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.

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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.

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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

you don't." I would like to recommend an article by B.G. Braun (1984). Professor Merskey seems to overestimate the power of hypnosis. As Braun explains, MPD cannot be produced by hypnosis, but it can be unveiled by hypnotic techniques.

BRAUN, B. G. (1984) Hypnosis creates multiple personality: myth or reality? *International Journal of Clinical and Experimental Hypnosis*, **32**, 191–197.

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The neglect of anger in Western psychiatry

SIR: I read with interest the review on anger by Kennedy (*Journal*, August 1992, **161**, 145–153), and fully support the view that the clinical assessment of anger, its antecedents, consequences, and treatability has been neglected. In the handbook on psychiatric examination (Institute of Psychiatry, 1987) which is piously used by psychiatric trainees, mood assessment includes, among others, spirits, anxiety, tearfulness, and guilt, but not anger. Clinically, extreme states of depression or anxiety are readily regarded as a disorder which is out of a patient's own control and requires psychiatric treatment. In contrast, similarly severe attacks of rage are often conceived, if not stigmatised, as being within a person's own moral responsibility, unless the anger is epiphenomenally thought to underlie manifest depression and hence should be 'ventilated'. Unlike sadness or apprehension, anger easily provokes negative countertransference and may selectively be repressed by the psychiatric profession. If morbid anger has a biological basis akin to depression or anxiety and responds equally well (or poorly!) to psychiatric treatment, then many affected subjects may have been unjustifiably sent to prison.

Dr Kennedy may like to add to his review the Chinese concepts of emotions and pathogenesis (Wu, 1982). Traditional Chinese medicine, as recorded in the classical text of *Huang-ti Nei-ching* (the 'Bible of Chinese medicine') more than 2000 years ago, stresses the importance of a balanced life, and the regulation of the seven emotions (*qi-qing*). Instead of a simplistic depression-elation paradigm, the seven emotions include joy, anger, worry, contemplation, sorrow, apprehension, and fright which may dialectically interact with one another. Depression does not rank high among these emotions, explaining to some extent the reputed lack of lexicon to express depression and the controversial issue of there being less depression in the Chinese (Xu, 1987). Excessive emotional activity of any kind may cause imbalance of *Yin* and *Yang*, blockade of *Qi*, malfunction of organs and hence illness. More specifically, violent anger is hurtful to *Yin*, and violent joy is hurtful to *Yang*. A person with an irascible personality is described as *hou-qu-ta* rather than 'borderline' among Mandarin-speaking Chinese (Lin *et al*, 1980). Sorrow counteracts anger, lending some credence to the psychoanalytic theory that anger repressed and turned against the self becomes depression.

In investigating the Korean culture-bound 'anger' syndrome of *Hwa-Byung*, Lin *et al* (1992) recently suggest the addition of an 'anger syndrome' in the DSM–III system. Notwithstanding the social risk of legitimising anger and aggression as disease states, morbid anger deserves a fair share of the enormous and not always fruitful research efforts that Western psychiatry has elected to spend on depressive and anxiety states.

INSTITUTE OF PSYCHIATRY (1987) *Psychiatric Examination: Note on Eliciting and Recording Clinical Information in Psychiatric Patients* (2nd edn). Oxford: Oxford University Press.

LIN, K. M., KLEINMAN, A. & LIN, T. Y. (1980) Overview of mental disorders in Chinese cultures: review of epidemiological and clinical studies. In *Normal and Abnormal Behaviour in Chinese Culture* (eds A. Kleinman & T. Y. Lin), pp. 237–272. Boston: D. Reidel.

——, LAU, J. K. C., YAMAMOTO, J., *et al* (1992) Hwa-Byung – a community study of Korean Americans. *Journal of Nervous and Mental Disease*, **180**, 386–391.

WU, D. Y. H. (1982) Psychotherapy and emotion in traditional Chinese medicine. In *Cultural Concepts of Mental Health and Therapy* (eds A.J. Marsella & G.M. White), pp. 285–301. Dordrecht: Reidel.

XU, J. M. (1987) Some issues in the diagnosis of depression in China. *Canadian Journal of Psychiatry*, **32**, 368–370.

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The Northfield Experiments

SIR: As psychoanalysts practising analytic group psychotherapy in a mental hospital, we read with great interest Harrison & Clarke's paper about the Northfield Experiments (*Journal*, May 1992, **160**, 698–708). It might be of interest to the readers of the *Journal* to know that there is a psychotherapeutic ward in a state hospital in Switzerland (Haus 14, Kantonale Psychiatrische Klinik Wil, St Gallen) which is explicitly committed to the concepts developed at Northfield. This is the only psychoanalytically orientated unit in a large clinic, and we