Multiple personality
A single case study with a 15 year follow-up

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SYNOPSIS A review of the literature relating to multiple personality is presented together with a study of a single case of hysterical aetiology that demonstrates the development of multiple personality from a fugue amnesic state. A re-examination of this case after 15 years without significant psychotherapeutic intervention demonstrates a tendency towards remission. The view that multiple personality is a form of fugue, not necessarily hysterical, in which an alternative personality is adopted and that this behaviour is reinforced by the attention that it receives, is discussed.

From time to time the phenomenon of multiple personality has attracted the attention of psychiatrists, particularly in the early part of this century, and it has always been a popular, if misleading, concept of mental illness for the layman. However, few new cases have been published recently, particularly in Great Britain but, in many of the reported cases, the clinical picture is confused by the production of similar, if not identical, mental states by hypnosis. In addition, there have been no long-term follow-up reports, although some studies have extended over a few years. This present study of a single case describes the clinical course of the illness uncomplicated by hypnosis, and also reports the state of the patient 15 years later.

REVIEW OF LITERATURE
The first recorded case of multiple personality was that of Mary Reynolds of Pennsylvania (Mitchill, 1816; Plumer, 1860; Mitchell, 1888). This 19 year old English-born girl, who exhibited other conversion symptoms, developed her secondary personality during a prolonged fugue state, and subsequently alternated between this and the primary personality. The next case, Sorgel, an epileptic whose personality altered during an epileptic fugue (von Feuerbach, 1828), was followed by two British cases published in 1845 (Mayo 1845; Skae 1845). The number of reported cases increased around the turn of the century both on the Continent (Felida X: Azam (1887); Louis Vive: Camuset (1882); Leonine and Lucie: Janet (1887); F, the sergeant of Bazeilles: Mesnet (1874); Emil: Proust (1890)); and in America (Ansel Bourne: James (1889); Alma: Mason (1893); the Tinsmith: Osborne (1894); Revd. Hana: Sidis and Goodhart (1904); Miss Beauchamp: Prince (1905)). In 1900 Flournoy reported perhaps the most fully documented case of all, Mlle. Smith.

The first collection of cases was made by Binet (1896): 10 years later Prince (1905) reviewed 20 cases of multiple personality, and subsequently expanded the concept as an explanation of other psychological abnormalities. Janet (1907) discusses multiple personality in terms of somnambulisms, distinguishing three types: 'reciprocal somnambulisms', 'dominating somnambulisms', and complex or mixed cases. Like Sidis and Goodhart, and Prince, Janet stresses the importance of dissociation, tracing this concept from sleep-walking to multiple personality by way of fugue states, but he also regarded suggestion as an important aetiological factor.

In the first 40 years of this century the diagnosis was made frequently and many of these cases have been published. Several published under the title of multiple personality, however, are no more than prolonged fugue states (Riggall, 1923; Copeland and Kitching, 1937), or an
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encapsulated amnesia for a specific traumatic period of the patient’s life (Forsyth, 1939). In 1944 Taylor and Martin reviewed 72 cases of multiple personality, taking as their criterion ‘two or more personalities each of which is so well developed and integrated as to have a relatively coordinated, rich, unified and stable life of its own’. They discuss three types of organization (1) alternating, in which the personalities are mutually amnesic, (2) co-conscious, in which the secondary personality has memories of external events of the periods when the primary personality is dominant, and (3) intraconscious, in which the secondary personality also claims knowledge of the primary personality’s own thoughts and feelings (but not vice versa). The authors conclude that multiple personality is a genuine phenomenon, based on a dissociative mechanism and stress the importance of role playing in its genesis. They regard it as the extreme end of a continuum of failure of integration—restlessness during sleep, somnambulisms, daydreaming, partial dissociation of the personality, psychoneurosis, and multiple personality.

About the time of Taylor and Martin’s review, Harriman (1943) published his work on the role of suggestion in the aetiology of multiple personality. He produced secondary personalities in normal but selected subjects by means of post-hypnotic suggestion, not only by directly suggesting a new personality to be adopted, but also by the more indirect technique of suggesting that the subject has no intimacy or close identity with his normal personality, the subject then adopting a second personality or role. Orzech et al. (1958) demonstrated that the alternations between ambivalent attitudes that subjects show, and which may sometimes be polarized to the extent that the individual says that he feels like two people, may be brought about by changes in the prevailing mood produced hypnotically. The authors postulate that the same process may occur in multiple personality, although they acknowledge that they did not produce distinct personalities by this technique.

