruba of Nigeria, where a traditional but disintegrating background was found to be most inimical to mental health.\(^7\) There were 17 diagnoses of personality disorder among 628 Black patients admitted to Ingutsheni Hospital, Bulawayo, during 1975, an incidence of 2.5%.

However, because of our reservations concerning the value of such figures, we concluded that some discussion of the problems of diagnosis and differential diagnosis of personality disorder would be appropriate.

The illustrative cases were drawn from patients admitted to Ingutsheni Hospital during 1978; all patients showed unequivocal social breakdown and all had been previously misdiagnosed. In each case an attempt was made to formulate the psychopathological disorder to see whether this would be applicable in our practice.

### PROBLEMS OF DIAGNOSIS

#### Personality Disorder Versus Personal Illness

In clarifying some of the issues, Foulds\(^8\) has provided an elegant conceptual model through his imaginative use of Venn diagrams. He points out that the presence of symptoms alone is not sufficient for the diagnosis of personal illness; there must be an element of unmanageability or breakdown. Therefore, persons with personal illness are a subset of the set of persons with personal symptoms (Fig. 1). This may be notated XY. Those persons who are not actually ill may be designated 'personally disturbed' and labelled y in the diagram. (Strictly speaking, every person in the universe of discourse who is not contained in the set Y is labelled Y, i.e. personally healthy and symptom-free, and every person outside subset X is labelled X. Thus, y represents the intersection of subset X and Y, written \(X \cap Y\).)

![Fig. 1. Diagram showing personal illness as a subset of personal symptoms.](image)

With the shifting balance between resources and stress, the patient will move from set Y to subset X as personal illness develops, and back to set Y if he recovers, or even to Y if he becomes symptom-free. For example, a schizophrenic illness may have a chronic, intermittent course with periods of exacerbation alternating with periods of remission; there is thus irregular subset shift.

Similarly, persons with traits which are distressing either to themselves or to society are termed personality deviants (Fig. 2); these are comprised by set B. This set has a subset, A, of personality disorders representing personalities whose deviant traits give rise to behaviour which is unmanageable by themselves or society. Thus, A is a subset of set B, or \(A \subset B\). Persons with deviant traits but not disordered personalities, i.e. all members of set B who are not members of subset A, may be designated 'discordant personalities' and labelled \(b\) in the diagram (or more strictly \(\bar{A} \cap B\)). Again, the patient may move from set B to subset A and back again as his deviant traits become unmanageable to a greater or lesser extent, although it is unlikely that treatment could be so successful as to render the patient entirely free from deviant traits (B). For example, a hysterical personality may periodically lapse into dissociated states during which his disturbed behaviour becomes socially unmanageable; therefore, he will display intermittent subset shifts which may closely resemble those encountered in personal illness. Moreover, the disturbance of behaviour may well be nonspecific; for example, violent or destructive behaviour may occur in either psychotic illness or personality disorder.

![Fig. 2. Diagram showing personality deviants.](image)

From these considerations, it is clear that personality disorder and personal illness may give rise to episodes of disturbed behaviour which may be clinically very similar and cause great difficulty in differential diagnosis unless the background personality and natural history of the disorder are very carefully examined.

#### Case 1

A Black man aged 22 years was admitted to Ingutsheni Hospital on 17 May 1978 as a criminal mental patient, having been found mentally disordered before arraignment on a charge of arson. On 3 May 1978 he had set fire to his sister's flat which he was occupying during her absence. When asked to make a plea he talked nonsense, claiming to be recruiting for the Zambian Air Force.

On admission he was aggressive. His account of himself was full of evasions, justifications and rationalizations, but there was no real evidence of thought disorder and consciousness was clear. He denied any crime but gave a long circumstantial account of how somebody else had set fire to the flat by throwing burning material through a broken window. He also denied any mental illness and claimed that the two doctors who committed him had...
relied on hearsay evidence and not their own personal observations.

He had been admitted to Ingutsheni Hospital twice previously, on 12 July 1974 and 31 August 1976, under the care of one of us (T.B.). On each occasion there had been a history of noisy, overactive or aggressive behaviour and a diagnosis of schizophrenia had been made. An EEG on 7 September 1976 showed an excess of fronto-central theta activity but no evidence of epilepsy.

