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).

References