Professional and lay opinions on multiple personality disorder

SIR: There is little knowledge of the state of professional opinion with regard to the validity of the diagnosis of multiple personality disorder. Following the publication of an article on this topic (*Journal*, March 1992, **160,** 327–340) I took the opportunity to enclose a questionnaire with reprints which were supplied on request and some of which were also offered to colleagues. Of 90 reprints sent out, 44 were returned, of which 38 were analysable. Ten of those responding with analysable forms had received the reprint, at least in part, on my initiative.

The questions asked related to region of residence, professional identification, views on MPD, and whether the respondent wished to receive the results of the survey. Before considering the arguments in the article mentioned, 5 of the 38 responding had believed that MPD was a common condition (position (a)), 21 believed that MPD as defined in DSM–III–R occurred occasionally but was overdiagnosed (position (b)), and 12 did not believe in it (c). Subsequently, four still held it was a valid entity or condition and quite common, 15 supported the view that it occurred occasionally, and 19 rejected the diagnosis.

The present sample cannot be considered to be representative. It is potentially biased by the inclusion of colleagues whom I knew to be sympathetic to my views, although not all supported them fully and a number of others whom I might have asked to fill in forms were not approached because they had received copies of the article before the questionnaire was designed. It is also biased by the likelihood that proponents of the diagnosis, or others considering it to be a realistic diagnosis, were probably more likely to write for copies of the article than those who were not interested, or who disbelieved in it and were not attending to the literature on the topic.

The results resemble those which were obtained with a lay audience in March 1992 with the same questionnaire. At a talk given in Sarnia Ontario, at the request of the local Mental Health Association, approximately 100 questionnaires were handed out and 50 completed of which 42 were analysable. Those responding included 2 general practitioners, 1 lawyer, 1 member of the clergy, and some 35 allied health professionals, or individuals, with an interest related to their occupation, for example, social workers, psychologists, nurses, health administrators, etc., and 12 others. Before the talk 17 believed in position (a), 16 in position (b), and 9 in position (c). Subsequently, 13 held to position (a), 8 held position (b), and 21 position (c). These responses seem very like those of the largely medical audience which commented after reading the article itself. Thus informed individuals were likely either to reject or restrict the diagnosis of MPD.

From some of the comments made to me both privately and on the questionnaire forms, I have the impression that many more psychiatrists would reject the diagnosis of MPD altogether, provided that they could be satisfied that occasional fugue states with a change in temperament or apparent personality style, could still be recognised as diagnosable dissociative conditions. I think there should be no difficulty in doing that even if the diagnosis of MPD were to be given up completely.

The questionnaire is available from the author on request.

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Cannabis and the PSE

SIR: Dr Mathers and Professor Ghodse recently reported on a study of the psychopathology of psychotic patients admitted to hospital with positive urine tests for cannabis, compared with psychotic drug-free controls (*Journal*, November 1992, **161,** 648–653). They found that five items on the Present State Examination (PSE) administered within one week of admission were significantly more common in the cannabis-using group. These were changed perception, thought insertion, non-verbal auditory hallucinations, delusions of control, and delusions of grandiose identity. The authors suggested two reasons for this: that it may be a chance finding due to the large number of items in the PSE, or that these may be the features of acute cannabis intoxication. In their summary, they suggest that cannabis precipitates relapse in those with major psychotic disorders. Another explanation which would fit their findings which they did not discuss would be that subjects who are experiencing a psychotic relapse may increase their drug use secondary to this, either in an attempt to self-medicate or due to the disinhibiting effects of psychosis. This drug use may then modify the presentation of the underlying illness, accounting for the differences observed using the PSE. According to this hypothesis the correct diagnosis in most cases in this

study would be "paranoid schizophrenia with a presentation modified by cannabis use".

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Conversion mnemonic

SIR: I enjoyed reading the articles by Mace (*Journal*, September 1992, **161**, 369–389). However, the mnemonic I have devised as a teaching tool about 'conversion' contains possibly important elements which were not addressed in the articles:

C = Conscious control lacking
O = Organic aetiology unproven
N = Neurological symptoms prevalent
V = Verisimilitude to physical illness
E = Etiologically
R = Related to
S = Stressor
I = Indifference may occur
O = Organic sequelae possible
N = Not culturally sanctioned

The elements 'indifference', 'organic sequelae', and 'not culturally sanctioned' were largely omitted in the discussion by Mace.

La belle indifference (inappropriate lack of emotion or concern for the implications of one's disability (Stedman, 1990)) was, perhaps, the most striking omission in a historical review of conversion hysteria. This concept, like the concept of conversion itself, appears to have withstood the test of time; although the implications of the attitude described by *la belle indifference* remain to be clarified. Perhaps *la belle indifference* refers to the physician's attitude when an organic aetiology cannot be proven, similar to the suggestion by Mace that 'conversion' refers to a change in the physician's attitude towards a patient who defies traditional diagnosis.

Possible organic sequelae are important in considering the natural history of untreated conversion symptoms. Phenomena such as contractures, disuse atrophy, decubiti, and invalidism all demonstrate that patients with conversion can, ultimately, progress to serious physical illness.

Classical descriptions of conversion symptoms usually exclude culturally sanctioned behaviour. Otherwise, behaviour such as 'glossolalia' ('speaking in tongues' associated with certain religious sects (Kaplan & Sadock, 1989)) might further confuse the issue.

The concept of conversion will certainly continue to undergo a fascinating evolution. Specific disorders without proven organic aetiology (e.g. 'chronic fatigue syndrome' (Goldman, 1992)) are also testing current diagnostic boundaries of neurology and psychiatry.

GOLDMAN, M. B. (1992) Neuropsychiatric features of endocrine disorders. In *The American Psychiatric Press Textbook of Neuropsychiatry* (2nd edition) (eds S. C. Yudosfski & R. E. Hales), p. 528. Washington: American Psychiatric Press.

KAPLAN, H. I. & SADOCK, B. J. (1989) Diagnosis and psychiatry: examination of the psychiatric patient. In *Comprehensive Textbook of Psychiatry/V* (5th edition) (eds H. I. Kaplan & B. J. Sadock), p. 472. Baltimore: Williams and Wilkins.

STEDMAN (1990) *Stedman's Medical Dictionary, 25th edition.* Baltimore: Williams and Wilkins.

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Gender difference of schizophrenia in seasonal admissions in Scotland

SIR: Using a national sample from England and Wales, we reported that an excess of first admissions was present in summer months in female but not male schizophrenics (Takei *et al*, *Journal*, October 1992, **161**, 506–511). Since this summer excess of admissions was also demonstrated in patients with a diagnosis of mania, we suggested that female schizophrenia has some aetiological or precipitating factor in common with mania.

To determine whether the gender difference in season of admissions in schizophrenia is reproducible, we obtained data on all first admissions for schizophrenia in Scotland between 1961 and 1990. The diagnosis of schizophrenia was coded using the 7th revision of the International Classification of Diseases (ICD) (World Health Organization) for those admitted between 1961 and 1967, ICD–8 for those admitted between 1968 and 1979, and ICD–9 for those admitted between 1980 and 1990. We tested the cyclical variation in admissions using the Edwards' method, the advantages of which we have previously discussed (Takei *et al*, 1992).

The results revealed that there was a significant cyclical seasonality in schizophrenic admissions ($n = 14964$, $\chi^2 = 12.26$, d.f. $= 2$, $P < 0.005$). When the sexes were examined separately, a highly significant cyclical seasonality was found in female ($n = 6875$,