Describing Ted Bundy's Personality and Working towards DSM-V

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Ted Bundy is perhaps the most heinous and notorious serial murderer in the recent history of the United States. The many books (e.g., Rule, 2001) and papers (e.g., Moes, 1991) that have been written about Ted Bundy testify to the fascination that the public continues to have with this case. Perhaps the most obvious reason for this interest in Bundy is the fact that he was able to function and even flourish in his career and personal life, while carrying out and evading arrest for a longstanding series of brutal rapes and murders.

Seventy-three psychologists from APA Division 42 recently took the opportunity to participate in a study concerned with the personality structure of Ted Bundy (Samuel & Widiger, 2006). The psychologists were provided a brief one and a half page vignette compiled from historical sources and reference materials. The psychologists were then asked to describe Bundy in terms of the American Psychiatric Association's personality disorder nomenclature. The most commonly diagnosed personality disorder was antisocial, which was endorsed by almost 96% of the sample. In fact, nearly 80% of the respondents described Bundy as a prototypic case of antisocial personality disorder. Considering the history of brutal rapes and violent murders perpetrated by Bundy, this diagnosis is not particularly surprising. However, it is also worth noting that nearly 95% of the sample also saw Bundy as meeting sufficient criteria to be given the diagnosis of narcissistic personality disorder. Over 50% of the psychologists also viewed Bundy as being above the diagnostic threshold for the borderline and schizoid diagnoses.

This variety of personality disorder diagnoses offered by the members of Division 42 certainly supports the complex nature of Bundy's personality. However, this degree of diagnostic overlap was not limited to the case of Ted Bundy, as two other historical cases

from the clinical and personality literature (e.g., the case of "Earnst" from Murray, 1938, and "Madeline" from Wiggins, 2004) were also evaluated by the clinicians and both were also seen as meeting criteria for at least two personality disorder diagnoses. As private practitioners are all too well aware, very few clients fit neatly into the categories within the American Psychiatric Association's (2000) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). It is not at all atypical for a client to present with a mixture of two, three, or even four personality disorder diagnoses.

This substantial overlap among the personality disorders is only one among the many reasons (e.g., lack of coverage and extensive heterogeneity within categories) why many have called for a major overhaul of the American Psychiatric Association's personality disorder nomenclature. Work is now beginning on the development of the fifth edition of the American Psychiatric Association's diagnostic manual, and personality disorders may lead the list of sections that are most in need of a change (see http://www.DSM5.org for a summary of the ongoing work of DSM-V). One heavily researched alternative is a dimensional system of general personality structure developed by psychologists, the Five-Factor Model (FFM) of personality (Costa & McCrae, 1992).

The FFM was developed as a model of general personality structure and later applied to personality disorders. It is comprised of five bipolar domains of personality functioning that have been labeled surgency or extraversion (vs. introversion), agreeableness (vs. antagonism), conscientiousness (vs. disinhibition), neuroticism (vs. emotional stability), and intellect or openness (vs. closedness to experience). The psychologists Costa and McCrae (1992) have proposed that each of the five domains is underlain by six facet scales, which provide further differentiation within each domain.

A strength of the FFM is that it has extensive construct validity that includes convergent and discriminant validity across self, peer, and spouse ratings, temporal stability across the lifespan, cross-cultural replication, and behavioral and molecular genetic support (Widiger & Trull, in press), as well as links to a wide variety of important life outcomes (Ozer & Benet-Martinez, 2006). A considerable body of research has also demonstrated that personality disorders can be readily understood as maladaptive variants of the domains and facets of the FFM (Costa & Widiger, 2002).