Since the second world war there has been a decline in the rate at which new cases have been reported. Thigpen and Cleckly published their extensive study of a single case, Eve, in 1954, but the phenomenon was discussed only in terms of existing concepts of dissociation (Thigpen and Cleckly, 1954). In their review of multiple personality, Sutcliffe and Jones (1962) considered that the diagnostic confusion of the early part of the century, the interest shown in hypnosis, in concepts of self-identity, and in quasimagical transformations of the self, together with the ready availability of unsubstantiated causal theories, fostered the development of multiple personality and hence led to the upsurge of reported cases.

These authors also suggest that up to half of the early cases that they reviewed could have had an organic aetiology—mainly brain damage and epilepsy—and that this possibility of an organic cause added respectability to the concept. To the cases discussed by Sutcliffe and Jones could be added that described by Maddison (1953) after a head injury and the case described by Lewis (1953), occurring in the setting of partially treated GPI. The case reported by Franz (1933), which is shown later (Lipton, 1943) to be possibly schizophrenic, is another example of multiple personality occurring in a state other than hysteria. Sutcliffe and Jones discuss the work of Abeles and Schilder (1935) who collected 63 cases of transient loss of personal identity lasting up to two weeks where the diagnosis of an acute psychotic illness or organic confusional state had been excluded. Sutcliffe and Jones postulate that many of these might have been labelled multiple personality if sufficient attention had been given to the loss of personal identity. They thus accept that some degree of shaping of the personalities occurs during treatment, but do not see this as a sufficient explanation. They reject the idea of conscious simulation, concluding that the phenomenon is an extension of normal role playing behaviour; and they stress the importance of amnesia, suggesting that the subject’s self perceptions should be regarded as delusional.

The importance of role playing had previously been emphasized by Taylor and Martin (1944), the patient entering a fugue state and adopting a role from his past experience of phantasy. Congdon et al. (1961) report a case which clearly exhibits the gradual transition from imagined playmate, through conscious role playing, to unconscious alternation between the two roles or personalities.
The extent to which medical attention may encourage the development of secondary personalities has been discussed further by Gruenewald (1971). She drew attention to the fact that in many of the cases such personalities emerge during psychotherapy, particularly if hypnosis is used, and argues that the use of hypnosis may indicate an approval of the dissociative process, and also that the interest shown by the therapist reinforces the dramatic aspects of the condition. Nearly 70 years earlier Janet (1907) had said ‘Whatever precautions one may take, the ideas of the observer in the end influence the development of the somnambulisms of the subject and give it an artificial complication’. Indeed, some authors argue that multiple personalities are only the artificial productions of the medical attention that they arouse (Slater and Roths, 1969).

In their recent single case study, Ludwig et al. (1972), defining multiple personality as ‘one or more alter personalities, each presumably possessing different sets of values and behaviour from one another and from the primary personality, and each claiming varying degrees of amnesia and disinterest for one another’, have attempted an objective analysis of the condition. They show that the personality differences can be assessed by objective rating scales (McDougall, Adjective Check List, MMPI), that the nature of the amnesia can be explored by paired word-learning tests and logical memory tests, and that the amnesia is especially marked for emotionally laden words, demonstrated by the galvanic skin response. They also demonstrated differences in the EEG and the visual evoked potentials between the personalities. Others, also attempting objective analysis of a case, have demonstrated differences in microstrabismus, the transient loss of oculomotor parallelism, by a frame by frame analysis of a film of Thigpen and Cleckley’s case Eve (Condon et al., 1969). This phenomenon has not been observed in normal subjects but has been seen in some schizophrenics. Ludwig et al. also used a conditioning paradigm in an attempt to explore the extent of generalization of new learning between personalities, and, although the results are inconclusive, some spread of conditioned response from one personality to another was demonstrated. They conclude that it would be extremely difficult to simulate these results, and stress that this is adaptive behaviour by which the normal personality avoids situations with which it cannot cope. The authors, dissatisfied with explanations in terms of role playing alone, put forward the concept that the appearance of each personality represents a state of altered consciousness. The development of independent, mutually exclusive personal histories is considered to be based upon some type of ‘state dependent learning’, analogous to the lack of transfer of material learned in a drug state to a non-drug state, although such material is recoverable if the original state is re-entered. Ludwig et al., while classifying multiple personality as a hysterical dissociative reaction, because of the altered state of consciousness, see the condition as a bridge between conditions with organic loss of awareness of integrated identity (TLE, alcoholic blackouts, toxic confusional states) on the one hand, and purely psychologically determined states such as fugues and twilight states on the other.

