Louise Pembroke continues her series on how we improve relationships between service users and psychiatrists

When relationships break down

'Malignant alienation'[1] is a concept psychiatrist Gethin Morgan wrote about mostly in relation to self harm and suicide. I think it's an important one because this is about the worst possible place a relationship can reach.

This is when staff find someone so hard to like or support (often because of repeated self harm or failure to improve) that a therapeutic nihilism occurs. They not only give up on the service user but can have a very casual attitude towards their possible death. Morgan's studies[2] showed that alienation between service users and others appeared to gain momentum and be associated with a fatal outcome.

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An example of this can be seen in my study, *Analysis of Accident and Emergency Doctors' Responses to Treating People Who Self-Harm.*[3] A&E staff quoted psychiatric liaison services saying, "Oh yes we know her, she's probably going to kill herself but don't worry, you've got your notes all in order." There is not only expectation of death but zero support available to that person. In palliative care, people are supported to die as good a death as possible and to make the most of the time they have left. Yet in psychiatry it can appear to be the opposite. I've witnessed people overdosing for weeks on end until organ failure occurred, or being told by a consultant, "You'll be dead by the time you're 28." These individuals were pronounced hopeless and dropped like hot potatoes.

My own experience of malignant alienation included the assumption by A&E and medical staff that I would die at some point by my own hand, and a duty psychiatrist proclaiming me as 'incurable' after a five-minute assessment where I was given no opportunity to answer his questions. The student nurse told me his prognosis as she felt indignant about his inability to state exactly what was incurable.

Another aspect of malignant alienation is 'beyond sectioning', where people are clearly in a very bad way and the damage they are doing is life threatening, but psychiatrists stop sectioning because they can't see an improvement with medication or behavioural therapy. Not that I am advocating sectioning; it's just an observation that some people who would have been previously sectioned reach a 'point of no return' and are consequently offered zero support. Again, I refer back to the palliative care comparison. If a psychiatrist has given up on a person and expects them to die, surely the person still deserves support in dying?

A consultant friend has used a Section 3 with *no* forced medication or behavioural treatment. He used it simply for safe-keeping because the service user's self harm was life threatening. Equally, he visited a woman who had experienced severe eating distress all her life and didn't want yet another session of forced re-feeding. He complied with her wishes but set up the appropriate palliative care. These are good examples of how to maintain a relationship with people who are in dire circumstances but still need support, and without further alienating them.

When relationships break down I think it has a lot to do with expectations. If the person doesn't improve then it can be viewed by the psychiatrist as a personal failure, and I don't think many psychiatrists will openly admit to their feelings on that. Morgan says, 'Psychiatric healthcare professionals are particularly prone to expectations of healing all, for two reasons. Firstly, the personality of the carer is often the therapeutic tool, unlike surgery or medicine where the means of treatment are simpler to separate from the self. Thus the psychiatric carer confuses professional capacity to heal with a sense of self worth. Secondly, change in psychiatric patients often occurs slowly, frustrating the drive of those ardent to see improvement."[4]

Some people will always be harder to work with, harder to like, but then Phil Barker would say that you don't have to like a person to honour them.

1. Morgan H.G. (1979) *Death Wishes? Understanding and Management of Deliberate Self Harm*, Chichester: Wiley.
2. Morgan H.G. (1992) 'Suicide prevention: hazards on the fast road to community care', *British Journal of Psychiatry* 160: 149–53. Morgan, H.G. and Priest, P. (1984) 'Assessment of suicide risk in psychiatric in-patients', *British Journal of Psychiatry* 145: 467–9.
3. Hadfield, J., Brown, D., Pembroke, L., Hayward, M. (2009) 'Analysis of accident and emergency doctors' responses to treating people who self-harm', *Qualitative Health Research* 19(6):755–65.
4. Watts, D. and Morgan, G. (1994) 'Malignant alienation: dangers for patients who are hard to like', *British Journal of Psychiatry* 164: 11–15.