

Psychopathology of the double

DEAR SIRS

We read with interest Beveridge's account of the psychopathology of the double as described in James Hogg's novel *The Private Memoirs and Confessions of a Justified Sinner* (*Psychiatric Bulletin*, June 1991, 15, 344–346). We would like to draw attention to another literary description of this phenomenon in Shusaku Endo's novel *Scandal* (1988). Endo is one of Japan's foremost writers. He was born in Tokyo in 1923 and converted to Catholicism in his youth. *Scandal* is regarded by some as his best work.

In this novel he recounts the story of an ageing Christian writer, Suguro Sensei, who is enjoying the fruits of a successful literary career in contemporary Japan. To what extent the novel reflects the personal experience of the writer is a matter for conjecture; certainly there are explicit parallels.

The novel opens at a prizegiving ceremony held in honour of Suguro, during which he glimpses a face in the audience which he recognises as his own. He is subsequently tormented by the shadow of his invisible 'double' who appears to be frequenting Tokyo's hotels and bars. He is reported as indulging in sado-masochistic acts with a group of women who claim to recognise this 'double' as Suguro. The 'real' Suguro denies these reports; the 'double' is everything that Suguro is not and the achievements of a lifetime are threatened by the reports of unacceptable behaviour ascribed to this 'double'. The climax of the novel occurs in a Tokyo hotel where Suguro discovers that the 'double' is none other than himself, and that the sado-masochistic actions of the 'double' are his own actions. In this scene he encounters and comes to accept the disowned parts of himself.

Endo succeeds in his use of the phenomenon of the double as a literary device to explore the complexity and polarity within the human psyche. He recognises the relationship between sin as transgression and the unconscious need for self-expression of "people who are suffocated by the lives they lead". There is much psychological insight of value to practising psychiatrists in this novel.

C. POURGOURIDES
FEMI OYEBODE

*The John Conolly Hospital
South Rednal
Birmingham B45 9BD*

Reference

ENDO, S. (1988) *Scandal*. London: Penguin Books.

Training schemes

DEAR SIRS

The article by Birchall & Higgins (*Psychiatric Bulletin*, June 1991, 15, 357–359) provides a particularly good example of an efficient well-run scheme.

I am concerned that the organisers of the Liverpool Training Scheme have decided that after only two failures at the Part I examination, trainees must leave the rotation. I accept that failure in this exam may indicate unsuitability for psychiatric practice, but surely each case should be dealt with individually. Ill health, family problems, poor exam technique and even difficulty with the language may all adversely affect a candidate's performance. Psychiatrists should be aware of the dangers of "rigid inflexibility".

Psychiatry requires trained doctors of all grades. Training on a rotational training scheme is suitable for equipping a potential staff grade doctor or sessional clinical assistant/general practitioner with important and useful skills necessary for psychiatry.

It is vital that all organisers of schemes recognise that many post-membership registrars "are suitable for consultant grade but are unable to obtain senior registrar posts because of the shortage of such posts". I consider it imperative that these very assets are protected and not lost to psychiatry.

Training scheme organisers need to be sympathetic and abandon rigid guidelines. The authors' figures indicate that some trainees take as long as six years and four months while the mean time is four years four months! – four months longer than the length of the 'old combined rotations'.

In Nottingham, during the four years I have been here, all those who have completed four years of training have passed the membership examination – a record that is probably hard to beat.

O. JUNAID

*Chairman, Collegiate Training Committee
Mapperley Hospital
Nottingham NG3 6AA*

Appeals against Section 2 of the Mental Health Act 1983

DEAR SIRS

I read with interest the letter of Drs O'Dwyer and Neville (*Psychiatric Bulletin*, April 1991, 15, 225–226) but was unclear whether the patients in their study who appealed against detention were representative of all who submitted appeals during that time or just those who reached the stage of Tribunal. Certainly their data coincide with previous findings (Mawson, 1986) that Tribunals discharge 17% of all cases they hear. This, however, may be misleading. Recent preliminary data from my own study, gathered from one hospital in the Mersey Region, seem to show that the impact of an appeal against detention may be greater than previously thought.