The 10th of 11 children, of whom 7 are alive, he was his mother's favourite but had hardly any relationship with his father, a Nonconformist minister, who was a stern disciplinarian. Antisocial tendencies appeared at 4 years of age, when he set fire to a granary while playing 'locomotives'. Subsequently he often evaded school by 'acting sick'.

At the age of about 13 years he started mixing with older boys and indulging in drinking, smoking dagga and sexual activity. Magazines were his favourite reading matter and Charles Manson was his hero. He used to lecture the other boys about the 'hippie' way of life, which made him unpopular with his teachers, but the repeated punishments did not worry him.

He left school at 16 years of age, having passed Form II (Standard VII), after which he had 14 or 15 jobs, none of which lasted longer than 2 or 3 months, until he joined the Air Force in 1978. After 3 months he was boarded out on medical grounds, but blamed his previous admissions to Ingutsheni Hospital for this.

For a couple of months before admission he had worked as a full-time artist, an interest he had developed at school, which he claimed earned him fantastic sums of money; it was his ambition to become a great artist like Michelangelo. He had been recurrently in trouble with the police, mainly for fighting in public; he said that he enjoyed organizing fights in the township and had been involved in stone-throwing at political rallies.

Final formulation. Lacking identification with his father or other significant adult figure, he remained childishly immature, expecting reliability in others but formal effort only to 'excuse level' in himself; alibis were a prominent feature of his thinking. Capable of only transient, superficial relationships, he displayed a low frustration tolerance with impulsive, aggressive or destructive outbursts when thwarted. Much of his life was lived in fantasy, in fact he had virtually no artistic talent and his earnings from that source were meagre to say the least.

Diagnostic label. He was labelled as personally healthy, with a personality disorder (YnA).

Course and outcome. Apart from occasional injections of chlorpromazine to control his noisy overactive behaviour during the night he remained well, until discharged to stand trial on 21 June 1978. On 16 August 1978 he was readmitted because he had been confused, overactive and aggressive in court. By the time he was admitted he was quite coherent and rational and it appeared that he had deliberately simulated mental illness to evade prosecution. Again he was given no treatment and remained well until he was once more discharged to stand trial on 11 September 1978.

Comment. In retrospect, the two previous diagnoses of schizophrenia were incorrect; the episodes of disturbed behaviour were much more likely to have been dissociative phenomena in a setting of hysterical personality disorder and often manipulative in character.

Personal Illness and Personality Disorder Occurring Together

Most workers would agree that the categories personal illness and personality disorder are not mutually exclusive but may co-exist in the same patient, causing further diagnostic problems. In terms of Foulds' concepts the sets are intersecting (Fig. 3). From the diagram it is clear that there are nine theoretically possible intersections, which are probably conceptually adequate to deal with the complexity of the situation. From a practical point of view, however, the intersection of the subsets of personal illness and personality disorder is the most significant (XnA).

Case 2. A Black woman aged 39 years was admitted on 13 July 1978 after Red Cross workers had found her wandering near their headquarters, unable to speak.

She was first admitted to a general hospital in 1973, because of abdominal and chest pains, insomnia, and loss of weight and libido. After she had slightly improved she was discharged, after which she was treated as an outpatient until 1976, when her condition suddenly became much worse. She became so afraid of the dark that she wanted the light left on throughout the night, which caused quarrels with her husband. They consulted a nganga who told them that the illness was caused by ancestral spirits, who needed to be propitiated by her parents. Her husband sent her to her home, but her father, a Nonconformist minister, refused to brew beer and complete the ritual because of his Christian faith.

The quarrels with her husband continued until December 1977, when she again tried to persuade her parents to propitiate the spirits; again they refused. Her fear of the dark did not improve and during April 1978 she went to stay with her brother. Far from being any improvement, her condition deteriorated, until in June 1978 she was admitted to Ingutsheni Hospital under the care of one of us (F.B.C.), after an outburst of violence towards her mother, smashing utensils in the home and two attempts at suicide, once by hanging and once by drinking a detergent.
On admission she was obviously depressed, which was attributed
to the deteriorating relationship with her parents and her husband. The latter started a relationship
with another woman after she had left home in April. She was treated with antidepressant drugs, appeared to make a rapid recovery and was discharged, only to be readmitted the next month after having twice become lost while walking between her relatives' homes.

