Clozaril Monitoring Service. The suggestion that there is a need to be particularly aware of physical illness is a moot point. Except for haematological problems (which are reversible on drug withdrawal), clozapine has fewer contraindications than other antipsychotics.

There are many situations in which such liaison and (initially) intensive monitoring is commonplace: for example, lithium treatment of bipolar disorder, or physical treatments such as gold injections for severe rheumatoid arthritis.

There are now examples of efficient community/out-patient services which are giving clozapine to large numbers of patients without the need for incarceration in hospital. Two models essentially operate in the UK: a clozapine clinic where patients all attend on a single morning for blood sampling and prescription; or community psychiatric nurses (CPNs) trained to take blood. A single CPN suffices for a large number of patients, and in practice the clinic nurse works 1–2 sessions a week (Launer, 1991).

It is an inescapable fact that the reintroduction of clozapine is one of the most dramatic advances in psychopharmacology since the introduction of phenothiazines in 1957. It would be a pity if overstated economic fears conspired to deny extremely sick patients a chance for recovery which they previously may never have had, and shortsightedly deny catchments the opportunity for making real savings in patient care.

KANE, J., HONIGFELD, G., SINGER, J., *et al* (1988) Clozapine for the treatment of resistant schizophrenia. *Archives of General Psychiatry*, **45**, 789–796.

LAUNER, M. (1991) Experience with clozapine. *Psychiatric Bulletin*, **15**, 223–224.

R. W. KERWIN
L. S. PILOWSKY
A. REVELY
I. P. EVERALL
J. BEARN

Institute of Psychiatry
Denmark Hill
London SE5 8AF

M. LAUNER

Burnleigh General Hospital
Burnleigh
Lancashire

Multiple personality disorder

SIR: Recent correspondence (Correspondence, *Journal*, September 1992, **161**, 415–420) continues to perpetuate the erroneous notion that multiple personality disorder (MPD) either does not occur in the UK or is a misdiagnosis of some other condition.

My first encounter with MPD in a clinical setting in the UK occurred without warning some ten years ago in a working class, uneducated, psychologically unsophisticated patient without prior knowledge of the condition. The transformation was so all-encompassing that it transiently made me doubt my own sanity.

Since then I have either personally interviewed, treated, or been consulted about many other cases, both in urban Surrey and in Aberdeen. Why, in that case, does the literature continue to insist that MPD is a peculiarly North American phenomenon?

I believe the answer lies in the uncomfortable relationship between psychotherapy and psychiatry in this country. Many MPD patients have told me that they feared to reveal their condition to psychiatrists, sensing that they would be misunderstood and thought to be schizophrenic. Such is the scepticism of the psychiatric establishment regarding this condition that the fear was perhaps not entirely misplace. Psychotherapists, whose attitude is, we hope, less judgemental, seem from my observations to be often quite familiar with clinical cases of MPD, through either personal experience or supervision. Professional ridicule and accusations of gullibility await those who are foolish enough to declare an interest in public, or seek to study this fascinating condition.

The much greater integration of psychotherapy into psychiatry in the USA may explain the greater rate of diagnosis, as a non-judgemental 'therapeutic' attitude is a prerequisite for detection of MPD, which can be effectively concealed from external observers for decades.

I suspect that the same judgemental scepticism pervades the review committees of our journals. I have not as yet managed to publish on this topic except through the medical columns of women's magazines whose motives are far from altruistic. I believe that this condition has much to teach us on the structure of personality. At the very least it deserves a fair hearing.

IAN F. MACILWAIN

Elmhill House
Royal Cornhill Hospital
Aberdeen AB9 2ZH

SIR: Professor Merskey's opinion (*Journal*, March 1992, **160**, 327–340) that the diagnosis of MPD is the very cause of the disorder and does not prove its existence leads to the classical double-bind state: "You're damned if you do and you're damned if