of evidence about the moral and interpersonal dimension of the patient's disorder, and is as relevant as a feeling about the dangerousness of a patient in a forensic assessment. In so far as the PD patient can control aspects of his or her behaviour, feedback about suffering or discomfort the patient's behaviour, feedback about suffering or discomfort the patient's behaviour causes others is a necessary part of the therapeutic process (the therapist stands in symbolically for 'others' here). Understanding the PD patient's dilemma involves making an appropriate and helpful response which may or may not involve 'sympathy' at a given point in time.

I would argue that PD is a valid clinical diagnosis when a developmental perspective is adopted. The aim in a diagnostic assessment of PD would be not to elicit symptoms but to trace a developmental pathway "with the particular pathway followed always being determined by the interaction of the personality as it has so far developed and the environment in which it then finds itself" (Bowlby, 1988). By viewing the PD patient's present state as a part of a process of complex interactions it is no surprise to perceive control *and* dyscontrol, healthy *and* unhealthy responses. Neither is it then a surprise to find the PD patient eliciting a variety of responses in the diagnostician. It seems more useful to view PD as a maladaptive trajectory which the therapist meets (or does not!) side on and has first to reconstruct backwards through a dialogue with the patient in order to negotiate a change of direction forwards.

While we continue to view PD through the polarity of ill or not-ill, we are surely unlikely to progress in this under-conceptualised and under-researched area of mental disorder. That PD is a clinical reality which urgently requires a more appropriate conceptual and therapeutic framework is underlined in a recent study of 50 465 conscripts, which found that PD carried a threefold risk of subsequent suicide relative to controls (Allebeck *et al*, 1988).

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SIR: The conceptual difficulty underlying any discussion of personality disorder concerns the attribution of responsibility. One attempt to solve this problem has been to introduce a rigid dichotomy separating 'illness' from 'non-illness'. The latter group has come to include those called personality disordered, despite behavioural and psychological abnormalities. These rather abstract notions have contributed to an unfortunate and more concrete result, the rejection of the personality disordered patients.

It is important for a doctor to be aware of rejecting feelings towards a patient, but although this information is useful clinically, it cannot be the basis for a satisfactory classification. Criticisms of the reliability and validity of personality disorder have been made elsewhere. For all these reasons we agree with Professor Gunn that the concept and not just the name must be discarded.

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Psychiatric Morbidity in the Territorial Army

SIR: The paper by Birtchnell *et al* (*Journal*, July 1988, **153**, 56–64) raises many points of interest, but there is one in particular to which I should like to draw attention.

Using the Depression Screening Instrument, it was found that about one in five members of the Territorial Army showed sufficient symptoms of depression to be regarded as a 'case', and this is confirmed by the other two methods of assessment, the GHQ and BDI. It is odd that the authors had no comment to make on what seems to me to be a remarkably high prevalence of psychiatric morbidity in the Territorial Army.

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(We regret to hear that Professor Hamilton has died since submitting this letter).

SIR: We were indeed aware that the level of 'caseness' was high in the Territorial Army (TA) sample. We chose not to comment upon this largely because we used the sample specifically for the purpose of comparing the DSI with the two established instruments and, as Professor Hamilton observed, the prevalence levels, using the three instruments, were similar.

In the Discussion section of the paper we inadvertently distracted the attention of the reader from the high level in the TA sample by drawing comparison with the levels for young married Thamesmead women and for women in the same age range as the Thamesmead women recorded in Camberwell by Bebbington *et al* (1981); two population samples with relatively high 'caseness' levels. Dr Bebbington has kindly produced for us 'caseness' levels for subjects under the age of 50, which would correspond with the age-range of the TA subjects. These are 5.6% for men, 17.5% for women, and 12.0% for the sexes combined. The corresponding levels for the TA sample, using a DSI cut off point of 13+, were 8.9% for men, 35.8% for women, and 21.3% for the sexes combined. The levels using the BDI and the GHQ were comparable. Thus the level for TA women was particularly high, although one should remember that a high proportion of these women would be in the vulnerable age-range of 25–34. We would not wish to comment further on this finding at this stage, but we do have further data on the TA sample which we intend to publish in due course.

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Screening for HIV

SIR: Davies (*Journal*, June 1988, **152,** 857) apparently sees no distinction between the investigation of a full blood count in suspected alcoholics, which may help consolidate the diagnosis, if the MCV is raised, and HIV screening in a psychotic patient from the known high-risk groups. Once treatment has been instigated, alcoholics, if motivated, can abstain, and providing no irreversible neuronal or liver damage has occurred have a reasonable chance of survival. AIDS is lethal. No known cure exists at present.

I cannot agree with Dr Davies when he suggests that certain psychotic patients should be routinely screened for HIV status. Diagnosing AIDS in a psychotic patient benefits neither the patient, his or her family, nor the medical staff, for the following reasons:

(a) The treatment of the psychosis is symptomatic. Knowledge of HIV status does not affect treatment outcome, in contrast to syphilitic infection for which a specific treatment exists.
(b) If the test is not made, the patient and his or her family are spared the devastating effects of such a diagnosis.
(c) If adequate precaution is taken with every patient, staff are at minimal risk of contracting the disease.

Many patients who are not of high-risk groups and who have no symptoms typical of HIV infection may carry the virus – therefore it is mandatory that patient carers exercise due caution when dealing with all patients. Patients with AIDS may perhaps on occasions "spit and spray blood", but this I believe is more likely to happen when they are labelled as HIV positive. With the expected increased prevalence of AIDS, HIV encephalopathy will probably increase significantly and educated staff should feel comfortable in caring for these patients. Are these people, if disturbed, not entitled to proper treatment? Knowledge of HIV status does not provide staff with any extra protection.

AIDS is a transmissable disease, but the public via the mass media have been educated regarding the HIV virus and the modes of transmission, and this would appear to be the most reasonable means of controlling the spread of the disease. I do not believe that screening plays an important role in helping to control the spread of this virus. In conclusion, therefore, I have great reservations about the value of HIV screening. Generally, when dealing with a lethal illness such as AIDS and its accompanying social stigma we in the medical profession should use common sense and treat these patients with the compassion they need.

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SIR: Dr Davies' astonishment (*Journal,* June 1988, **152,** 857) is matched by my own. I am astonished at Dr Davies' whole approach towards the AIDS problem. He makes a number of assertions which need to be challenged.