CLONINGER, C. R. (1987) Neurogenetic adaptive mechanisms in alcoholism. *Science*, **236**, 410–416.
CRAUFURD, D. (1989) Psychiatric genetics. *Current Opinion in Psychiatry*, **2**, 101–105.
GILLIGAN, S. B., REICH, T. & CLONINGER, C. R. (1987) Etiologic heterogeneity in alcoholism. *Genetic Epidemiology*, **4**, 395–414.
GEORGE, F. R. & GOLDBERG, S. R. (1989) Genetic approaches to the analysis of addiction processes. *Trends in Pharmacological Sciences*, **10**, 78–83.

Multiple personality disorder

SIR: Fahy (*Journal*, October 1988, **153**, 597–606) provided a useful critical review of the highly peculiar nosological category of multiple personality disorder (MPD). I suggest that, taking into account the many uniquely odd characteristics of this diagnosis, an alternative hypothesis is needed to account for this most rum condition.

More than any other diagnosis, patients allegedly suffering from it have become major media celebrities, fêted in the popular media. In the history of medicine or psychology, has any condition been so reliably rewarding to those supposedly 'suffering' from it; or to the physicians and psychologists who attend them?

The condition arouses excessive interest and excessive claims. Clinicians reporting such cases usually show an infatuation with them. Like new parents, they can never miss an opportunity to show photographs, movies, or videos of their uniquely talented offspring, or to tell you of their latest cute trick.

The distribution of MPD is bizarre. There is no normal distribution of cases. I've never met a clinician who, over any significant period of time, has seen just one case. The vast majority of talented, sensitive, observant clinicians have never seen a case at all. A very small number of clinicians report the great majority of case reports.

Spontaneous remission is probably the norm, unless the patient becomes engaged with a clinician already primed and interested in the condition. It seems to be one of the few conditions which almost invariably get worse in therapy; the extent of the patient's pathology is directly proportional to its amount and intensity, and shows the most evolved and disturbed anomalies in the most intensively studied cases. It appears to be the norm that further 'personalities', often more entertaining and rewarding for the audience, emerge in therapy.

My hypothesis is that MPD is an iatrogenic, largely culture-bound disorder, with some resemblances to folie à deux, arising when a bright, suggestible patient meets a bright, suggestible physician convinced that MPD is an important diagnosis. Selective reinforcement of symptoms, unconscious and conscious, progressively shapes the symptoms and behaviour of the patient, and the depiction of MPD is elaborated and reinforced. Patients usually show clear primary or secondary gain, but this is often not noted or acknowledged by their therapists, whose own secondary (and maybe primary?) gains are similarly covert.

Procedures regularly followed, such as naming the alternative 'personalities' and having long, carefully recorded conversations with them, serve to preserve and reify these otherwise transient situations, locking them into publicly shared 'reality'. Any 'as-if' quality to the original experiences is stamped out. The inevitable audio and videotaping provides a handy record of the nuances of the successful performance, and an aide-memoire for both participants, to enable the maintenance of a consistent portrayal.

There is no convincing evidence that MPD is a naturally occurring condition, let alone a distinct diagnosis. It is a symptom complex that may be superimposed on other psychopathologies, consequent upon the unfortunate matching of a susceptible patient with a susceptible therapist and trainer. The diagnosis is dysfunctional, focusing attention selectively in a way that will almost invariably worsen the condition, rather than improving it. It occurs in the context of the availability of lengthy psychotherapy. Where the health care system or health insurance does not sponsor this indulgence, the condition simply does not occur.

MICHAEL A. SIMPSON

Garden City Clinic
Johannesburg
South Africa

How many sheltered housing places?

SIR: We recently conducted in Montréal a survey comparable to the Glasgow Rehabilitation Survey (Livingston & Bryson, *Journal*, May 1989, **154**, 620–624), and found a strikingly similar rate (29%) of patients who would be able to live in the community. However, our consultants estimated that more sheltered housing would be needed, especially group homes directly supervised by nursing staff.

