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Correspondence

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Points of style

SIR: We welcome the introduction of structured summaries to the *BJP* (Editorial, *BJP*, January 1994, **164**, 1) but suggest a further alteration to style. The Method and Results sections of papers describing original research should be printed in the same size of type as for review articles and for the Introduction and Discussion of research papers.

In our teaching and supervision of research we emphasise that the method is the most important part of any study, and merits the most careful attention to detail. However, in our postgraduate seminars we find that the Method section of published research is too often incomprehensible or insufficiently detailed to allow critical appraisal. We suspect that one reason for this is the practice of printing the Method in a smaller typeface – with the implication that it is less important or will be of interest only to a few readers.

Many scientific journals allow the Method prominence equal to that of the rest of the paper. We examined the layout of the two main UK weekly medical journals and the 11 prominent specialist journals readily available in our library. While the *BJP* is not alone in its use of smaller typeface for Method and Results, the majority of other relevant journals do give equal prominence to all parts of a research paper.

A small increase in size of Method and Results may cause pressure on space. However, in many papers the introductory remarks and the discussion would benefit from being shortened – or perhaps printed in smaller typeface! At least this practice would discourage the risky strategy of browsing through papers for the 'bottom line' as given by the authors in the Summary or Discussion.

Critical appraisal of the medical literature is a necessary skill for clinicians, and for those purchasing care for patients (Sackett *et al*, 1992; Sheldon *et al*, 1993). In taking up our suggestion, the *BJP* would take a small step in encouraging psychiatrists to develop that skill.

SACKETT, D.L., HAYNES, R.B., GUYATT, G.H., *et al* (1992) Surveying the medical literature to keep up to date. In *Clinical Epidemiology: A Basic Science for Clinical Medicine*, pp. 359–378. Boston: Little Brown.

SHELDON, T.A., SONG, F. & DAVEY SMITH, G. (1993) Critical appraisal of the medical literature: how to assess whether health-care interventions do more good than harm. In *Purchasing and Providing Cost-effective Health Care* (eds M.F. Drummond & A. Maynard), pp.31–48. Edinburgh: Churchill Livingstone.

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EDITOR'S REPLY: From the July issue of the *BJP*, the Method and Results sections will appear in the larger type.

Malignant alienation

SIR: At a time when the government has set targets for reducing rates of suicide it is unhelpful for Watts & Morgan (*BJP*, January 1994, **164**, 11–15) to provide it with a ready scapegoat – mental health professionals – should these targets fail to be achieved. The medicolegal consequences of their thesis, moreover, were it to be generally accepted, would be dire, since it provides a clear and direct rationale for negligence actions against psychiatric staff caring for patients who have committed suicide.

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The editorial consists of a series of sweeping statements, as if of fact, of a generally psychodynamic nature. Psychodynamic formulations are, at best, hypotheses, and are intrinsically tautologous in nature; thus, for example, the same mental process can result in two quite different patterns of thought, depending how far along the chain one stops, as with Freud's formulation of paranoia as a function of latent homosexuality. Such explanatory systems are, therefore, from a scientific standpoint, extremely weak, since they are intrinsically unfalsifiable. Dynamic psychology is no basis on which to propound a thesis with such potentially profound implications.

Central to the whole argument seems to be the proposition that patients do not behave badly; instead, the most outrageous behaviour is a maladaptive expression of inner distress which calls for care and sympathy rather than censure. This is a question of moral belief. While in some instances people behave badly as a result of distress or pathology, most bad behaviour that is encountered in psychiatric practice is the result of conscious, wilful decisions on the part of patients; this is at one with mainstream Western moral philosophy and the principles of English law.

I do not consider that Watts & Morgan do mental health professionals justice in their formulation. In my experience, psychiatric staff are remarkably tolerant of extremes of offensive and violent behaviour, particularly when these occur in patients with well defined mental illness, and to accuse them of acting on the basis of unresolved countertransference hate when they are abused or assaulted by patients who are in full control of their faculties is unwarranted, and to propose that in so doing they directly place the patient at high risk of suicide is improper.

Watts & Morgan's thesis would appear to absolve patients of all responsibility for their actions, which is as absurd as the Szaszian rejection of the concept of diminished responsibility – the truth lies somewhere between these two poles. If, in the absence of clear-cut pathology causally related to untoward behaviour (and the link must be established by more substantial evidence than psychodynamic speculation), we deny patients recognition of their responsibility for their acts, then we also deny them recognition of their essential human dignity, while at the same time creating an intolerable burden for us as mental health professionals. The concept of 'omnipotence' referred to so frequently by Watts & Morgan has much more in common with the paternalism of their approach than with what actually goes on psychiatric wards and in community mental health centres.

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Authors' reply: Having already made our case, we are content in the main to leave others to assess for themselves Dr Davis' response to it. It does, however, seem important to respond in more detail to Dr Davis' anxieties concerning what he regards as potential adverse medicolegal aspects of the concept which we propose.

Setting limits for difficult behaviour, thereby deciding on the degree of personal responsibility appropriate to each individual, is practically a day-to-day task which any psychiatrist has to face. It also happens to be one of the most difficult. Suicide can occur after limits have been set with scrupulous care, and such a situation should not reflect adversely upon the health care professionals concerned. At no point does our editorial imply that patients should be absolved indiscriminately from personal responsibility for what they do. We merely propose that the many complex factors which beset us as we manage suicide risk, and these concern not only those relevant to the patient but our own reactions as well, should be reviewed systematically and objectively. We believe that such an approach should help to reduce the risk of adverse medicolegal repercussions, rather than increase it as Dr Davis fears. Finally, may we say that we object to his implication that the concept of malignant alienation reflects badly on the dedication and tolerance of mental health professionals, whom it is intended to enable rather than denigrate.

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Managing the manipulative therapist

Sir: Malignant alienation refers to the process by which carers develop negative feelings for their difficult patients which are inadequately dealt with, so that they start rejecting their patients under the cover of rationalisation. Patients are thereby exposed to progressively greater risks of suicide. I fully concur with all their points, but was surprised that Watts & Morgan did not discuss the concept of manipulation.

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