In order to compare this alternative dimensional model to the current DSM-IV categories, the members of Division 42 were also asked to describe Bundy in terms of the domains and facets of the FFM using a brief, one-page rating form (a copy can be obtained at http://www.uky.edu/~widiger/ffmrf.doc). Of course, the most notable aspect of Bundy's FFM profile was the consistently low ratings on all six facets of antagonism, indicating that the clinicians saw him as manipulative, deceitful, mistrustful, arrogant and callous. However, consistent with the reports of Bundy's success in political endeavors, the clinicians also rated him highly in the domain of extraversion, describing him as assertive, active, and thrill-seeking although also extremely low in the extraversion facet of warmth. Bundy was described as being particularly low on all the facets of neuroticism, with the exception of angry hostility. This indicates that he was seen as relatively free from experiencing negative emotions such as anxiety, depression, and self-consciousness, but also as having great difficulty controlling his anger. Perhaps the most noteworthy finding from the FFM ratings was his generally high ratings on the domain of conscientiousness. In contrast with the impulsive, undercontrolled behavior that one would typically expect from an antisocial criminal, Bundy was described as being

competent, orderly, achievement oriented and deliberate. Perhaps it was his characteristic style of careful planning and deliberate execution that enabled Bundy to avoid capture and arrest for so many years.

After describing Bundy in terms of both the DSM-IV and the FFM, the Division 42 members were then asked several questions to determine which of the two models they felt had greater clinical utility. The ultimate purpose of a diagnostic manual is to help a clinician understand and treat a patient (First et al., 2004). Although clinical utility has always been an important consideration for the DSM nomenclature, a common criticism of the American Psychiatric Association diagnostic manual is that it is developed by researchers largely for the purpose of helping researchers conduct more reliable and valid studies rather than being constructed and revised to facilitate the clinician in making treatment decisions. Matters of clinical utility will purportedly be given more priority in the construction of DSM-V (First, 2005).

In our study we asked the practicing psychologists six questions to compare the DSM-IV to the FFM with regard to clinical utility. One aspect of clinical utility for which the FFM was judged to be significantly higher than the DSM-IV was for communication with a client or other layperson. In other words, the members of Division 42 viewed the FFM as being better suited than the DSM-IV for describing the client's personality to him or herself. This is perhaps not surprising considering the FFM is based on lay language (e.g., extraversion) while the DSM-IV terminology tends to be filled with psychological jargon (e.g., histrionic). Additionally, the clinicians also rated the FFM as being more useful for describing Bundy's global personality. Again, this is not surprising as the FFM was developed to comprehensively cover a full range of personality traits, while the

DSM-IV has been criticized for its lack of coverage. For example, the FFM description included not only traits that were maladaptive for Bundy (e.g., the traits of antagonism) but others as well that contributed to being successful as a criminal (e.g., high levels of conscientiousness). A full, complete understanding of a patient requires a consideration of both adaptive and maladaptive personality functioning.

Somewhat more surprising, perhaps, was that the FFM was also rated as having more utility for comprehensively describing all of Bundy's important personality difficulties. This indicates that even though the FFM was designed to cover general personality traits, it might also be able to provide a valuable description of personality pathology.

Finally, the clinicians were also asked to rate how useful each of the two models would be for informing treatment planning. In this case, the ratings for the FFM were again significantly higher than for the DSM-IV. This finding suggests that members of Division 42 believed they would be relatively better able to develop viable treatment plans based on the FFM descriptions than they can with the existing DSM-IV system. This was a bit surprising considering the psychologists described themselves as being generally unfamiliar with the FFM, while having obviously been trained with the DSM nomenclature.

While these results provided interesting and important feedback from clinicians regarding the potential clinical utility of the FFM and DSM-IV, it only represents a first step. Surveys of clinicians' opinions regarding proposed changes to the diagnostic nomenclature have never been a systematic component of the revision process. The manual is constructed largely for the purpose of facilitating clinical practice, yet how the

manual is perceived and used by clinicians has not really informed its previous development. We would suggest that the authors of DSM-V, in fact, request clinicians to pilot proposed changes to determine their perceptions of the utility of the proposal. In any case, we want to thank the member of Division 42 for their very helpful and informative participation in our own study.

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