Canada's health and social care systems grant universal access to services. In Montréal, all psychiatric in-patient facilities are public. The recently revised provincial mental health policies call for further transfer of mental hospital in-patients to the community. Hôpital Louis-H. Lafontaine is a 2000-bed mental hospital currently covering a catchment population of 330 000. However, until 5 years ago it also served as a long-term facility for the French-speaking population of Greater Montréal (2.8 million

inhabitants). The hospital population has steadily declined since 1960, when the census indicated 5621 in-patients. Our survey was conducted on a random sample of 300 of the 831 in-patients aged 18–60 with a primary functional psychiatric diagnosis. A short questionnaire was sent to the consultants. We provided a choice of operationally-defined residential facilities, and asked the consultants to indicate the most appropriate setting for the patient. Response rate was near 99%.

The consultants estimated that 51% were not suitable for community placement, 19% would need nursing home facilities, and 29% could be discharged to community settings. Out of this latter 29%, 13% were for group homes supervised by trained staff, and 12% for hostels or group residences staffed by private owners or a warden; only 3% were envisaged in cluster flats, and less than 1% in independent accommodation.

Our consultants estimated a greater need for facilities staffed by professionals than was found in the Glasgow survey. The discrepancy may stem from at least two sources. Firstly, our consultants' perception may be more conservative in terms of the amount of supervision required by the discharged patients. However, the estimates of potential discharge rates were very similar. Secondly, the residential services practices may differ. For example, one of us (AL) trained in London and saw some "residence staffed by non-professional personnel" actually staffed by trained psychiatric nurses (paid as non-professional).

It will be interesting to compare our experience with the Scottish one in the years to come. Attention should be paid to carefully describing the type of accommodation and the level of staffing. In the end, only actual trial of discharge and follow-up to assess outcome will indicate how many sheltered housing places with professional staff are required and what resources need to be committed to this end.

ALAIN LESAGE
RAYMOND MORISSETTE

Hôpital Louis-H. Lafontaine
7401 rue Hochelaga
Montréal, Québec
Canada H1N 3M5

Affective 'switch mechanisms'

SIR: We fear Mobayed (*Journal*, June 1989, **154**, 884) has got hold of the wrong end of the stick. In our paper (*Journal*, January 1989, **154**, 48–51) we referred to our previous results which showed that SAM enters the CSF, is linked with CSF 5HIAA and folate metabolism, and influences prolactin. We not unreasonably thought that anything which influences prolactin and CSF HVA might have an effect on the dopamine system. Nowhere have we excluded an effect on serotonin also.

M. W. P. CARNEY
T. BOTTIGLIERI

Northwick Park Hospital and
Clinical Research Centre
Watford Road, Harrow
Middlesex HA1 3UJ

E. H. REYNOLDS

Kings College Hospital
London SE5

The opiate prescribing debate continued

SIR: Hill (*Journal*, June 1989, **154**, 888–889) may well consider prescribing a tot of best Scotch whisky to an alcoholic, if it would stop his patients robbing someone and paying a gangster for adulterated meths.

It is important to realise that any response, including continuing as before, is a policy which must be evaluated, otherwise clinging to it is purely emotive, especially if continuing as before sees a relentless increase in the drug problem. This is just what has happened in America since the 1920s and in western Europe since the 1960s.

Our own appraisal found that, paradoxically, making drugs available in a controlled fashion *reduced* the problem (Marks, 1987; *Lancet*, 1987). It therefore seems reasonable to conduct a further experiment on the lines of the Mersey Clinics' experiments in Widnes and Warrington to see if our findings can be repeated or refuted.

JOHN MARKS

Halton General Hospital
East Lane
Runcorn
Cheshire WA7 2DA

References

MARKS, J. A. (1987) Treatment of drug addicts. *British Journal of Addiction*, **82**, 813–814.
LANCET (1987) Management of drug addicts. *Lancet*, *i*, 1068–1069.

Case conference correction

SIR: I wish to dissociate myself from some of the remarks attributed to me in the case conference report by Howells & Beats (*Journal*, June 1989, **154**, 872–876). The second sentence of what I am alleged to have said is ungrammatical, inaccurate and offensive in tone. As the conference was not tape recorded I cannot quote my exact words, but I do recall commenting