Latini, R., Tognoni, G. & Kates, R. E. (1984) Clinical pharmacokinetics of amiodarone. *Clinical Pharmacokinetics*, **9**, 136–156.

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Regarding the 'difficult patient'

Sir: I read Hinshelwood's (1999) editorial soon after assessing a 16-year-old patient with severe but by no means unusual problems. The patient had been referred by a social worker and not by a psychiatrist, and came from a background characterised by severely disrupted parenting, neglect and multiple forms of abuse. There was a two-year history of repeated self-cutting and drug misuse. In the previous six months the patient had undergone three brief psychiatric admissions to two adolescent units following repeated suicidal overdoses and escalating risk-taking behaviour. The referring social worker told me that the patient had been described to her as "untreatable". I found the last discharge summary thought-provoking. The multi-axial diagnosis read as follows:

I nil

II nil

III nil

IV nil

V Anomalous parenting with repeated loss of love relationships, emotional abuse, neglect

VI Moderate social disability

I was astonished that the attending psychiatrists failed to come up with any Axis I or Axis II diagnoses. It is possible that this reflects a failure of current diagnostic systems to describe severely disturbed adolescents. Such adolescents are often (but inaccurately) diagnosed as conduct disordered (Lewis *et al*, 1984). It is generally held that their age excludes a diagnosis of personality disorder, but there is evidence for the validity of borderline personality disorder in children (Greenman *et al*, 1986). An alternative term, complex post-traumatic stress disorder, has been proposed (Herman, 1992), and could also be considered. I was alarmed at the "untreatable" label, which is at variance with empirical findings on the treatment of borderline personality disorder, for example Najavits & Gunderson (1995) describing adults, and Meijer *et al* (1998) describing adolescents.

In any event, I suspect that the above multi-axial formulation reflected an emotional failure rather than an intellectual failure on the part of the professionals concerned. I would agree with Hinshelwood that we often distance ourselves from such patients because of the intensity of their emotional contact with us, their refusal to conform to our ideas of sick-role behaviour and, I would add, the horror of their life histories. I believe that this reaction is stronger with adolescent patients because of the parental feelings that they evoke in professionals. Also, the history of maltreatment is sometimes ongoing as the patient is often still residing with or is in contact with the perpetrators of the abuse. These challenging patients are both treatable and in need of treatment, and we should not evade our responsibilities towards them.

Greenman, D. A., Gunderson, J. G., Cane, M., *et al* (1986) An examination of the borderline diagnosis in children. *American Journal of Psychiatry*, **143**, 998–1003.

Herman, J. L. (1992) *Trauma and Recovery. From Domestic Abuse to Political Terror*. New York: Basic Books.

Hinshelwood, R. D. (1999) The difficult patient. The role of 'scientific psychiatry' in understanding patients with chronic schizophrenia or severe personality disorder. *British Journal of Psychiatry*, **174**, 187–190.

Lewis, D. O., Lewis, M., Unger, L., *et al* (1984) Conduct disorder and its synonyms: diagnoses of dubious validity and usefulness. *American Journal of Psychiatry*, **141**, 514–519.

Meijer, M., Goedhart, A. W. & Treffers, P. D. A. (1998) The persistence of borderline personality disorder in adolescence. *Journal of Personality Disorders*, **12**, 13–22.

Najavits, L. M. & Gunderson, J. G. (1995) Better than expected: improvements in borderline personality disorder in a 3-year prospective outcome study. *Comprehensive Psychiatry*, **36**, 296–302.

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'Scientific' psychiatry

Sir: It was a pleasure to read Hinshelwood's (1999) editorial. It was a thoughtful and sensitive discussion of the role of what he termed 'scientific psychiatry' within the diagnosis and treatment of paranoid schizophrenia and severe personality disorder. He skilfully highlighted what seems to be a clear dichotomy in the profession between evidence-based and more interpersonal approaches to knowledge within psychiatry (Hunter, 1996). It did seem, however, that the editorial fuelled this divide by restricting itself to only the potential faults of the former. Hinshelwood seemed to claim that the 'scientific' approach compromised patients' management by dehumanising both them and their psychiatrists. Patients would become illnesses to be treated and psychiatrists would avoid personal involvement.

This approach raises two issues. First, the scientific approach to these illnesses is not all negative. The understanding of schizophrenia, for example, over the course of this century, using a scientific approach, has resulted in treatment which has transformed, markedly 'humanised', and partially destigmatised many sufferers' lives.

Second, the nature of knowledge has been debated for centuries (Ayer, 1956). However, some literature makes it seem as if we had just discovered the problem. As psychiatrists, we deal with the full breadth of humanity and it thus seems naïve to approach epistemology by simplistic polarising of the issues. Surely the solutions are more likely to be found using models incorporating multiple forms of knowledge acquisition, and a more mature approach to a very complex and long-standing philosophical issue.

Ayer, A. J. (1956) *The Problem of Knowledge*. Harmondsworth: Penguin.

Hinshelwood, R. D. (1999) The difficult patient. The role of 'scientific psychiatry' in understanding patients with chronic schizophrenia or severe personality disorder. *British Journal of Psychiatry*, **174**, 187–190.

Hunter, K. (1996) "Don't think zebras": uncertainty, interpretation and the place of paradox in clinical education. *Theoretical Medicine*, **17**, 225–241.

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HoNOS 65+ glossary

Sir: The HoNOS 65+ glossary submitted in December 1998 (Burns *et al*, 1999) has been superseded. The current glossary is available via www.umds.ac.uk/psychiatry/soap/ and from the office of the College Research Unit HoNOS 65+ Implementation Group (tel. 0181 690 5647). Details of a HoNOS 65+ training service for England and Wales from 1 September 1999 are now also available.

Burns, A., Beevor, A., Lelliot, P., *et al* (1999) Health of the Nation Outcome Scales for Elderly People (HoNOS 65+). Glossary for HoNOS 65+ score sheet. *British Journal of Psychiatry*, **174**, 435–438.

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