have had more to do with the fallout from the media ordeal it underwent than from any other factor.

Regarding Weich & Lewis's suggestion for an intent-to-treat analysis, we obtained bed-day data from almost every patient who entered the trial. Analysis of this variable did constitute an intent-to-treat analysis and these data accounted for the bulk of the economic benefit. Regarding other variables, substitution of the missing data with values from previous data points in the trial may have been even more misleading than omitting those patients from the analysis. Regarding our repeated tests of statistical significance, these had to be done to know what happened separately at each rating time point, as the DLP might have been more helpful at some times than at others. This was indeed what we found.

Drs Weich & Lewis write of "satisfaction ratings by assessors who were not blind to treatment status". In fact our assessors did not rate satisfaction. If what is intended is a criticism that the assessors were not blind, we pointed out (p. 182) that "For safety, raters had to ask carers about risks during the coming interview, and so could not be blind to treatment group". We would be curious to know how Drs Weich & Lewis would deal with this methodological problem which is almost inevitable in patients who are so unpredictable and not infrequently dangerous.

We are sure that the writers' colleagues and others would be interested in the evidence that "the standard of routine post-discharge care at the Maudsley (the control treatment) was notoriously bad at the time". Regarding 'realistic' approaches, the DLP's problem/goal-oriented method of working is now part of the Thorn training programme for community nurses in London and Manchester.

In what seems to be their takeaway message, the authors allude to a "powerful argument in favour of asylum for the acutely mentally ill, particularly in our inner cities". This has long been obvious to workers with the seriously mentally ill in their homes and neighbourhoods. It was part of the DLP's ideology on its first day of operation, as indicated in our top paragraph above. The need for some in-patient beds for this population is clear from the way the DLP was run. We found that such beds should be run by the same team which does the community care – i.e. community care is not enough. Continuity of care, too, is important. Ideally there would be no need for an interface if a patient's care was continuously in the hands of the same keyworker and team both in the community and in the ward.

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Investigating multiple personality disorder

SIR: I commend Piper (*BJP*, May 1994, **165**, 600–612) for acknowledging the existence of multiple personality disorder (MPD), irrespective of how narrowly he chooses to define the condition or how rare he considers it to be.

I will not respond to a number of points and criticisms of the disorder and myself raised by Piper, as many of these issues have been covered in previous exchanges of letters elsewhere. In particular, his concerns about the reliability and validity of the Dissociative Experiences Scale (DES) were answered recently in the *American Journal of Psychiatry* (Piper, 1994; Putnam & Carlson, 1994).

I concur with Piper that a major part of the problem with the acceptability of MPD lies in the ambiguity of the DSM criteria. I too have criticised the gross inadequacies of these criteria. We have the empirical data to sharply delineate MPD from other psychiatric disorders. The failure to do so in the DSM–IV reflects a political rather than a scientific problem.

I agree with Piper that the nature of the alter personalities is the critical issue. Not surprisingly, he is able to extract from several decades of clinical literature, differences of opinion as to what the alter personalities constitute and how fully developed they are. The MPD field has now reached a general consensus that the alter personality states are limited psychological constructs organised around a contextualised sense of self with a restricted range of affect, behaviour and autobiographical memory (Putnam, 1992). Although early clinical accounts tended to dramatise the individuality of these entities, more recent work emphasises their component nature within the larger psychology of the individual. More focused clinical and experimental inquiry regarding the cognitive continuities and discontinuities of the alter personalities states should inform future debate.

MDP may also be considered within the larger domain of the study of dissociation, both normal and pathological. Many different kinds of data exist demonstrating that trauma is significantly associated with increased dissociation. In more recent

studies traumatic experiences are documented and quantified within limits, addressing concerns about the 'reality' of self-reports. Critics of MPD often ignore the larger scientific investigation of dissociation, now encompassing hundreds of published studies.

Although sharp differences of opinion will no doubt continue, I appreciate Piper's willingness to move the debate away from the question of its existence, and onto the larger questions of what MPD is, and how we should approach it clinically.

PIPER, A. (1994) Screening for multiple personality disorder with the dissociative experiences scale (letter). *American Journal of Psychiatry*, **151**, 1248–1249.

PUTNAM, F. W. (1992) Discussion: Are alter personalities fragments or figments? *Psychoanalytic Inquiry*, **12**, 95–111.

—— & CARLSON, E. B. (1994) Drs Carlson and Putnam reply (letter). *American Journal of Psychiatry*, **12**, 95–111.

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A spiritual dimension to mental illness

SIR: Sims' belief in the need to recognise patients' religious experiences (*BJP*, October 1994, **165**, 441–446) presents a challenge. My experience in the UK was of an almost complete silence on this intensely personal issue. In Zimbabwe I have found that the spiritual resonates clearly through everyday life. Patients and staff, and even government ministers, will raise spiritual concerns in relation to mental illness. Many Shona patients and their families see a spiritual dimension to mental illness and often seek spiritual remedies. These spiritual issues are not addressed in Zimbabwe by formal Western psychiatry, any more than in the UK; there is often tension or conflict between these spiritual and biomedical positions.

Sims encourages us to evaluate the role of religious or spiritual experience in the treatment of our patients. There is a lack of spiritual care or nurture offered generally by psychiatrists and their colleagues, particularly to those individuals with long-term disabilities. By this I mean the provision of suitable and accessible opportunities for spiritual or religious expression analogous to the provision of adequate diet or accommodation, not just as alternative treatment modalities. Some patients may have specific needs for spiritual counsel or intervention as part of a truly holistic management approach. Sims rightly warns of the dangers of adopting a priestly role. However, this should perhaps encourage us to work more closely with those who do have such a role – the local clergy, church counsellors, and hospital chaplains. At the same time, it may not always be inappropriate to act as a spiritual guide to individual patients in much the same way as a therapist guides clients through psychotherapy.

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A HUNDRED YEARS AGO

Insanity and Crime

A case was heard recently at the Central Criminal Court which illustrates very well the mode of procedure in the case of a person of unsound mind who is charged with crime. The counsel for the defence said he desired the issue to be tried whether the defendant was of sound mind and fit to plead to the indictment. The jury was accordingly sworn to try this issue. Counsel then stated that the defendant was 67 years of age. His mind had been affected for a considerable time. Some twelve months ago steps were taken with a view of having him certified as a person of unsound mind, and his son was advised that that was a proper course to take. Unfortunately, the counsel added, the son did not act upon the advice given, but had his father looked after in the hope that the state of his mind would improve, but it did not improve. Medical evidence was given to the effect that the defendant was of unsound mind, and Dr. Savage stated that as long ago as January, 1894, eight months before the charge was made against the defendant, he had been prepared to certify him as of weak mind, and had advised that he should be made a ward of the Court of Chancery. The jury found that the defendant was insane, and unfit to plead to the indictment; and the Recorder said that the defendant would be detained during the Queen's pleasure. The case has a useful moral for the public. Had his friends acted upon the medical advice given to them, the crime would never have been committed, and this unfortunate man would not have had to have spent his declining years in Broadmoor.

Reference

British Medical Journal, 26 January 1895, 217

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