SIR: Van Der Hart & Boon (*Journal*, March 1989, **154**, 419) detect a note of ambivalence in my review of the diagnosis of multiple personality disorder (*Journal*, November 1988, **153**, 597–606), and hope to help me by prescribing a careful reading of Janet's contributions on the subject. However, my examination of these references reveals an attitude of ambivalence on the part of Janet, not mentioned by the above authors, and makes me think that I may be in good company. In his book *The Major Symptoms of Hysteria* Janet (1965) appeared to be puzzled, as are many latter-day critics, by the remarkable concentration of cases in America, the bizarre symptomatology, and the "mystic admiration for the subject, an exaggerated seeking after surprising and supranormal phenomena" which was evident in the case descriptions of the time. He also emphasised the rarity of genuine cases of multiple personality. He commented on the effects of elaborate exploration and naming of the alternate personalities when he wrote, "Once baptised, the unconscious personality is more clear and definite; it shows the psychological traits more clearly" (Janet, 1989). While he may have thought this was a good thing, Janet may have been detecting a tendency for therapists to reinforce the symptoms or add to their complexity.

It is clear from hysterical and contemporary reports that the symptoms of MPD present against a background of a wide variety of psychological symptoms and underlying psychiatric disorders. Drs Van der Hart & Boon agree that the DSM–III and DSM-III-R criteria for MPD are vague, and imply that the diagnosis is probably overused in the USA. Transient dissociative reactions such as the case reported by Fahy *et al* (1989) would meet the current diagnostic criteria. These cases may respond without resorting to specialist MPD treatment programmes. This makes nonsense of the assertion that the diagnosis is necessary or justified as a way of identifying the most apt type of treatment. Until the advent of improved diagnostic criteria and convincing evidence about the comparative efficacy of different types of treatment, the literature on this topic will remain confusing and frustrating. A certain amount of ambivalence is probably inevitable, and may be a lesser failing than the dogmatism and loose scientific standards which have been commoner failings in this field.

Dr Fleming suggests that MPD has been unfairly picked on when the influence of pathoplastic factors such as cultural and iatrogenic factors are exaggerated in this case, but are ignored when it comes to other conditions such as panic disorder. It would be mischievous to argue that the publicity given to panic disorder matched that given to MPD. The numerous documentary, fictionalised, and cinematic depictions of MPD have been assimilated into public awareness and have probably affected the public perception of all psychiatric disorders. The potency of recent well-publicised cases to excite the public imagination was clearly demonstrated by the "thousands" of self-diagnosed cases who contacted the authors of *The Three Faces of Eve* following the book's publication (Thigpen & Cleckley, 1957, 1984). The authors, whose diagnostic criteria for MPD are very stringent, considered only one of these cases to be genuine.

I do not 'disbelieve' in dissociative disorders as Dr Fleming suggests. Indeed, the critics of the diagnosis of MPD believe that the patients present themselves to psychiatrists with a complex history of dissociative symptoms. What I am proposing is that one set of symptoms are being seized upon, and are possibly elaborated in therapy. The logical conclusion of any other position is to suggest that each dissociative symptom merits a completely separate diagnosis. While I agree with Slater's sentiment, quoted by Dr Fleming, that we should listen closely to our patients, I suspect that Slater himself would have taken a jaundiced view of much of the literature on MPD. Indeed, in the article from which Dr Fleming selectively quotes, Slater (1982) emphasised the risk that the hysterical symptoms themselves, especially if viewed as the final diagnosis, become a way of "avoiding a confrontation with our own ignorance" and are consequently one of the main obstacles to communication and mutual understanding.

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