

working in the superficially dry fields of information processing and artificial cognition.

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#### Self-rating

SIR: McLaren (*Journal*, November 1988, **153**, 708) regards an individual's rating of himself (as either good or bad) as irrational and self-defeating. Certainly the concept of overall or global self-esteem does not make sense in the context of contemporary society. However, it does make sense in the context of evolutionary biology (*Lancet*, 1988), and it may help us to lead people away from the harmful tendency to rate themselves globally if we understand why this self-evaluative behaviour might have evolved.

The development of high or low global self-esteem may be seen as a preparation for crucial situations in which decisions have to be made between self-assertion and self-effacement. High global self-esteem is a strategy for self-assertion, low global self-esteem a strategy for self-effacement.

It is likely that the capacity for both high and low self-esteem is present in everybody at birth, the selection of strategy being made at predetermined stages. Crawford (1987) made a useful distinction between *developmentally contingent strategies*, in which the selection is made early in life, long before the strategy has to be 'played', and *concurrently contingent strategies*, in which the selection is affected by factors operating at the time of the 'play'. In human beings it seems likely that the level of self-esteem which determines the decision between self-assertion and self-effacement in any adult situation is both developmentally and concurrently contingent.

A developmentally contingent low self-esteem strategy may be inculcated by parents in one or more of their offspring (by withholding praise or administering punishment) as part of an evolutionary parental strategy in its own right; or it may be imposed by other adults, such as teachers, as a form of inverse

nepotism; or by older siblings to whom it may be an advantage for younger siblings to be predisposed to self-effacement; or it may be selected in the self-evaluative rough-and-tumble of childhood or the adolescent peer-group. These individuals, who are familiar to us in our clinical work, enter and endure adult life with chronic low self-esteem which is often very resistant to treatment.

In other patients we can identify a concurrently contingent low self-esteem strategy in the form of a depressive state. Some people respond to stress with elevation of mood, giving them enhanced vigour and competence associated with a rise of self-esteem; others respond with a reduction of mood, giving them reduced vigour and competence associated with lowered self-esteem. Either strategy is effective at dealing with the prototypical interpersonal stress situation in which two equal adversaries are in competition and neither will give way – a situation which we share not only with other primates but with all other vertebrates. In humans the environmental factors will be more complex than in animals, and will almost certainly involve the acquisition or loss of allies, so the proximate causation may well be one of loss rather than of manifest competition.

The view of depression as a concurrently contingent low self-esteem strategy is not in conflict with other causative theories of depression, whether they be psychoanalytical, behaviouristic, neurophysiological, or biochemical; nor is calling depression a strategy in conflict with its conceptualisation as disease, reaction, or posture (Hill, 1968). It is merely adding the perspective of ultimate (evolutionary) causation to those methods which seek to analyse proximate (immediate) causation.

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#### Pre-pubertal Depressive Stupor

SIR: I read with interest the case report of pre-pubertal depressive stupor (*Journal*, November 1988, **153**, 689–692). I reported a similar case several years ago (Warneke, 1975). This patient was first admitted in a depressive stupor at the age of 12 years. He was initially admitted to a pediatric service where

a viral encephalitis, among other things, was suspected. A comprehensive neurological workup was negative, and the stupor resolved with time and supportive care. However, the patient was re-admitted at the age of 14 years to a psychiatric service under my care, clearly exhibiting signs of classic mania. During a prolonged hospital stay, the clinical state changed to a depressive stupor, resolving quickly with the use of electroconvulsive therapy. The patient eventually left hospital and was stable on lithium, although he had subsequent re-admissions in the following years. There was a strong family history for affective disorder. The results of the dexamethasone suppression test would have been interesting; however, the test had not been adapted for use in psychiatry as yet.

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#### Multiple Personality Disorder

SIR: Fahy's thorough review of the literature on multiple personality disorder (MPD) (*Journal*, November 1988, 153, 597-606) reveals an ambivalence which makes us wonder whether the author has actually recognised and treated MPD cases. He acknowledges the fact that typical MPD symptoms such as psychogenic amnesia and alterations in behaviour, attitudes, and taste are presented before contact with a clinician is established and before hypnosis is used. He correctly criticises claims that MPD is an iatrogenic disorder. Yet, referring to the rise and fall of hysteria at the end of the 19th century, he downplays its existence as a separate syndrome. He states that supporters of the diagnosis point to the wide distribution of cases in time and place, but that this distribution no longer extends outside the USA.

Dr Fahy's historical review overlooked an important European source. A century ago, the French psychiatrist Pierre Janet conducted a series of careful clinical studies on hysteria (Janet, 1889, 1901, 1907). He regarded hysteria as a broad class of mental disorders which had a dissociative foundation in common, and were in many cases related to traumatic experiences. Hysteria included somatisation disorder, conversion disorder, psychogenic amnesia, psychogenic fugue, MPD, and certain other syndromes with predominant dissociative features.

Characterising MPD as having distinct alter-personalities with their own sense of self and their own life history, and having different patterns of amnesia between these personalities, Janet clearly regarded MPD as a separate syndrome.

As Dutch clinicians working in a psychiatric outpatient clinic, we are currently treating 15 MPD patients, and in consultation and diagnostic interviews we have seen many more. In conformity with the findings of American research studies, all of these patients had a severely traumatised childhood, had been known to psychiatry for many years under widely divergent diagnoses, and had not benefited from conventional treatment approaches. In our experience, they generally respond favourably to MPD-specific treatment. MPD is clearly not an American disease, but our American colleagues are worthy of our praise for refocusing attention on a disorder which has not had a fair chance in psychiatry.

We agree with Dr Fahy and others that DSM-III and DSM-III-R criteria for the diagnosis of MPD are vague, especially with regard to the definition of personality. Many of the patients to whom we would give the DSM-III-R diagnosis of 'dissociative disorder not otherwise specified' are perhaps seen as MPD cases in the USA. A more rigorous set of diagnostic criteria is urgently needed. Although MPD often coexists with other Axis I and Axis II disorders, we disagree with Dr Fahy's conclusion that MPD has arbitrarily become the primary diagnosis and that MPD symptoms do not justify a final diagnosis. The most important reason for giving the MPD diagnosis priority is that in otherwise intractable cases, apt treatment can be provided.

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#### Lofepamine-induced hyponatraemia

SIR: We would like to report a 74-year-old spinster who developed hyponatraemia while receiving lofepramine.