positive perception of anticholinergic drugs by the patients may be that they relieve the discomforting experience of bradykinesia or *akathisia* associated with antipsychotic medications".

That "the relative liability for Parkinsonism of the various antipsychotic drugs available cannot be confidently predicted" is clearly Dr Barnes' personal opinion. A large literature (see Tamminga & Gerlach, 1987) presently supports the view that drugs such as clozapine, sulpiride or thioridazine are much less prone than high-potency neuroleptics to produce extrapyramidal side-effects. Finally, the relationship between anticholinergic treatment and the development of tardive dyskinesia is certainly debatable, but, as the discussant himself recognises, the experimental and clinical evidence supporting a predisposing role of anticholinergics is compelling, and it would have been irresponsible for us to ignore it.

In conclusion, we welcome Dr Barnes' comments although they do not lead us to propose changes in the document's recommendations.

WHO Heads of Centres
*L. Prilipko

Division of Mental Health
World Health Organization
1211 Geneva
27 Switzerland

*Correspondence

References

Kane, J. M. (1988) Neuroleptic treatment of schizophrenia. In *Neurochemistry and Neuropharmacology of Schizophrenia* (eds F. A. Henn & L. E. DeLisi), p. 196. Amsterdam: Elsevier.

Tamminga, C. A. & Gerlach, J. (1987) New neuroleptics and experimental antipsychotics in schizophrenia. In *Psychopharmacology: the Third Generation of Progress* (ed. H. Y. Meltzer). New York: Raven Press.

Sir: The WHO Consensus Statement (*Journal*, March 1990, **156**, 412) provides welcome guidance in view of the widespread use of concurrent anticholinergic antiparkinsonian and neuroleptic medication. Studies in Oxford, Birmingham and Newcastle have shown that 50–55% of patients are maintained on both drugs concurrently and, in some cases, for over 12 months (McClelland *et al*, 1974).

There are additional reasons for not routinely co-prescribing the two agents. A longitudinal survey (Johnson, 1978) demonstrated that Parkinsonian side-effects show marked spontaneous fluctuation, making the interpretation of the effects of treatment difficult to interpret. Moreover, in one study, a deterioration in schizophrenic symptoms was observed when an antichlorinergic antiparkinsonian drug was introduced (Johnston *et al*, 1983).

However, there remains a useful role for these antiparkinsonian anticholinergic drugs in certain areas of clinical practice. For example, many clinicians would consider prescribing both drugs concurrently in patients with a previous history of acute dystonic reactions. The statement failed to highlight the uncommon, but potentially fatal, complication of asphyxia secondary to neuroleptic-induced laryngeal pharyngeal dystonia (McDonal, 1981) or to oesophageal dysmotility (Moss & Green, 1982) which might be preventable in this way. Similarly it has been observed (Van Putten, 1974) that many patients dropped out of treatment as a result of drug-induced extrapyramidal disorders. Hence patients who have previously defaulted due to such side-effects may benefit from co-prescription.

The decision as to whether to use anticholinergic antiparkinsonian drugs may only be decided by a clinical assessment of the balance of risks. It is important to emphasise that once prescribed it is essential that the patient and the indications for such therapy are reviewed regularly.

Jean Antoine Boodhoo
Martin Sandler

Lucy Baldwin Hospital
Olive Grove
Stourport-on-Severn
Hereford and Worcester

References

Johnson, D. A. W. (1978) Prevalence and treatment of drug induced extrapyramidal symptoms. *British Journal of Psychiatry*, **132**, 27–30.

Johnstone, E. C., Crow, J. J., Ferrier, I. N. *et al* (1983) Adverse effects of anticholinergic medication on positive schizophrenic symptoms. *Psychological Medicine*, **13**, 513–527.

McClelland, H. A., Blessed, G., Bhate, S. *et al* (1974) The abrupt withdrawal of antiparkinsonian drugs in schizophrenic patients. *British Journal of Psychiatry*, **124**, 151–159.

McDonal, C. E. (1981) Haloperidol and laryngeal dystonia. *American Journal of Psychiatry*, **138**, 1262–1263.

Moss, H. B. & Green, A. (1982) Neuroleptic associated dysphagia confirmed by oesophageal manometry. *American Journal of Psychiatry*, **139**, 515–516.

Van Putten, T. (1974) Why do schizophrenic patients refuse to take their drugs? *Archives of General Psychiatry*, **31**, 67–72.

