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.

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