I studied the legal outcome of all appeals of patients detained under Sections 2 and 3 (1988–1990). Early results show that of 73 patients who

exercised their right to appeal, 14 (19%) withdrew their application before tribunal, 20 (27%) were regraded to informal status by the Responsible Medical Officer prior to tribunal and of those actually reaching the tribunal stage 34 (47%) were detained and 5 (7%) discharged. In total 34% were regraded to informal. Certainly there seems to be a trend of greater discharge rate than previously recognised. McCreadie (1989) commented on a trend in one psychiatric hospital in Scotland to allow 28 day detentions to run for the full length. Consequently it is tempting to say that this elevated discharge rate reflects a direct effect of appealing. Further evaluation is needed to clarify this point.

It is important that the right of patients to appeal against detention is looked on not only as a necessary and expensive evil but also as a way of promoting good clinical practice. Prompt and regular reviews of the legal status of patients, however provoked, may well enhance the quality of the clinical relationship between mental health professionals and their clients. A shift in the balance of power in the doctor-patient relationship toward a more equal basis can only be welcomed, while the benefits to those detained are obvious.

SARA J. CUNNINGHAM

*Winwick Hospital
Winwick, Warrington WA2 8RR*

References

- MAWSON, D. S. (1986) The function of Mental Health Review Tribunals under the Mental Health Act 1983. *Medicine, Science & Law*, **26**, 291-294.
- MCCREADIE, R. G. (1989) The operation of the Mental Health (Scotland) Act 1984 in one psychiatric hospital. *Health Bulletin*, **47**, 204-206.

DEAR SIRs

I note Dr Cunningham's comments and would like to make the following comments in reply.

- (a) Only two of our patients withdrew from their tribunal prior to the tribunal date and these were not included in the data.
- (b) None of our patients was discharged from Section 2 prior to their hearing at the Tribunal.
- (c) Dr Cunningham has studied the legal outcome of appeals under both Section 2 and Section 3 and has found that of those reaching Tribunal, 34% were graded to informal. However, considering these patients are detained under both Section 2 and Section 3, this could merely reflect the improvement after treatment of those on Section 3. In my view, this needs further investigation as my figures have only considered patients on Section 2 and it is misleading to combine the two groups.

- (d) Dr Cunningham claims that 7% were discharged at the Tribunal but this is beyond the Tribunal's powers, the Tribunal having only the power to state whether the patient should be detained on a Section or should be regraded to informal. It is unclear how these patients were discharged.

Finally, the difference in discharge rate between Dr Cunningham's sample and our sample may simply reflect varying clinical practices which we found among the three hospitals which we studied, indicating the need for further evaluation of this method of appeals and detention as we have previously recommended.

J. M. O'DWYER

*Meanwood Park Hospital
Leeds LS6 4QB*

Guardianship and treatment

DEAR SIRs

We have recently been involved in some correspondence with the Mental Health Act Commission, which may be of interest to members.

We wrote for advice about procedure regarding the situation of patients who had been placed on a Guardianship order, who suffered from chronic mental illness, but whose main need was social care. Our anxiety arose about a particular case where such a patient might deteriorate from the point of view of their mental illness and need compulsory admission for treatment.

We wondered if fresh applications need to be made for Section 3 but received the following advice:

"Thank you for your letter to the Commission received here on 21 June 1991, and the point you raise in it. I agree with your understanding of Section 19.2(d) of the Mental Health Act in that you can transfer from Guardianship to Section 3 under this Section of the Act without seeking a fresh treatment order. I must stress however, that this is my personal opinion only and cannot be regarded as formal legal advice as the Commission is unable to give this."

This obviously raises many questions about the use of Guardianship in vulnerable chronically mentally ill patients and may facilitate earlier treatment of such patients which would be desirable in certain selected cases.

We hope that this issue can be clarified further from the legal viewpoint but feel that this response may be of sufficient importance for wider debate.

MARK ARDERN
SEAN LYNCH

*St Charles Hospital
London W10 6DZ*