Little has been written evaluating the treatment of multiple personality, except that the aim is to resynthesize to the primary state. Sidis and Goodhart believed that it was essential to produce a rapid alternation between the personalities by physical or psychological stimuli and by shortening the intervening state enabling each personality to gain insight into the other. The most commonly used method of treatment has been hypnosis, and Gruenewald (1971) used the techniques of suggestion derived from hypnotherapy, without the induction of an hypnotic trance, in treating her case. It would appear that few reported cases have escaped therapeutic interference of this kind and hence there is little information available as to the natural history of multiple personality untreated. Janet suggests that the frequency of the personality changes becomes less with age, with a tendency for the lively energetic personality to predominate. Lipton reviewed his case five years after his first report, but his patient may have been suffering from a schizophrenic illness, and thus be atypical (Lipton, 1948). Similarly, Lewis gives a 20 year follow-up on the case that he reports, but this man suffered from GPI.

CASE REPORT

Mrs. A.B. was 25 when she was first admitted to a
psychiatric hospital, complaining of recurrent faints, amnesia, and blindness. She was initially referred by her general practitioner because she had twice tried to attack her 5 month old baby. She came from a strict working class family and both her father, who had been married and widowed before, and her mother, who was younger by 20 years, had died. Her father was an authoritarian figure and a perfectionist, while her mother had feelings of inferiority, feared people looking at her, and was generally rather gloomy. The patient was the middle of three sisters, all of whom were said to be jealous of each other, and she always felt the odd one out, rejected by her family. Her birth and early development were uneventful, although her early childhood was marked by nightmares and temper tantrums. After normal education from the age of 4 until 14 years, the patient trained and worked as a secretary until she joined the WRAF at 19. Under the influence of her family she became pregnant at the age of 24. She then married the man with whom she had been cohabiting, pending his divorce. He was 10 years senior and had a rather unstable employment record. The patient had recurrent bronchitis and asthma until the age of 21, and developed left-sided migraine at 19. When she was 22 rheumatic heart disease was diagnosed on routine examination, but the severity of this was not appreciated until she became pregnant. She had a mild stammer as a child, and her sister later reported that if she was unable to obtain her own way while playing with other children she would pretend to faint. Although she was a shy person, she was cheerful, energetic, and had many friends. She was an avid reader, particularly of fiction and biographies.

Her illness started some 15 months before her first psychiatric admission at a time when she was pregnant, anaemic, and doubting the stability of her relationship with her future husband. She developed frequent ‘fainting’ attacks, up to 20 times in one day, which she was able to prevent when in public. Initially, these lasted for about half a minute but later might last several hours. Four months later she developed periods of mutism lasting up to four hours, and, about the same time, experienced visual and auditory hallucinations of little green men in yellow coats talking to her companionly after arguments with her husband. Five months later she ‘fainted’ in a public house and was admitted to a general hospital as an emergency. After two months in hospital she was discharged well and immediately married. After the birth of her daughter the ‘fainting’ started again, but, in addition, when she recovered consciousness, she was often unaware of her own identity until another ‘faint’ occurred. During these periods, which lasted up to five days and of which she subsequently had complete amnesia, she sometimes presented as an entirely different personality. At this time three personalities were reported: ‘Alma Smith’, a Newcastle prostitute; an unnamed 12 year old girl; and a German woman called ‘Elke Schweik’. In this third personality she spoke a few phrases of German, although normally she spoke none. Three weeks before admission she developed periods of blindness lasting from the time she woke to about midday. While she was aware of this disturbance and of the periods of mutism that had also occurred, she remained completely unaware, in her primary personality, of the periods of loss of identity and changes in her personality, except as blank periods in her life. Before admission the possibility of epilepsy was considered. She was told this and treated with anticonvulsants. After this she had two episodes in which she frothed at the mouth, growled like a dog, grabbed her baby, and attempted to bite her. These atypical attacks were terminated by a smack on the face from her husband.

