well supervised situations. It also helps the understanding of adult patients' descriptive histories. Knowledge of developmental, family and service interaction issues can allow trainees to reappraise the context of the histories of adult psychiatry patients, not only of those patients' adolescence but also of the situations in which the patients now find themselves.

Despite College recommendations, many trainees may not have the opportunity to complete their training by having worked with children or particularly with adolescents as a specialist placement.

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Malignant alienation – agent and host interaction?

DEAR SIRS

Morgan & Priest (1984) coined the term "malignant alienation" when describing patients who had committed suicide while receiving in-patient care or shortly after discharge. A theme of inexorable alienation had been evident in many cases, whereby ward staff became critical of the patient's behaviour. Behaviour was construed as provocative, unreasonable and over-dependent. In some cases disability was thought to be deliberately assumed. The process was malignant because of the relentless drive towards a fatal outcome. The authors felt that malignant alienation might be provoked by recurrent relapses or difficult behaviour – problems arising from the patient. These patients committed suicide, but did they truly kill *themselves*?

Who are these "difficult" patients, and how might health care professionals react to them?

The characteristics of such patients might be summarised as follows. Patients who do not improve with treatment, those who present challenging behavioural problems, and those where a clear diagnosis and/or treatment plan is lacking.

Health care professionals should be aware of their own attitudes and feelings to all patients, but particularly those engendered by difficult patients. There may be many staff whose own neurotic blindspots actually prevent the giving of appropriate care. For example, the doctor who habitually undertreats patients for fear of hurting or upsetting them. The nurse who over-identifies with an aspect of the patient and tends to be overly optimistic about the clinical outcome, or alternatively becomes irritable with the patient when progress is slow. The doctor who feels that a poor response to his treatment is a personal insult, who then uses dangerous or unwarranted treatments in an attempt to salvage his pride. Such interactions become even more testing with difficult patients. Surely the lesson to be learned is to become more aware of our own responses when dealing with patients? This self-observing quality is a most important attribute.

Sir Denis Hill put his finger on another crucial attribute. In defining the requisites for a good psychiatrist he included "protection of the patient from the negative aggressive aspects of one's self" (Hill, 1978). But what is this negative aggressive aspect?

Aggressive instincts are generally now seen as being directed outwardly and are not necessarily negative. Indeed, these instincts may be part of a biological inheritance which serves to preserve us. In this way aggression is seen as the basis for human achievement and mastery in the world, valuable in the process of differentiation and personal autonomy. The complexities, hierarchies and conventions that form the framework of society may have evolved as a defence against negative aspects of aggression, ensuring cooperation and the survival of the species rather than allowing unrestrained inter-personal destruction (Storr, 1968).

Is an awareness of the negative aspects of outwardly directed aggressive impulses useful when considering malignant alienation?

Not long ago a staff nurse from the psychiatric ward telephoned me. She was distressed and upset. A patient had just gone AWOL from the ward and she feared for his safety. We talked it over. She had alerted the patient's family and general practitioner, and informed the police. I knew that this nurse was level-headed and usually coped well with such incidents. What was so different now? I went over to the ward to see her. It became clear that the patient had been "difficult" that day, threatening staff and pushing them to their limits. This was compounded by staff shortages through sickness. Under considerable stress this nurse had wished the patient dead. The feeling was conscious momentarily, and was only a fantasy, but it had occurred. So when the patient finally absconded the nurse felt her own murderous feelings had played their part, and she feared greatly for his life.

Can a synthesis be achieved here? Malignant alienation may be the harbinger of suicide with difficult patients. Staff feelings could play a part in fueling the process. Negative feelings towards the patient initially lie hidden. With further adverse interaction these feelings may tumble briefly into

consciousness, albeit as fantasies. As with the nurse in the story above, such feelings are immensely powerful. If the patient is the host to difficult behaviour or recurrent relapses, then perhaps the staff are the agents of malignant alienation via negative aggressive feelings. Who is to say that these feelings might not actually begin to "kill off" the patient, inexorably driving the process of alienation to a malignant end? Such an idea may be uncomfortable to even consider; and thus worth consideration.

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Assessment of parenting

DEAR SIRS

Reder & Lucey provide a timely consideration of some key ideas in an interactional framework for the assessment of parenting (*Psychiatric Bulletin*, June 1991, **15**, 347–348) and with the rapid incorporation of some of the Children's Act provisions into our practice, the era of impressionism as regards assessment of parenting ability must needs pass.

In addition to the logical progression expounded by Reder & Lucey, three further headings ought to be borne in mind, even if as child psychiatrists we honestly say we do not know their full import.

(a) The setting or context in which the assessment occurs and this includes the contribution of the assessor.

(b) Cultural factors and differences, which have to include the diversity of influences as well as the assumed norms.

(c) The child, whose own individual character and temperament may be such that he or she tests parenting ability and limits of safety beyond imagining.

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Intermetamorphosis of Doubles or Double-Golyadkin Phenomenon – a new syndrome?

DEAR SIRS

Owen wonders (*Psychiatric Bulletin*, May 1991, **15**, 302) if he is suffering from Fregoli's syndrome as he has become convinced that Mr Thomson, the gentleman who appears wearing a bowler hat is *in reality* a man with a moustache called Mr Thompson. As Dr Owen is an avid student of Hergé, he must know that Thompson and Thompson tend to appear in duplicate forms (see Fig. 1). It is thus far more likely, that they are mistaken each for the other! While this is certainly a variant of a misidentification syndrome or a reduplicative phenomenon, it cannot be considered as Fregoli's syndrome in which Dr Owen (or somebody else) would have to be convinced that a subject kept his identity but changed his bodily appearance. If Dr Owen mistakes Thomson for Thompson (the one with the stick; Fig. 1) he has to also mistake Thompson for Thomson – both in terms of physical appearance and actual identity. In this case we are dealing with intermetamorphosis (Silva *et al*, 1989), or, to be completely accurate, 'intermetamorphosis of doubles'. Again, Hergé has made an important contribution to the existing body of specialist literature (Kamanitz *et al*, 1989) by extensive reports of numerous dramatic incidences caused by Thomson's and Thompson's confusing experience of being doubles. We suggest the scholarly term 'Double-Golyadkin Phenomenon' for this widely underestimated but highly distressing condition (modified after Markidis, 1986, after Dostoyevski, 1846, see Förstl *et al*, *Psychiatric Bulletin*, **14**, 705–707).

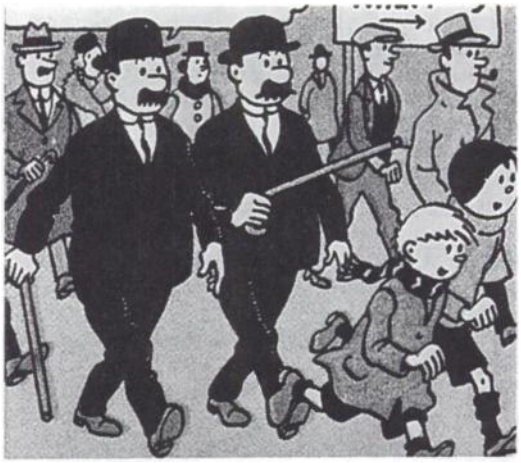

Fig. 1. Thomson (moustache, hat) and Thompson (with a stick).

As shown by Dr De Pauw's further study in the field of 'Psychiatry in Literature' (*Psychiatric Bulletin*, May 1991, **15**, 302 after March 1991, **15**, 167–168),