When readmitted in July she was depressed to the point of wishing herself dead; she blamed herself for the hostility between her husband's parents and her own. She had abandoned her church and expressed the idea that the Bible was a way of cheating used by Europeans to make Blacks forget their ancestral spirits.

Both her parents were devout members of the Brethren in Christ Church. They wanted their children to grow up to be devout Christians and were very strict on discipline; although the mother loved her children she was not averse to beating them if they misbehaved. There were numerous rules; for example, they were not supposed to play with children who did not go to church.

The patient became a well-behaved, God-fearing child who never fought with others; she was the 4th of 9 children, 3 girls and 6 boys. She kept to herself and enjoyed helping her mother with the housework. Nevertheless, she had marked mood swings and was afraid of the dark. At school she suffered from fainting attacks and failed Standard IV because, after a heavy punishment by the teacher, she lost her voice for 3 months and was unable to complete the examination.

During her adolescence she was very obedient towards her parents and rarely went out with girls of her own age. She married at 24 years of age, at which time she was still a virgin. Even after marriage she did not enjoy intercourse, but participated in it to please her husband; they had 3 children. They were happily married until 1972, when her husband had a motor-cycle accident and broke both legs. Her husband's relatives claimed that either she had bewitched him or the other man involved in the accident was her lover. Her husband seemed to agree with his relatives, which worried her so much that she could neither eat nor sleep; she also lost a considerable amount of weight. Eventually, her work began to suffer and she had to give up the teaching post she had held since 1962. This illness culminated in her admission in 1973.

Final formulation. Discipline during her childhood was loving but overly severe, producing an obedient, compliant child at the price of developing a submissive, dependent and anxious personality. Parental prohibition also prevented peer group identification which may have been influential in preventing the development of a mature adult sexual role. Her depressive illness was obviously precipitated by the deteriorating relationship with her husband after the accident, but was aggravated by the conflict between traditional and Christian ideals.

Diagnostic label. She was labelled as personally ill, with a personality disorder (XnA).

Course and outcome. Treatment was commenced with amitriptyline 50 mg twice daily and chlorpromazine 200 mg three times daily, which was followed by two courses of electroconvulsive therapy given on three occasions. She gradually improved and by 6 September 1978 she was cheerful and related well to other patients; her phobia of the dark had disappeared and she was sleeping well.

After this improvement her husband was persuaded to visit her. They were reconciled and when discharged on 28 September 1978 she returned directly to his household. Comment. The original diagnosis of depression was inadequate because it took no account of the underlying submissive personality disorder.

PROBLEMS OF CLASSIFICATION

Even supposing that the diagnosis of personality disorder can be made with reasonable reliability, there remains the problem of classification. There are two broad approaches to this problem: (i) empirical classifications based on overt behaviour (e.g., the Diagnostic and Statistical Manual of Mental Disorders lists 13 types: paranoid, cyclothymic, schizoid, explosive, obsessive-compulsive, hysterical, asthenic, antisocial, passive-aggressive, inadequate, sexually deviant, alcoholic and drug-dependent personalities); and (ii) aetiological classifications based on some underlying structure of the personality.

In psychoanalytical terms, different constellations of abnormal personality traits are associated with failure to negotiate three maturational phases; oral, anal and phallic. For example, an anal personality is extremely neat and tidy, suppresses emotion, is pedantic, obstinate, stingy and punctual.

Neither approach is entirely satisfactory, for behaviour patterns are not stable in time but are shaped by environmental circumstances. Further, there is no general agreement among psychiatrists over the extent of normal trait variation or which aetiological factors ought to be considered.

As a solution to these problems Presley and Walton suggest that patients should be evaluated in terms of five dimensions, viz: (i) social deviance — egocentricity, lack of regard for the consequences of actions, inability to profit from experience, irresponsibility, impulsiveness, conscience defect, superficiality in personal relationships, sexual provocativeness; (ii) submissiveness — timidity, meekness, submissiveness, introspunitiveness, indecisiveness, avoidance of competition, dependency, absence of officiousness; (iii) schizoid — stubbornness, detachment from others, avoidance of close relationships, suspiciousness, insensitivity to the feelings of others; (iv) obsessional — stubbornness, overindependence, meticulousness, officiousness and lack of suggestibility; and (v) hysterical — excessive displays of emotion, ingratiation, need for attention, insincerity.

