THE DISPOSITION AND ORGANIZATIONAL EFFECTIVENESS OF PERSONALITY DISORDERS IN A MILITARY SETTING

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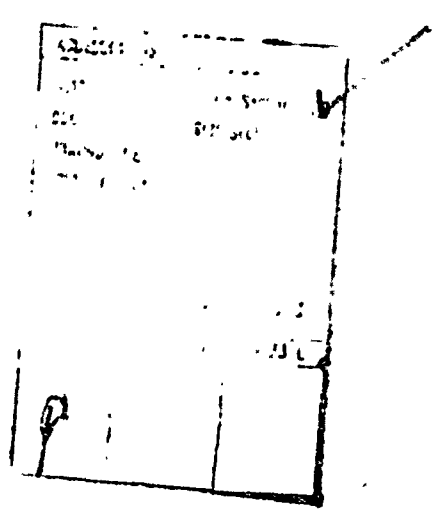

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Navy psychiatry has had the responsibility of dealing with service members diagnosed "Personality Disorder" for several decades, accounting for 50% of the 300,000 sick days and 75% of the 4,500 medical discharges from the naval services per year. Ninety-seven percent of these cases are enlisted men (Arthur, 1966). From the beginning, these men have proven to be a problem for the clinical and administrative decision makers. Fifty percent of the hospital beds in the inpatient facilities of Navy psychiatric services are occupied by personality disorders, while an equal portion of these kinds of cases fill the schedules of outpatient facilities. Most of the outpatients are never hospitalized, but are dealt with through administrative procedures which either return them to active duty or discharge them from the service. Anecdotal impressions indicate that those personality disorders who become hospitalized are sent to the hospital on orders from a command which has become exasperated by the behavior of the men and want psychiatry to assume the responsibility of coping with their problems. The inference is that personality disorders do not need hospitalization and that decisions in those cases do not follow sound clinical rules. The findings of the Army studies essentially support the contention that these men are a troublesome class of problem to be clinically treated, and that much clearer definitions of the relationship between the patients' symptoms and effective performance are needed if clinical and administrative decisions are to assist in meeting the needs of the military, and the personal as well as service needs of the military member (Wichlacz, Jones, & Strayer, 1972). Although prognostic indicators for selecting men diagnosed personality disorder to return to naval service have been developed

(Edwards & Berry, in press), and some therapeutic support measures have been formulated (Iorio, Edwards, Berry & Gunderson, 1972), the prognosis for these men for effective military performance is poor (Berry, Edwards, Gunderson, et al, 1971).

This study examines the proposition that clinical decisions are not based on reported clinical symptom patterns. The question is raised concerning the efficacy of present clinical decisions for patients diagnosed personality disorder. Considering the expense of these cases to the system and the poor diagnosis for effective service, the present study attempts to define the clinical characteristics of the personality disorder more clearly within the structure of the Navy in order to facilitate the formulation of clinical and administrative decisions which will both serve the Navy and benefit the service member.

Method

A two-step analysis of enlisted men diagnosed personality disorder was undertaken. Phase I consisted of a comparison of MMPI profiles (reflecting reported symptomatology) of 60 men with the diagnosis personality disorder with 40 men at the same hospital diagnosed as schizophrenic. Phase II consisted of a comparison among three goups of men diagnosed as personality disorder: (a) 206 hospitalized Navy enlisted men, (b) 52 Navy enlisted men seen at outpatient facilities who were recommended for admission to a hospital, and (c) 381 Navy enlisted men who were given administrative dispositions. In Phase II, reported symptomatology was recorded from the Cornell Medical Index (a yes-no checklist of bodily and emotional complaints)(Arthur, Gunderson & Richardson, 1966).

Results and Discussion

Phase I

The profiles for the hospitalized schizophrenics and personality disorders were nearly identical, but several features of the profiles were noteworthy:

1. The validity (F) scales were between 80 and 85 for both groups, skewing the interpretation of the test results when the faking factor is taken into account. Both groups were admitting to unusual experiences.
2. The Schizophrenic scales (Sc-8) were at a T-value of 95 for both groups, again reflecting admission to bizarre experiences and symptoms.
3. The mean score for the ten clinical scales was 74.2 for schizophrenics and 76.0 for personality disorders. Each group admitted to a substantial number of pathological symptoms.
4. The mean difference between the groups was substantially accounted for on scales 4 and 9, Psychopathic Deviate (Pd) and Hypomania (Ma), respectively. The schizophrenic group scored 75 while the personality disorder group scored 82 on scale 4-Pd. The personality disorder group scored 75 while the schizophrenic group scored 69 on scale 9-Ma. The personality disorder group reported more socially unacceptable experiences or attitudes and more expansiveness and irritability.
5. The reported symptom patterns appeared to have little relationship to diagnosis and distinctive clinical management decisions for personality disorders.

Phase II

In view of the fact that hospitablized schizophrenics and personality disorders report similar characteristics, symptoms, and attitudes, a question arises with regard to what disposition a clinician might have towards

hospitalized personality disorders. Again, anecdotal experience suggests that the personality disorders are willing to admit to any number of symptoms for some purpose (perhaps separation from the service). Another alternative would be that both groups are disturbed enough to require hospitalization.

In order to clarify the issues further, a separate sample of personality disorders in outpatient and inpatient settings was examined. In an attempt to discuss symptomatology more directly, the Cornell Medical Index (CMI) "yes" responses, indicating symptoms being reported as present, were analyzed for inpatients, outpatients recommended for admission to a hospital, and outpatients to whom administrative dispositions had been given. Several remarkable findings were noted:

1. The mean score for reported symptoms was somewhat lower for outpatients recommended for admission than for administrative dispositions (38.9 vs. 39.4; $p < .05$). Inpatients had the highest mean score of any group (41.21)
2. Two subscales from the CMI (I and J), with a total of 16 items report fatigue and general self-perception of health. The scores paralleled the total score distribution; admissions recommended group, 1.6; administrative group, 2.1; inpatients, 2.2.
3. The 51 item CMI back page, considered an index of reported emotional stability, presented a different pattern. The outpatient groups were essentially the same (administrative, 15.0; admission recommended, 14.6), while the inpatient group (17.3) scored significantly different from either outpatient group.

Comment

The MMPI and the CMI are used only to define the samples in this study. No attempt was made to examine the validity of either instrument. The results suggest that decisions were not made consistently in the case of personality

disorders. In Phase I, the MMPI profile indicated severe disturbance, yet decisions were made which did not reflect the MMPI patterns. In Phase II, the decisions again were not consistent with reported symptomatology (CMI scores).

With two separate measures in two separate samples of personality disorders, several questions concerning the personality disorder and dispositional decision for the personality disorder are raised. Since personality disorders respond with statements of pathology on the MMPI in a similar manner to psychotics, what meaning can be given to the protocol of the personality disorder? Is he severely disturbed? Is he saying that he will respond to any number of symptoms to find his way out of the service? The mixed pattern of responses on the CMI might be taken as an indication that the last question can be answered affirmatively. The total CMI profile suggests that men reporting more symptoms can be dealt with outside of the hospital. Perhaps personality disorders can be banned from psychiatric wards, to be dealt with more effectively at an administrative level.

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