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Correspondence

Editor: Ian Pullen

Contents: Multiple personality disorder/Preconscious perceptual processing/Reconquest of the subjective/Guilt or morbid remorse?/Availability of the Hospital Anxiety and Depression (HAD) scale/ Fingerprints and statistics/Hemispheric imbalance in schizophrenia/Applicability of psychotherapy for non-Western people/Psychological outcome of abortion/'Socrates' symptom'/Clozapine in the community/ECT anaesthetics/Out-patient ECT for depression in a man with moderate learning disability/Are polioviruses a cause of schizophrenia?/ Supervision of repeat antidepressant prescribing in general practice.

Multiple personality disorder

SIR: We read with interest the article by Merskey (*Journal*, March 1992, **160**, 327–340), in which he examined a number of cases of multiple personality disorder (MPD) from the earlier literature, in order to determine whether there is any evidence that MPD was ever a spontaneous phenomenon.

Since human behaviour can be understood if we have sufficient information about a person's development – his biological, psychological and sociological history – (Ewalt *et al*, 1957) we would direct attention towards inheritance of ancestral beliefs in the aetiology of psychopathology. In particular, we would underline the concept of soul in an anthropological context.

Frazer (1922) reports a number of races in whom there was a belief that several souls were harboured in the same body. For example, he reports that the Caribbeans believed that there is a soul in the head, another in the heart, and others in all the points in which there is an arterial pulse. The indian Hidatsa interpreted the phenomenon of agony, supposing that man has four souls, which leave the body in succession. The Daiachi of Borneo and the Malesian believed that every man has seven souls and the Alfur of Minahassa (Celebes) believed that there are three souls. The indians of Laos supposed that the body is the seat of 30 souls.

Evidently, these primitive beliefs, and subsequently the religious beliefs, show evocative similarities with MPD, and suggest the presence of univocal elements of thought with different types of behaviour, with respect to different times and places.

We conclude with two remarks. First, since the developmental history of our species casts an unmistakable shadow on our mental lives, the comprehension of psychopathological behaviour may be facilitated by an ethnological approach. Second, in a multicultural Europe, the transcultural approach to clinical problems is more and more necessary (Cox, 1991).

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SIR: The recent questions and concerns raised in the *Journal* about the "unprecedented numbers" of cases of multiple personality disorder (MPD) diagnosed in North America require a response (Merskey, *Journal*, March 1992, **160**, 327–340). Although the diagnosis of MPD has received attention and support in Europe and Latin America, there is a strong resistance in Britain to accepting this condition. There it is argued: (a) that MPD is a misdiagnosis of organic conditions or bipolar illness; or (b) created by iatrogenic suggestion; or (c) induced in suggestible patients by popularised accounts in the media.

The arguments against the validity of MPD made thus far in the *Journal* rely on examination of historical or dramatised accounts of the condition and inexplicably fail to examine the large number of modern scientific studies published in reputable journals. These increasingly sophisticated studies, using standardised measures and structured diagnostic interviews available to all interested professionals, have documented the existence of a complex psychiatric syndrome that is frequently misdiagnosed. The

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growing professional acceptance of MPD in North America is a response to these scientific studies and not to the reports in the mass media, which are largely a by-product of the resurgence in professional interest.

The arguments made in the *Journal* are specious in that they do not account for why the particular symptom of having two or more alter personality states should be so tractable to suggestion or contamination effects. The other symptoms expressed by MPD patients are taken at face value – as are those of most psychiatric patients. Why should asking a patient if he has ever felt as if there were another part or side to him be more likely to induce an alter personality than, for example, creating hallucinations or ruminations by inquiring if he has ever heard voices talking to him when no one was present or had thoughts that occurred over and over again that he could not get out of his head? Why should one symptom be suggestible and another not?

The argument that MPD is produced by merely reading *Sybil* or seeing the movie, *Three Faces of Eve*, is likewise flawed. A number of dramatic psychiatric disorders, such as anorexia nervosa, bulimia nervosa, obsessive–compulsive disorder, and bipolar illness, are daily topics in books, magazines, newspapers, films, radio and television. Are all of these conditions produced by suggestions from the mass media? Of course not! Why is MPD singled out as being uniquely susceptible to media contamination compared with other psychiatric disorders? Arguments based on postulated suggestion and contamination effects should be tabled until critics can convincingly demonstrate a specificity of suggestion and contamination for alter personality states and MPD compared with other psychiatric symptoms and disorders.

British critics of MPD frequently assert that these cases are not seen in England. Patients meeting DSM–III criteria for MPD have even been described in the *Journal* – although the authors chose to give them other diagnostic labels (Fahy *et al*, 1989; Bruce-Jones & Coid, 1992). Ian Hacking has documented that early historical cases fitting the MPD template were described in Britain well before the first French cases were reported towards the end of the 19th century (Hacking, 1991). MPD, as defined by DSM–III/DSM–III–R criteria, does indeed exist in Britain.

The real question is why does British academic psychiatry choose to ignore the peculiar disturbance in identity characteristic of these patients? This is the critical difference between the British and North American positions. North American interest in MPD does not represent an infatuation with the DSM–III–R diagnosis *per se*. Rather, it reflects a clinical belief that direct interaction with the alter personality states provides a more effective therapeutic approach to certain symptoms. A reading of the North American clinical literature – as opposed to the sensationalised popular press accounts – quickly demonstrates that reputable clinicians do not believe that the alter personalities represent distinct 'people'. The North American model advocates a therapeutic approach that balances interventions made with the person as a whole with interventions directed towards specific alter personality states associated with pathological behaviour.

Whether the North American model is more therapeutic than the British model remains an open question for the present. Preliminary reports do suggest efficacy for the North American approach compared with prior "non-MPD" treatment of these patients. If the North American model of MPD were merely a fad and conferred no therapeutic advantages it would have melted away by now and have been replaced by another faddish diagnostic label. The continuing increase in the numbers of MPD cases reflects our clinical experience that this model, and the therapeutic interventions associated with it, represents an effective treatment approach to a very difficult group of patients. Future debate should focus on the crucial question of therapeutic efficacy rather than on diagnostic labels. It is what we can do to help our patients and not what we call them that is important.

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SIR: Merskey (*Journal*, March 1992, **160**, 327–340) argues that being diagnosed as having MPD would be better managed with the "view that certain other diagnoses are acceptable alternatives: mania, certain depressive illnesses, schizophrenia, obsessional neuroses . . ." Each of these "alternatives" is a primary diagnosis according to both ICD–9 and DSM–III–R, and these must *all* be diagnosed if also present and must be accounted for in the treatment plan. But to selectively leave out the dissociative symptoms

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