application of the Wells' Check-List Differentiating Pseudodementia from Dementia (Wells, 1979); (c) exclusion of depression by Hamilton Rating Scale for Depression (Hamilton, 1960). The diagnosis of conversion disorder was based upon a semi-structured psychiatric interview. Patient assessment also included interviews with relatives, and socio-environment evaluations. In addition, all six patients satisfied DSM–III–R, Lazare's (1981) and Kirby & Harper's (1988) criteria for the diagnosis of conversion disorder. The six patients identified as affected by cognitive impairment probably related to hysterical conversion reaction were included in a three-year follow-up programme. The follow-up consists of a monthly interview with patients and their relatives, a physical-neurological examination and laboratory tests every six months, and a yearly neuropsychological assessment. At the end of year 2 the outcome for the six patients was: four diagnoses of cognitive impairment definitely related to conversion disorder (one man, three women; median age 64 years; range 61–69); one diagnosis of cognitive impairment possibly related to conversion disorder (associated with depressive illness) (a 64-year-old man); one diagnosis of cognitive impairment not related to conversion disorder (diagnosis of primary degenerative dementia) (a 73-year-old man).

The relatively high number of cases of conversion pseudodementia identified by this study could possibly be related to multiple factors: (a) our apparently privileged standpoint as a result of our department being the only referral centre providing psychiatric assessment and care for the whole Val Trompia population (Brescia Province, Italy; 106 244 inhabitants in March 1990); (b) a peculiar sociocultural environment able to cluster a pathology still confined to sporadic observations; (c) the possible evolution of hysterical symptoms since Charcot (1878) established the classical pathological reference patterns. In this regard it must be underlined that in the families of all four of the above-mentioned patients, at least one relative suffering from cognitive impairment could be found. The presence of affected relatives might provide a model to be mimicked. Interestingly, cognitive impairment may represent a new kind of hysterical syndrome which appears to be shaped by ageing and age-related disorders of contemporary society. Moreover, as recently speculated by Leff (1988), the expression of hysterical symptoms in the Western world has shifted from the bodily mode to the psychological mode; we believe that conversion pseudodementia might represent a paradigm of this evolution.

Although the present study is limited by the relatively small sample size and the incomplete follow-up, we would like to highlight this reversible cognitive dysfunction in order to underline the risk of an inaccurate diagnosis of dementia causing possible institutionalisation of the patient and subsequent deterioration, and to urge epidemiological research to provide quantitative data on this illness. In the light of our experience, it would be interesting to know if cases of dementia and pseudodementia, in which hysterical behaviours were identified or suspected, were detected in Copeland *et al*'s large study.

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AUTHOR'S REPLY: Liberini and his colleagues raise interesting points in their account of the incidence of conversion pseudodementia. Within the UK, conversion hysteria is generally thought to be rare, especially in older people. A benefit of increasing interchange between European psychiatrists will be the challenging of national diagnostic customs by epidemiological evidence.

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From the limited details given it seems that there are four new cases per year in their area. If we assume that the oldest fifth of the population is at risk and a duration of illness of 10 years, we can estimate the prevalence. Doing this reveals that our failure to find a single case in a sample of 1070 is not surprising ($P \approx 0.12$). One would have to know more about the population at risk to make more detailed calculations.

In our own study, taking the year 3 follow-up (the only one done by psychiatrists) we can confirm that no diagnosis of conversion pseudodementia was made by the psychiatrists. The AGECAT computerised diagnostic system does not make a diagnosis of hysteria, the nearest equivalent is the diagnosis of hypochondriacal neurosis (Larkin *et al*, 1992), and there were six cases with syndrome case levels. Of these, two were AGECAT organic cases, both of these had been organic cases at year 0. The remaining four had Mini-Mental State scores of 24, 26, 29 and 30. One had received an AGECAT diagnosis of depression at year 0, at year 3, and was depressed at year 6 follow-up. The remaining three were cases of hypochondriacal neurosis at year 3. One was depressed at year 0 and was again depressed at year 6. One was well at year 0, and a subcase of anxiety at year 6. One was a subcase of depression at year 0 and was not seen at year 6.

The whole area remains a difficult one, we note that the ECA study found an increase in cognitive impairment in people with somatisation disorder (prevalence ratio 5.94), but that this was not significant (Swartz *et al*, 1991). It would be interesting to know whether the cases of pseudodementia in the study of Liberini *et al* recovered at follow-up, perhaps the ultimate test of pseudodementia; we look forward to eventual publication of their study.

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Multiple personality

SIR: Merskey (*Journal*, March 1992, **160**, 327–340) reviews historical literature on cases of multiple personality. He reaches the conclusion that they can be accounted for as an iatrogenic creation based on (a) misdiagnosis of organic or bipolar illness, (b) the conscious development of fantasies, (c) hysterical amnesia and retraining, and (d) explicit or implicit hypnotic suggestion or other forms of therapist persuasion. The article is more like one side of a debate than a scientific review of the literature. In every case in which there is insufficient information, a common problem in reviewing historical case material, the author concludes that the possibility of contamination by therapist suggestion is indeed a probability. The author seems to take particular delight in highlighting the 'embarrassing failure' of American psychiatrists to make a proper diagnosis, a deficiency remedied when the hapless patient is fortunate enough to return to Great Britain.

Dr Merskey acknowledges that many of the patients in these studies have various dissociative symptoms such as dissociative amnesia. If they do in fact have real dissociative symptoms, then the disagreement is really about phenomenology, i.e. a failure of integration of memory, rather than a more pervasive failure of integration of aspects of identity.

While such scepticism can help to strengthen diagnostic procedures, this article constitutes an unusual attack on the diagnostic abilities of psychiatrists who make the diagnosis of MPD. It is true that patients prone to dissociative disorders are generally highly hypnotisable and therefore unusually vulnerable to direct or indirect suggestion. Nonetheless, to argue that all of this form of psychopathology can be accounted for by misdiagnosis, and accidental or deliberate suggestion, is at variance with a wealth of data which suggests otherwise. The author concedes in his diatribe the existence of genuine dissociative psychopathology independent of iatrogenesis.

We intend to include a tightened version of the diagnosis of multiple personality disorder in the fourth edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association. In addition to some changes in language, we are reintroducing the requirement that the dissociative amnesia be a part of the syndrome in order to make the diagnosis. We strongly encourage further research in this complex but important area of psychopathology.

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