be discarded, because it constitutes 'an enduring pejorative judgement'. This point of view would be laudable if they had shown that the diagnosis could not be reliably made, or that it held no validity, but this they have not done.

Drs Lewis & Appleby have shown that the diagnosis of personality disorder conveys to psychiatrists a negative moral connotation, presumably by virtue of its attribution of individual responsibility for socially unacceptable behaviour. As with hysteria (Miller, 1988), this attribution of responsibility may well be difficult to prove. However, the issue is an important one, since patients who are responsible for such behaviour may not be helped by being treated as 'sick'. The moral judgement which follows this line of reasoning, assuming it is valid, is no more or less deserved than that passed on others who display similar behaviour without receiving the diagnostic label of personality disorder. Debt (or lying or theft or a range of other types of behaviour) should only be deemed exempt from moral judgement where attribution of personal responsibility is waived, as for example in severe depression or dementia. If patients with personality disorder are responsible for their behaviour, then moral judgements are not misplaced. If they are not responsible, then such judgements should not be made. Drs Lewis and Appleby, however, have not addressed this issue.

Surely a more worrying conclusion to be drawn from this study is that the consequences of diagnosing personality disorder are far-reaching. Once the label is given it is not easily removed, and attempts to diagnose or treat psychiatric illnesses such as depression are reduced or even abandoned. Patients with a personality disorder (or patients without one who are so misdiagnosed) thus appear to have been made responsible also for behaviour which would in others have been excused! Worse still, they have effectively been denied the benefit of potentially efficacious treatments.

If the diagnosis of personality disorder can be shown to warrant exemption from the usual attribution of responsibility for socially unacceptable behaviour, then psychiatrists and others must change their judgemental attitudes. While the validity of this diagnosis and the reliability of its application remain in doubt, it should be used only with good reason and great caution. Only when it has been shown that the concept of personality disorder holds no validity should it be discarded.

C. C. H. Cook

University College & Middlesex School of Medicine
Middlesex Hospital
London W1N 8AA

Reference

Miller, E. (1988) Defining hysterical symptoms. *Psychological Medicine*, **18**, 275–277.

Sir: Drs Lewis & Appleby argue that because psychiatrists are unable to resist expressing their hostility towards the personality disordered (PD) patient by rejecting him or her the concept is invalid. It is the poor workman who blames his tools. Thus it is a false argument to abandon the concept of PD because psychiatrists feel uneasy in the face of the reality the concept represents. Rather, psychiatrists should examine their bad practice and understand it.

Psychiatrists, like other professionals, have poor tolerance of situations in which their accustomed sense of power, authority, and efficacy is eroded. With PD patients it is often the doctor who suffers and the patient who acts (out). The PD patient challenges the psychiatrist because, before therapy can even be attempted, extensive negiotiations have to be entered into (often of a contractual nature) with the patient as equal negotiator. This is far different from other clinical situations in which the patient is, by and large, the sufferer and forms the passive side to a markedly unequal power relationship. Moreover, the time scale in which therapy may need to be attempted is immensely long – as likely 10 years as 10 months – which again is not guaranteed to gratify the therapist's self-esteem or desire for readily observable results.

It is fundamentally misconceived to attempt to subsume PD under the concept of mental illness with "a classification based on symptoms". Historically PD has always been recognised as a separate entity, although the starting point of definition has been a comparison with mental illness, e.g. Pinel's manie sans délire. There is a suggestion that cultures quite different from our own recognise PD separately from mental illness (Murphy, 1976). The Eskimo term *kunlangeta*, meaning "his mind knows what to do but he does not do it", and the Yoruba term *arankan*, meaning a person who goes his own way regardless of others, both describe deviations from social and personal norms which increase the individual's tendency to be vulnerable to illness or other misfortune. Interestingly enough these disorders are not believed to respond to the conventional healer's techniques.

I would also disagree that a psychiatric classification loses credibility if it "contains value judgements or moral statements", since the latter are inseparable from and implicit in the human as opposed to the physical sciences. The psychiatrist's feeling of dislike and hostility is an important piece

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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 50465 conscripts, which found that PD carried a threefold risk of subsequent suicide relative to controls (Allebeck *et al*, 1988).

JILL CHALONER

Claybury Hospital
Woodford Bridge
Woodford Green
Essex IG8 8BY

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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.

LOUIS APPLEBY
GLYN LEWIS

Institute of Psychiatry
De Crespigny Park
Denmark Hill
London SE5 8AF

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.

MAX HAMILTON

The University of Leeds
30 Clarendon Road
Leeds LS2 9NZ

(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.

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