Examination at the time of admission revealed mitral stenosis and aortic incompetence and a mild anaemia. Her mental state was essentially normal apart from short gaps in her memory for the periods of altered personality. She was bright and witty, her talk was of normal construct, and her mood was appropriate. She expressed no abnormal ideas, no hallucinations were present at that time, and there was no cognitive impairment. She had some insight, particularly into the connection between her hallucinations and arguments with her husband. She was also able to recognize a link between the birth of her daughter and the return of her symptoms.

Investigations at this time showed no evidence of an intracranial lesion and the electroencephalogram showed only a nonspecific generalized abnormality. The chest radiographs showed slight cardiac enlargement consistent with mitral stenosis, and the haemoglobin confirmed the mild anaemia. In view of the lack of evidence for epilepsy, the anticonvulsants were discontinued, while the mild anaemia was treated with oral iron.

During her stay in hospital, she showed several changes of personality and other episodes of altered consciousness. Shortly after her admission she asked a nurse who she (the patient) was, saying that she had had ‘a turn’. A week later she was reported to have fainted and on recovery believed herself to be 16 years old and still living with her mother. Her account of her situation as a 16 year old was in
agreement with the account of her life given at the time of admission, and she was able to state correctly the age that her mother would have been when she was 16. Also her knowledge of current events for the period in which she said that she was living was accurate. She acted in a rather childish manner, appeared distressed by the questioning, worried about why she should be in hospital, and concerned that her mother did not know of her whereabouts. This state lasted for approximately 18 hours, ending spontaneously. There were then no alterations in her personality for a period of two weeks, during which time her registrar was away from the hospital. On the day of his return she talked more freely of her marital and housing problem and, later that evening, she entered the character of Alma Smith, a Newcastle prostitute. She gave an extremely elaborate account of Alma Smith’s life, with details of her childhood and experiences in the brothel. She was again able to give an accurate account of the current events for the time in which she purported to be living. Her behaviour, while similar to that of her normal self, seemed less direct and forceful; she was less humorous and less sure of herself and was described as ‘a shadow of her usual self, lacking colour and brightness but maintaining the basic contours’. Within this history of Alma Smith, there were incorporated two items from the patient’s own life: she gave her real date of birth, although giving her age as 20, and she said that she had a friend living outside London who had a baby 4 or 5 months old. This man had the same first name as her husband, did the same type of work, and drove the same type of car: she said that they pretended that they were married and that he had given her the wedding ring that she was wearing. This episode lasted about 20 hours. During the next month she remained relatively symptom free, and received supportive interviews from her doctor. She was often reluctant to go home at weekends, saying that she feared that she might harm her child or cause embarrassment through a change of personality. She had frequent disturbing dreams, often centred around her husband, and continued to have occasional brief episodes of amnesia. In one of these she believed that she was herself, but only 10 years old. This episode was not observed in hospital. In another she claimed to have become unconscious on the way and on recovery her wedding ring was missing: this was quickly found after the patient had suggested that it might be under a tray cloth. After two months in hospital her husband was innocently involved in a police investigation and she failed to return from weekend leave saying that she had decided to remove her daughter from care and stay at home.

Five months later the patient was readmitted. After the first admission she had felt well for about six weeks, but then began to develop episodes of personality change, again at a time when she feared that she might be pregnant. This pregnancy was confirmed on admission. During the three months before this she had changed her personality at least once a week, and for several weeks had been confined to bed because of difficulty in walking. She had also, at times, been unable to see, to talk, to hear, or to move her arms. Apart from complete blindness, other visual disturbances of a selective nature occurred; for instance, she would be able to see her baby but nothing else in the room, or she would see a tray being carried by her husband but not her husband carrying it. On all such occasions her husband was the last object to become visible. During this period she experienced changes of personality to four different characters: Alma Smith; ‘Ellen Briggs’, a 21 year old typist from Andover (the patient was stationed at Andover while serving in the WRAF); ‘Brenda Allen’, a real person who had been a friend of the patient; and a woman from 2002 A.D. Two of these personalities were observed in outpatients.