Sir: Putting aside for a moment the *content* of the recently published WHO concensus statement on prophylactic anticholinergic medication (*Journal*, March 1990, **156**, 412), I would like to deliberate on the fact that a more conventionally laid out review appeared in the same edition (*Journal*, March 1990, **156**, 413). I wonder if this might in part be reflecting

physicians' discomfort at being presented with conclusions rather than the more usual critical appraisal, and what would this imply for the 'reformed' National Health Service. The new emphasis on local management will bring doctors into much closer contact with the sort of skills seen in business, based often it seems on charisma, people-management ability and ideology, rather than the familiar (safer?) 'medical model' of a broad-balanced review and hypothesis testing. Could be a bit of a culture shock for all of us!

CARL S. LITTLEJOHNS

The North Wales Hospital
Denbigh
Clwyd, Wales

Multiple Personality Disorder

SIR: Coons (*Journal*, March 1990, **156**, 449) and Ross (*Journal*, March 1990, **156**, 450) criticise Simpson's assertion that multiple personality disorder (MPD) is an "iatrogenic, largely culture-bound condition" (*Journal*, October 1989, **156**, 565). Professor Simpson may overstate the case for the iatrogenic component, but more striking is the readiness of Drs Coons and Ross, both prominent writers in the field, to dismiss this consideration out of hand. Dr Coons suggests that MPD occurs in all countries, but his evidence is anecdotal and is at odds with the experiences of clinicians in the UK. It is my view that the type of patient reported in the American literature is extremely rare in this country.

However, I would accept that short-lived dissociative reactions occur when patients insist for a limited period that they have assumed the identity of another personality. Indeed, it would be odd if such a presentation was not one of the almost infinite variety of dissociative reactions. The evidence in support of this assertion comes from my own clinical experience (Fahy *et al*, 1989) and from the recent paper by Adityanjee *et al* (1989) from India who report three patients with short-lived dissociation of personality. In the Indian cases, as well as our own, the symptoms were seen as stress related, and they resolved without attempting to interview the alternates at length.

It is my contention that these relatively benign reactions may not be uncommon, and are most likely commoner in patients with other neurotic or post-traumatic syndromes. However, to attain the complexity of psychopathology seen in American cases of MPD, some element of reinforcement from therapists, relatives or the media is necessary. MPD researchers have largely ignored this factor in their investigations. Instead, Dr Ross suggests that variations in diagnostic rates between countries may be a reflection of the differing rates of childhood trauma, a theory which is unlikely to be relevant in differences between the UK and USA and which is supported by no evidence whatsoever.

Finally Dr Coons falls back on the tautological argument that the comments of sceptical observers of the MPD scene are rendered invalid because they are not seeing large numbers of real cases. The problem with this argument is simply that sceptics may well be seeing these patients but are coming to different opinions on diagnosis. If the diagnosis of MPD is to gain widespread credibility, then it is up to workers like Drs Ross and Coons to provide evidence of conceptual validity through *controlled* trials studying aetiology and treatment of this enigmatic condition.

TOM FAHY

Institute of Psychiatry
De Crespigny Park
Denmark Hill
London SE5 8AF

References

ADITYANJEE, RAJU, G. S. P. & KHANDELWAL, S. K. (1989) Current status of multiple personality in India. *American Journal of Psychiatry*, **146**, 1607–1610.

FAHY, T. A., ABAS, M. & CHRISTIE-BROWN, J. (1989) Multiple personality. A symptom of psychiatric disorder. *British Journal of Psychiatry*, **154**, 99–101.

ECT for pseudodementia

SIR: I read with interest the good review article by Benbow (*Journal*, August 1989, **155**, 147–152). Although Dr Benbow talked about the use of electroconvulsive therapy (ECT) in treating the patients who are demented as well as depressed, I was surprised that she did not mention the good response of ECT in 'depressive pseudodementia'.

The term 'pseudodementia' is a controversial one, but it is a fact that in some patients 'functional' depressive disorder may show intellectual impairments and memory difficulties resembling those of organic disorder. Pseudodementia is frequently encountered in elderly patients with the more severe kinds of affective illness (Post, 1982). Post reported that 10% of elderly depressed patients present with pseudodementia. The increased severity of depression could explain the good response of these patients to ECT.

MAMOUN MOBAYED

Department of Psychiatry
Windsor House
Belfast City Hospital
Belfast BT9 7AB
Northern Ireland