In the cases discussed, the main deviation in case 1 was clearly in the social deviance dimension and in case 2 in the submissiveness dimension, so that these patients could have been adequately described by a categorical
diagnostic model. However, the dimensional approach is particularly valuable when more than one type of deviant behaviour occurs in the same patient.

**Case 3.** A Black woman aged 48 years was admitted as a criminal mental patient on 19 June 1978, having been found guilty but insane following a charge of malicious injury to property. On 7 February 1977 she had broken 27 window panes with a stick. At her trial on 17 February 1977 a doctor gave evidence that he had seen her five or six times since 1974 and that on 10 November 1976 he had committed her to the Psychiatric Unit at Harare Hospital, Salisbury; he believed her to be epileptic. As a result of this testimony she was found mentally disordered during the trial and was again committed to Harare Hospital. A diagnosis of hypomania was made and she was treated with lithium, recovered and was discharged to stand trial on 16 December 1977. The special verdict was returned on 20 January 1978. After a further period of treatment at Harare Hospital she was transferred to Mondolozzi. There was no record of any seizures during the period at Harare Hospital and the diagnoses of epilepsy and hypomania were both considered suspect. Accordingly she was admitted to Ingutsheni Hospital for further investigation.

On admission she was very evasive and told a number of transparent lies, but there was no evidence of thought disorder. Her attitude was one of humility but this had an insincere, Uriah Heep quality about it.

She gave a history of having been particularly close to her father and fairly close to her 7 siblings, but not at all close to her mother, a very dominant personality who kept the family in order, including the father.

While at school she always numbered more boys than girls among her friends and from the time of her menarche she began to indulge in sexual intercourse. She had a sexual relationship with every boy she became fond of and developed quite a reputation. For a while her mother beat her for her promiscuity but eventually gave it up as a bad job.

After leaving school she worked as an unqualified teacher for a few years, then resigned to get married. Apparently her husband-to-be backed out because he had been responsible for the pregnancy of another woman, and the patient's father returned the lobola. This made her extremely depressed and anxious and for several months she remained at home with her parents. Eventually she recovered and went to work as a domestic servant. She had numerous sexual adventures and delivered 2 children by different fathers.

In 1972 her father died and after his death her brothers took all her property and repudiated all responsibility for her. She asked her mother to look after her children while she went to work, but the mother refused. Enraged by this rejection she burned down her mother's house, as a result of which she was arrested. Since her mother refused to care for the children the Social Affairs Department placed them in a home. The charges were dropped and the patient was admitted to Harare Hospital.

After her discharge she embarked on a period of solute living, with economic dependence on various 'boyfriends' in a kind of informal prostitution; she also indulged in bouts of heavy drinking. Ultimately, a row with her current lover resulted in an outburst of rage during which she smashed windows.

**Final formulation.** The lack of identification with her mother and the close relationship with her father led to failure to develop an adequate sexual identity, with consequent promiscuity from an early age and transient, superficial, largely physical relationships with men throughout her adult life. Her low frustration tolerance and need for immediate gratification led to aggressive and destructive outbursts when she was thwarted.

**Course and outcome.** An EEG on 21 June 1978 was normal. She remained well without treatment but frequently complained of various physical ailments such as chest pain and cough and seemed full of self-pity at these times. She repeatedly sought to manipulate her discharge. The Mental Hospital Board, after reviewing her case on 17 August 1978, recommended her transfer to a secure unit. She became extremely noisy and overactive when she learned that she would not be discharged immediately. She was transferred on 18 September 1978.

**Comment.** There seem to be deviations in both the social deviance and hysterical dimensions in this patient.

**CONCLUSIONS**

The diagnosis of personality disorder and its differentiation from personal illness is always difficult, but particularly so in Black patients for whom different cultural factors are operative than in Whites. Nevertheless, the application of conceptual models derived elsewhere to patients in our own practice has proved helpful; the personality disorders we have encountered have been explicable in terms of conventional psychopathology.

We wish to thank the Secretary for Health, Dr J. S. B. Preece, for permission to publish.

**REFERENCES**