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Editor: Ian Pullen

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Personality Disorder

SIR: I would like to congratulate Lewis & Appleby (*Journal*, July 1988, **153**, 44–49) on a neat and interesting paper. It tackles a fundamental problem in modern psychiatry. In clinical practice it is disturbance of personality which is one of our biggest challenges. As ICD-9 acknowledges, even schizophrenia is "a fundamental disturbance of personality", and it is the management of the personality disturbance which is one of the most difficult aspects of treating that or any other disorder.

I entirely agree with Drs Lewis & Appleby that part of the problem with our modern understanding of the concept of personality disorder is that it is regarded as something other than an illness and therefore inexcusable. An aspect of this process may be the use of the curious phrase "no formal mental illness" in medical reports on highly abnormal individuals. What, I ask myself, is an *in*formal mental illness? It could be that the word formal here is used to acknowledge the disorder while simultaneously barring that disorder from psychiatric help because it is inexcusable. It could also be that this device is used by the psychiatrist to escape the agonies and responsibilities of assisting difficult patients with protracted disorders that do not clear up.

Drs Lewis & Appleby do not speculate on the reasons for 'mental illness' to be associated with favourable psychiatric attitudes and 'personality disorder' to be associated with unfavourable ones. I would like to suggest that one important factor is that we currently believe that 'illnesses', such as depression, schizophrenia, and mania, have 'treatments' in the form of medication, but that personality disorders are 'untreatable'. Another factor is that patients with long-standing traits such as anhedonia, dependency, and aggressiveness are difficult to like. It is for this latter reason that I disagree slightly with Lewis & Appleby's final conclusion, proposing the abandonment of the term personality disorder. Changing names for objects that are disliked is a common ploy, but the stigma soon attaches itself to the new name: cf. water closet, lavatory, toilet, or subnormality, handicap, impairment. A more taxing approach, but one which may have a bit more success in the long run, is to change psychiatric attitudes through education.

Another device, which combines name changing with an improved clinical technique, might be to provide each patient with a personal function analysis in the same way that we currently provide each patient with a mental state analysis. This would give a list of functions with varying degrees of mutability and thus draw attention more clearly to treatment potentials. I have argued for this approach in greater length in a paper about to be published (Gunn, 1988).

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Reference

GUNN, J. C. (1988) Personality disorder: a clinical suggestion. In *Personality Disorders: Diagnosis, Management and Course* (ed. P. Tyrer). London: Butterworths (in press).

SIR: Our contemporary, existentialist, society is reluctant to pass moral judgements, and perhaps this underlies the assertion of Drs Lewis & Appleby that the diagnosis of personality disorder should