Examination at the time of readmission showed her behaviour to be much as before, but she talked more openly of the difficulties at home, and admitted freely to episodes of depression. She reported de-realization experiences, but there were no delusions, hallucinations, or compulsive phenomena present, and her cognitive functions were not impaired. Discussions on this admission were directed towards problems with her husband and, in retrospect, it is possible to see the relationship between these discussions and further episodes of personality change. On one occasion, she adopted the personality of an 11 year old schoolgirl, ‘Eve Johnson’, a real person who had been at the same school as the patient and who had described the patient at that time as ‘horrible and a show off’. During this change she talked and behaved as a child, though reverting to her normal speech during psychological tests. In these her score as a 25 year old adult on Ravens Progressive Matrices remained virtually unchanged (IQ Equivalent 110, 111 previously), while her score on the Mill Hill dropped considerably (81 compared with 111). When these results are scored for an 11 year old girl, however, the Mill Hill compares with the previous result (IQ 111), while the Matrices score increases (IQ 119). This change of personality lasted for four hours and resolved spontaneously. Soon after she developed a pulmonary embolus and was transferred for further treatment.

FOLLOW-UP

The period of follow-up extends over 15 years from the first admission. The information comes from
regular standard inquiries to the general practitioner for the first 10 years, a review of the outpatient notes of the hospitals that she has attended, a personal interview of her GP by one of us (B.D.C.) and a personal interview of the patient, husband, and younger daughter by one of us (B.D.C.), when the patient was aged 40.

After her transfer she had a further pulmonary embolus and subsequently underwent a mitral valvotomy. She remained in hospital until after the birth of her second child, and, although she had periods of amnesia at this time, no personality changes were recorded. However, on return home, personality changes occurred up to 12 times a day, together with amnesia, total blindness, deafness, aphonia, and paralysis. The most frequent secondary personality Alma Smith, followed by a character, not seen during either of her admissions, known as ‘June Harris’ and dating from the eighteenth century. Apart from these two there were no persistent alternative personalities observed by the husband. Alma Smith was amnesic of the time between her appearances, but has latterly asked the husband about events during these times. The frequency of dissociative and conversion episodes has gradually declined, although changes in personality have continued, particularly at night. When she was 29 the patient underwent a termination of pregnancy and was sterilized. By this time, both she and her family had accepted and tolerated the established pattern of personality change, although such changes still caused inconvenience and occasionally anxiety, lest a change should occur in an embarrassing situation. At the age of 35 she began part-time secretarial work, an event associated in time with a marked decrease in the frequency of personality change. For eight months before being interviewed for follow-up there were no personality changes, but three changes occurred in the week before the interview. She now has a good work record, but has few social contacts outside her work. Her marriage is not entirely happy but is much improved. She still has little interest in domestic duties, but is concerned for her family and their welfare. She occasionally experiences anxiety, but she attends her general practitioner infrequently, usually suffering from migraine.

After her second admission the only psychiatric treatment that the patient received has been supportive therapy at monthly intervals during the first three years and five years after discharge, during a period of marital stress she was prescribed a benzodiazepin. When she was 33 she sought help from the probation service about her marriage, but has latterly asked the husband about events during these times. The patient’s own appraisal of her illness, and particularly of her episodes of multiple personality, is that it is a ‘mechanism for avoiding trouble’. She implies that the difficulty in the early stages of her illness was her insecurity, being pregnant and not married. The development of multiple personality, however, followed the birth of her first child and she now sees the difficulties of that time as revolving around her husband’s isolationist attitude towards the rest of the neighbourhood and her own disappointment at being confined to a domestic life and unable to realize her own ambitions. The various characters she regarded as aspects of her own personality, but while she accepts Alma Smith as reflecting her Novocastrian early life and also her sexuality, which she normally has difficulty in expressing, she finds it more difficult to accept the personality of June Harris as an aspect of herself, as this personality’s submissive attitude towards men is at variance with her own. In her view, the gradual remission of symptoms has been most helped by accepting the personality changes and thus being less worried by them, by the sterilization operation, and by taking part-time employment.

