(Sinclair, 1988). He graduated in medicine at the University of Melbourne in 1915 and received his MD in 1920. He then worked in London and obtained the DPM in 1921, after spending some time at the Bethlem Hospital. He also obtained the MRCP in 1922 and FRCP in 1937. In 1938 he became a foundation Fellow of the Royal Australasian College of Physicians. He was awarded the Military Cross in the First World War for exceptional bravery.

Maudsley returned to Melbourne in 1923 where, in the words of one of his contemporaries, he "screwed a modest shingle on his father's residence in Collins Street [the local equivalent of Harley Street] and proceeded to divest the suckling infant of psychiatry of its swaddling clothes and present its dimpled features to a somewhat incredulous profession" (Ellery, 1956). He was a pioneer in launching psychiatry beyond the medical backwater of the asylum, extending its boundaries beyond the certification and custodial care of the insane. Through considerable effort and by his ability to command the respect of medical colleagues and of his larger society, he demonstrated psychiatry's place as properly within medicine and showed that it was humane, and relevant to those with mental disorders far short of gross insanity. In 1923, the year of the official opening of the Maudsley Hospital in Denmark Hill, he established the first psychiatric unit in a teaching hospital in Victoria – an out-patient clinic at the Melbourne Hospital. There he developed general hospital psychiatry along modern lines.

It is generally agreed that Maudsley conceived the idea for, and initiated the first meeting of, the Australasian Association of Psychiatrists in 1946 (Williams, 1963). The Association was at first based in Melbourne, in fact often meeting in his rooms in Collins Street. He was uniquely honoured by being elected President twice. Furthermore, through this initiative he became, in effect, the founder of the Royal Australian and New Zealand College of Psychiatrists which arose in 1964 from the Australasian Association of Psychiatrists in a manner forseen by him. He has been honoured for this contribution by having the headquarters of the College (Maudsley House) named after him.

Consistent with his awareness of the social implications of psychiatry, he was in 1931 one of the founding fathers, and later President, of the Victorian Council of Mental Hygiene, an organisation which brought together representatives from disciplines and bodies relevant to the problems of mental illness, both state and voluntary.

Maudsley was also an exceptional sportsman as well as a prominent figure in Australian society, becoming, like his father before him, President of the Melbourne Club.

It appears that Maudsley did not have the same philosophical bent as his great-uncle, and he wrote relatively little (Maudsley, 1929, 1948, 1950, 1957). Indeed, he provides a rather strong contrast. His contributions were those of an optimistic vision of what psychiatry could become (as the papers cited clearly reveal), an ability to inspire others, and of action. He anticipated the major directions psychiatry was to take in the succeeding half century and acted as a major catalyst in their unfolding.

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The opiate prescribing debate

SIR: At a recent conference organised by the College and the Department of Health, I heard eloquent pleas for a return to the British system of opiate prescribing, the change being justified because of the need to contain HIV infection. It was also suggested that there was so much illicit opiate available that there would be no danger of medical prescription creating more addicts. I think it would be useful if there was wider debate about this, in particular to see if there is any scientific evidence to justify what seems a purely emotive response. There is little consensus which would justify giving alcohol to alcoholics, but there seems to be no scientific information which would allow us to prove or refute the proposition that the nature of drug addiction problems are different.

Medical thinking is rarely scientific and unclouded by emotion, as is shown by the problems of

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evaluating safety in oral contraception, and as was shown by the belief that masturbation caused insanity. The dangers of addiction and HIV infection are both so great that we should, as a profession, try to get the right response and carry society with us.

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Children surviving parental murder

SIR: We agree with Black & Kaplan (*Journal*, November 1988, **153**, 624–631) that children surviving after the father has killed the mother should not automatically be placed with relatives, and that a child psychiatric team has an important role in the intervention following such tragedies. We have been involved in two cases recently which highlight Black & Kaplan's recommendations.

Case Report (i): A 12-year-old girl presented with multiple tics and vocal utterances a few months after starting secondary school. Her father had killed her mother when she was an infant, and she had been placed with her maternal grandparents, whom she had come to know as "Mummy and Daddy". They had taken her regularly, through her primary school years, to the grave of "Mummy Gloria", but had never told her who this was or what had happened. They completely refused to talk about her father, and her paternal grandparents had been totally excluded from contact with her before she had reached the age of 2. They refused to allow the girl to be seen by her father in prison. When the girl was 8 years old they were seen by a child psychiatrist, at the request of social services, regarding the advisability of access to her father. They refused to talk to the girl about her father, wanting to put off such discussion till she was older. In the face of the opposition to him, the father eventually gave up trying to make contact with the girl. In her first few months at secondary school she mixed with peers from the wider community, some of whom had passed remarks to her about her father having killed her mother. Shortly after this, her symptoms led to her referral to us. Despite various treatment approaches, her symptoms have run a fluctuating course, and her grandparents have persistently avoided all attempts to talk openly, either individually or in family sessions, about the circumstances of her mother's death. The girl's education has been considerably disrupted due to handicapping symptoms.

Case Report (ii): Three children, aged 4, 7, and 9, were referred to us by a social worker, along with three sets of maternal aunts and uncles with whom they had been placed following the killing of their mother by their acutely psychotic father. The social worker wanted counselling for the children and for the aunts and uncles, who already were non-verbally giving the message to the children that talk of the father was taboo. Joint interviews were held on a number of occasions with all three sets of relatives to discuss their loss of their sister, their feelings towards her husband, who was in a special hospital, and how the children's needs to grieve their mother and retain a positive perception of their father could be best met. There were also persisting fears regarding the short lived nature of the father's psychiatric illness and the possibility that his children might one day pose a similar threat to their own children. The children were seen individually and as a group. As their respective foster families all lived within a short distance of each other, and as they still attended the same school, their sense of identity as siblings was being maintained. Each was also a member of another family. They knew what father had done and had found a way of coping with it – he had "gone out into the cold without his cap on and had got a cold in his head". He was thus ill when he had killed their mother. All three families were helped to mark the anniversary of the tragedy by a visit to mother's grave for a shared placing of flowers.

In case (i) the psychological stresses of being placed with maternal grandparents who failed to resolve their grief and anger have probably contributed heavily to the development of a Gilles de la Tourette syndrome. In case (ii), intervention at an early stage after placement with maternal relatives will hopefully facilitate a better outcome.

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Capgras' syndrome and town duplication

SIR: Anderson (*Journal*, November 1988, **153**, 694–699) concludes that the Capgras phenomenon is not specific for people, but includes a range of objects of importance in the patient's life. Traditionally, the Capgras phenomenon was said to be a delusional misinterpretation of people enjoying a close personal relationship, most often the spouse, and this could be explained in psychodynamic terms by ambivalence on the part of the patient towards the person who has been duplicated. We describe a case in which the affective bond to the inanimate object is totally absent.

Case Report: Mr E. was a 32-year-old fireman, who presented to the casualty department complaining that the town in which he lived had been duplicated "somewhere in Asia". He had no previous psychiatric history. On the night in question, he presented unkempt and unshaven, in a high state of arousal. His speech was pressured and he described his thoughts as "crashing over each other". He said he had

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