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).

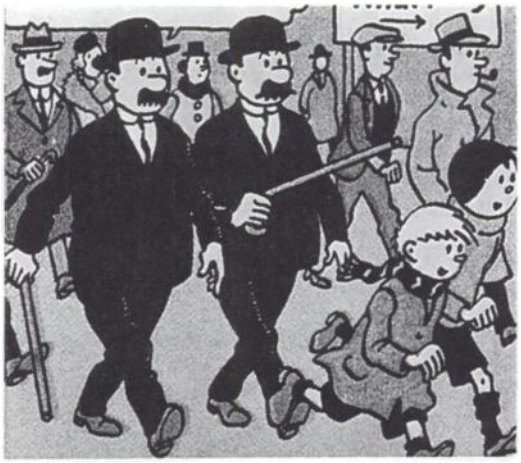

Fig. 1. Thomson (moustache, hat) and Thompson (with a stick).

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),

the approach towards German psychiatry should certainly be a most critical one.

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A full list of references is available on request from Dr Förstl.

DEAR SIRS

I thank Dr Förstl *et al* for their interesting and educational reply to my letter.

I wonder whether a syndrome has been described which might be applied to a psychiatrist who mistakenly identifies two almost identical syndromes? If so, perhaps *this* is what I am suffering from.

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A register of Munchausen cases?

DEAR SIRS

Davey (*Psychiatric Bulletin*, March 1991, **15**, 167) adds his voice to those calling for a register of Munchausen cases. An interesting natural experiment with such a register took place some years ago when a knowledgeable patient with feigned Zollinger-Ellison syndrome frequented many hospitals demanding Omperazole, a drug under investigation with the details of all receiving patients held on a central register (Daly *et al*, 1989). This register enabled the patient's travels to be recorded in some detail and the authors comment that he would not have been identified without a register. However, in their letter they suggest that the diagnosis of factitious illness was made before consulting the register. Further evidence that a 'black-list' is not essential for diagnosis is provided by the fact that this same man had already made an inconspicuous entry into the medical literature (Lovestone, 1987).

The arguments against a register are strong. We should be cautious at any such breach of confidentiality and the legal complications may be serious. I wonder at the effect of having a list of patients with feigned physical illness on the practice of liaison psychiatry. It might contribute to increasing the "is it psychological or organic" type of referral – an often unhelpful dichotomy.

Although Davey calls for a register, he fails to actually state why. Making a diagnosis of Munchausen syndrome is in itself not particularly helpful to the patient as we do not know how to treat this condition. Protecting the patient from iatrogenic harm is important, but we can trust our colleagues only to perform invasive procedures when a diagnosis of Munchausen syndrome is not yet being considered – and hence a register not consulted. Jones (1988), quoted by Davey, is more explicit. The benefits of a register are economic and to be calculated in terms of cost benefit analysis. This is a poor reason – even in the new NHS doctors must strive to be more than accountants.

I suspect the reason underlying calls for a register lie within the physician and not the patient. Being 'caught out' or 'conned' is an unpleasant experience and it is understandable that doctors should wish to avoid it. In the spirit of Asher I would propose a fourth variant of Munchausen syndrome 'Homo connus phobia et registerphilia' – a disorder of doctors.

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The use of carpets in geriatric and psycho-geriatric wards

DEAR SIRS

It is to be hoped that the eloquent and passionate protestations of Dr David Jolley (*Psychiatric Bulletin*, March 1991, **15**, 168–169) do not obscure the issues relating to the use of carpets in geriatric and psycho-geriatric hospital wards. He is partially right. Anyone who has worked in institutions caring for elderly people knows that offensive smells are not uncommon. While carpets are often associated with these smells, the smells are not confined to wards