which leads to further investigations (e.g. on the relative significance of the WAIS subtests) by the manipulation of the variables intrinsic to the programme.

S. McDONALD
C. McDONALD

Warlingham Park Hospital
Warlingham, Surrey CR3 9YR

Multiple personality disorder

DEAR SIRS

In the *Psychiatric Bulletin* (September 1989, **13,** 513), Dr Lal Fernando discussed his dearth of multiple personality disorder (MPD) patients in various countries including Canada. He also knew of no other colleagues with such cases. However, many of his Canadian colleagues are treating MPD patients as well as doing research. My own initial cases date from 1977 when I was working in Germany. Canadian psychiatrists have attended courses on the diagnosis and treatment of MPD and other dissociative disorders which were held at three of the last four annual meetings of the Canadian Psychiatric Association.

The time has come for psychiatry to look with an open mind at the recent advances in the scientific literature on the diagnosis of MPD. Arguments claiming this to be an American creation are now wearing rather thin. While we debate this issue in print, many MPD patients are being deprived of therapy both in Canada and the UK because some psychiatrists choose to make MPD an issue of "to believe or not to believe", rather than an issue of educated scientific investigation.

G. A. FRASER

Anxiety and Phobic Disorders Clinic
Royal Ottawa Hospital
1145 Carling, Ottawa
Ontario, Canada

DEAR SIRS

I have been practising psychiatry for a number of years, but have recently become interested in dissociative disorders, including multiple personality disorders. As such I found Dr Lal Fernando's letter (*Psychiatric Bulletin,* September 1989, **13,** 513) very interesting because until recently I would have agreed with him, as I had only seen one patient in this category during 15 years of practice. However, having taken some workshop training, now on the basis of my own clinical experience, I can no longer believe this.

It does not surprise me at all that a busy physician in a general psychiatric practice would often not detect these patients. Many have been repetitively abused, either physically or sexually, during their childhood years by persons who were in positions of authority and/or trust, in some cases their parents. As such they are often now very suspicious of anybody in authority, and physicians fall into this category. They are therefore, often extremely secretive. While I have never seen any study on the relative degree of secretiveness among different diagnostic groups of psychiatric patients, these would fall into a 'maximum' category. Possibly it is partially for this reason that Putnam *et al* (1986), reviewing 100 cases of multiple personality disorder, reported that the mean time from their first contact with the mental health system (with symptoms referable to MPD) up to their diagnosis was 6.8 years (range of zero to 23 years). Many had previously been given other diagnoses, the commonest were depression, neurotic disorder, personality disorder and schizophrenia. Somewhat less common were substance abuse, manic depressive illness, temporal lobe epilepsy, *grand mal* epilepsy, learning disability, brain tumour, and organic brain syndrome. In most patients there was more than one prior diagnosis (mean = 3.6 diagnoses, range zero to 11).

MICHAEL J. C. THOMSON

Woodlawn Medical Consultants
112 Woodlawn Road
Dartmouth, Nova Scotia B2W 2S7

Reference

PUTNAM, F. W., GUROFF, J. J. *et al* (1986) The clinical phenomenology of multiple personality disorder: review of 100 recent cases. *Journal of Clinical Psychiatry,* **47,** 285–293.

NHS White Paper

DEAR SIRS

Your comments on the NHS White Paper *Working for Patients* (*Psychiatric Bulletin,* July 1989, **13,** 385–389) are helpful and perceptive but do not address the roots of the problem. As you say, the incompetent construction of the paper, probably designed to fudge the issues, makes it difficult, particularly for lay people, to assess the implications.

There seems little doubt that if fully implemented the proposals would mean the end of the NHS as an overall service as inequality of care is built in.

The paper has been launched with no consultation and with expensive and aggressive propaganda. The damaging effect on mental health services could be severe and lasting. A firm riposte is needed; with co-operation from NHS psychiatric staff and patients, the College should take the lead.

I wonder if the College has fully addressed itself to the threat to mental health care and is ready to

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launch a full-blooded opposition to the White Paper through the media.

M. R. MORTON

'Caer Beris'
Pool Head, Bodenham
Herefordshire HR1 3HP

Alternative mental health care services for black people

DEAR SIRS

I was most impressed by the descriptions of alternative mental health care services for black people by Francis *et al* in the *Psychiatric Bulletin* (September 1989, **13**, 482–485). When the proposals of *Working for Patients* are implemented, I wonder if it will become possible for these groups to bill the relevant health authorities or budget-holding GPs for their work. If so, the local NHS facilities would presumably take a corresponding cut in revenue. This would certainly provide a stimulus for the NHS facilities to look at their cross cultural acceptability.

GYLES R. GLOVER

Charing Cross and Westminster Medical School
Department of Community Medicine
London SW1P 2AR

Appropriate terminology in cross-cultural studies

DEAR SIRS

I found disturbing the use, without definition, of terms such as "black" and "Afro-Caribbean" by Fernando (*Psychiatric Bulletin*, May 1989, **13**, 250–251) and Harrison (*Psychiatric Bulletin*, May 1989, **13**, 251). While this is, of course, a very common tendency in reports on "cross-cultural" studies, I suspect that the use of such terms has very little scientific value and serves mainly to evoke stereotypes. It is important that when studying or writing about various cultural groups, as much trouble be taken to describe the population involved as is taken to define any aspect of psychopathology being investigated. For example, it is usually more relevant to know the length of time migrants have been in the country, their age, sex, marital status, social class, command of the language and degree of acculturation than the amount of skin pigmentation present – and incidentally, the precise amount of pigmentation has not been without importance in interpersonal situations over the centuries.

I do appreciate that Drs Fernando and Harrison may well be using these terms as a form of shorthand – unfortunately, this is a practice fraught with dangers, and certainly likely to lead to bad science.

What, then, is the alternative? I suggest it is to define very clearly at the outset what one means by such terms, and perhaps to seek the advice of anthropologists as to the most appropriate and informative terminology for a particular purpose.

I. PILOWSKY

University Department of Psychiatry
Royal Adelaide Hospital
Adelaide, South Australia 5001

Mental Health (Scotland) Act 1984

DEAR SIRS

Perusing the Gaskell Publications of the Royal College of Psychiatrists Book List I discovered a publication on a hereto unknown piece of legislation "The Mental Health Act 1983 (Scotland)".

The name of the Scottish legislation is the "Mental Health (Scotland) Act 1984". There was also a Mental Health (Amendment) (Scotland) Act 1983.

By delaying a year Scotland produced a more sensible Act.

A. P. W. SHUBSACHS

Rampton Hospital
Retford, Notts DN22 0PD

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