Several points emerge from this survey which are worth making. Firstly, the respondents, whether consultants or juniors, are giving their views about psychotherapy supervision in rotational training schemes which are now well established, in which from the outset it is made clear to juniors that they will be encouraged to get experience of supervised individual and group psychotherapy. There are sometimes problems about finding the time for this and there needs to be a mutual recognition of the difficulty, and a willingness to help when such problems arise, by psychotherapist and psychiatrist alike. But this survey indicates that both consultants and juniors in general appreciate the specific contribution being made by specialist consultant psychotherapists.

Secondly, the findings do not support Drs Lieberman and Cobb's view that where independent departments of psychotherapy have been set up, there necessarily tends to be friction between psychotherapists and general psychiatrists. The evidence suggests rather that at St George's the climate is more one of mutual respect with an overall interest in the integration of biological, psychosocial and intrapsychic aspects of personality and mental disorder.

Thirdly, the stereotyped attitudes about general psychiatry and psychotherapy which have been suggested do not prevail. The questionnaire responses underline that probably what matters most is the kind of person an individual consultant happens to be.

Lastly, Drs Lieberman and Cobb's survey was carried out as long ago as 1978, before the St George's rotational training schemes had been developed, and it is a pity that their discussion makes no reference to these changes which have had implications for so many posts in the Region. This is not the place to look in detail at the merits of rotational training schemes, but so far as psychotherapy is concerned, the advantage of having a co-ordinated supervisory resource with effective liaison at consultant level would appear to have been demonstrated, as also the continuing demand for specialist consultants in psychotherapy.

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ECT instructions concerning cerebral stimulation

DEAR SIRS

I am a Senior Registrar and on starting my appointment I examined our new ECT machine and the document that came with it and was, to say the least, surprised at one of its functions.

The machine is the 'Ectonustim' which is manufactured by Ectron. There is a setting on this machine which allows for cerebral stimulation of a low voltage, non-convulsive stimulus.

The things that worry me most are: Firstly, the manufacturers' instructions on how the operator should understand the stimulus and be able to reassure his patients. I quote, '... position the head piece and very slowly increase the control. At a level of ½ to 1 units on the meter a faint tingling sensation is felt. At higher levels the optic nerves are stimulated and flickering can be seen. Note that any pain with stimulus disappears immediately stimulus is slightly reduced'. It appears to me that there are hazards in this, not least of which would be an unmodified *grand mal* fit if the apparatus was accidentally misused or if the machine was faulty. It seems that insufficient warnings and precautionary notes are detailed in the manufacturers' instructions. Secondly, I am rather concerned that the manufacturers suggest the use of cerebral stimulators in the way they suggest. I have always been taught that successful ECT depends on a convulsion with the smallest dose of electricity, and the manufacturers state: 'this [the cerebral stimulator setting] may be used to give a counter stimulus after ECT to reduce amnesia and confusion or to give a painful stimulus in conjunction with therapeutic suggestions for the treatment of hysteria'.

I would be grateful for your comments on these two points and also that of the morality of giving painful stimuli in the treatment of hysteria. It would be helpful if some form of guidelines or recommendations for the use of such a setting could be issued by the College.

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'Clomipramine Challenge Test'

DEAR SIRS

A corner stone in my clinical practice is what I refer to as the 'Clomipramine Challenge Test'.

When I am in doubt about the diagnosis of schizophrenic illness, and when the doubt is shared by my colleagues and is reflected in the patient's clinical notes, I stop all medication and prescribe Clomipramine 200 mg daily in divided doses. My hypothesis is that if the patient suffers from a schizophrenic illness, the patient will develop a florid schizophrenic psychosis within two weeks of the initiation of the 'diagnostic test'. If, on the other hand, the patient improves on this regime, I feel that this is good evidence for a diagnosis of a depressive illness.

I should be grateful to have my colleagues' comments on a 'Clomipramine Challenge Test' done in this fashion.

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