DISCUSSION

This hysterical illness may be divided into two phases. The first phase, from starting to cohabit until just after her marriage, consisted of episodes of loss of consciousness, periods of mutism, and the comforting hallucinations of little green men. There was no loss of personal identity and no alternative personalities developed. The second phase, after the birth of her child, is dominated by the alternating personalities but there are, in addition, episodes of loss of personal memories, blindness, paresis, and the atypical attacks in which she threatened her own child. (The symptoms have gradually waned during her two admissions and subsequently, although some features persist in a less severe form that her family has learned to accept.)

The first period, in which there was little medical attention, can be seen as a response to the stress of her insecure situation, the second a response to her inability to accept domesticity and motherhood in an unstable marriage. In addition to the psychosocial stresses, the first episodes of loss of consciousness, although at the time considered to be psychogenic, could, in view of her valvular heart disease, anaemia, and pregnancy, have had an organic cause. Subsequent medical and other attention may have encouraged...
their continuation and elaboration. This importance of medical interest in sustaining the phenomenon is also seen in the timing of her fugue states while in hospital and in relation to the follow-up interview.

The four predominant personalities seen while at hospital—the patient at different ages, Alma Smith, Eve Johnson, and the woman from 2002 A.D.—all have some relationship to the patient’s opinions about herself and others. Her sexual feelings, perhaps based on her strict moral and religious upbringing, seem especially important. In the episodes in which she was herself at a younger age, she expressed, clearly, concern about being away from her mother and of going against her mother’s warning about being with men. In Eve Johnson she is either repeating another girl’s opinion of her or some of her own opinions about herself. Her own feelings about sex and her premarital relationship with her husband show very clearly in her detailed account of herself as a prostitute, Alma Smith. The woman from 2002 A.D., while obviously drawn from fiction, appears to live a life where everything is mechanized and sex is of little importance—perhaps an idealized life for an incompetent housewife with sexual problems. Similarly, the character of June Harris can be seen as an expression of her husband’s expectation that she should adopt a subservient role.

The premorbid personality on which environmental stress, physical illness, and medical intervention played to produce this hysterical illness is demonstrated by the sister’s remarks, who saw the illness as being quite understandable. Even at school the patient had ‘fainted’ when in a situation that not all cases can be diagnosed as suffering from hysteria solely; some occur in organic states, notably epilepsy. Thus it is best seen as a particular, if rare, form of fugue state in which the phenomenon of multiple personality as genuine carries no implication of several personae occupying the same soma.

The review of the literature suggests that three factors are important in the aetiology of multiple personality: dissociation, whether this be spontaneous or induced by hypnosis; suggestion, including the veiled encouragement to develop the secondary personality that medical attention provides; and role playing. It also seems clear that not all cases can be diagnosed as suffering from hysteria solely; some occur in organic states, notably epilepsy. Thus it is best seen as a particular, if rare, form of fugue state in which an alternative personality is adopted. By fugue is meant a state of dissonance between personal and external reality for which there is subsequent amnesia. This definition is slightly broader than that of Stengel (1939, 1943), while including his concept of fugue. The alternative personalities that are adopted may be drawn from recollections of self at an earlier age, of others, of fictional characters, or from phantasy but all relate to problems experienced by the primary personality. The subsequent attention, medical or other, acts as a potent reinforcer of such behaviour, and there is a consequent elaboration of the secondary personality.

This present case illustrates such a model well. The patient, who shows other hysterical conversion symptoms under stress, repeatedly enters a fugue state in which she adopts a variety of personalities drawn from her past experience and
reading. Most of such personalities appear once or a few times only, but two, possibly because of the interest that they evoke in their husband and in her doctors and because of their particular significance to her, have persisted and to some extent been elaborated. The practical implications of this formulation are that such behaviour should be ignored as far as is possible, and that therapeutic techniques, particularly hypnosis, which sanction both the dissociative process and role adopting behaviour should be avoided, thus reducing the amount of reinforcement that the behaviour obtains.

This report also casts a little light on the natural history of multiple personality. The 15 year follow-up shows that, in this case at least, there is, as Janet suggested, a tendency towards remission with the passage of time, a finding consistent with the outcome of other hysterics (Ljungberg, 1957). In the case described, remission was associated in the patient’s view with the alleviation and passing of psychological stresses, and this would suggest that effective therapy should be aimed at discovering and removing the stresses that originally precipitated the fugue.

REFERENCES


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