ECT UNDER COMPULSION

In answer to an enquiry from the College Public Policy Committee about the giving of treatment to patients detained under a Section 25 order, Dr E. F. Carr, of the Department of Health and Social Security writes:

Our legal advisers consider that the inference from Section 25, supported by the plain indication of Section 29 that admission under Section 25 may be a matter of 'urgent necessity' justifying an abridged emergency procedure, is that *some* treatment may properly be given without his consent to a patient detained for observation. Their view is that treatment so authorized cannot exceed what is reasonably required by way of observation (i.e. for the purpose of diagnosis and the determination of what future care and treatment may be appropriate) or is immediately necessary in the interests of the patient's own health or safety or with a view to the protection of other persons. It is, of course, for the doctor concerned to judge, in the light of the facts of each case and these rather restricted criteria, whether he could properly administer ECT to a particular patient without the patient's consent. It seems to us that the advice given in the College guidelines on the use of ECT, about the seeking of consent of patients who are able to understand the nature and purpose of the treatment and the seeking of the approval of relatives in other cases, was wise. As indeed were the recommendations that, except in an emergency, two consultants' opinions should be sought and that a defence organization should be consulted in cases of doubt.

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Elephant and Castle, London SE1 6BY

TEACHING PSYCHOTHERAPY

DEAR SIR,

In their paper, Teaching Psychotherapy in Mental Hospitals, Dr S. Lieberman *et al* (*Journal*, April 1978, **132**, 398–402) stated, under the heading of Group *vs* Individual Supervision, 'Nearly all trainees preferred individual to group supervision of their psychotherapy. Generally, our attempts at group supervision were unsatisfactory. This was reflected mainly in poor attendance, and was a problem we shared with the two specialist psychotherapists already in the Region'. This does not accord with my experience of carrying out both types of supervision. I have not found one type of supervision to be superior to the other, but rather that each type involves different experiences of supervision.

In individual supervision, there is usually a more detailed dissection and discussion of sessions, and the ventilation of aspects of the countertransference and its possible relationship to personal problems in the trainee will certainly be more open than in the setting of a group.

However, in group supervision trainees have the opportunity, not only to present their own cases, but also to listen to their colleagues' cases, and all members can put forward their own ideas about the sessional material presented. This means a fair degree of exposure of the supervisee presenting to his colleagues, and necessitates his being able to tolerate some criticism of his work, which can only occur if there is a feeling of trust in the group between the supervisees themselves and, of course, between them and the supervisor.

The supervisor's role is crucial here and I think that two important ingredients in achieving this are (a) by maintaining a non-competitive relationship towards, and among, the trainees, and (b) by taking all contributions to the discussion as worthy of serious consideration in understanding the material. This trust takes a while to develop, but has been worth working for.

I am writing this to combat the notion that if individual supervision is not available group supervision is unsatisfactory. I should add that my supervisees at this Centre agree with the view expressed here.

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NURSE THERAPISTS

DEAR SIR,

I must thank the authors of the Monograph I reviewed (*Journal*, September 1977, **131**, 320) on Nurse Therapy for their good humoured response to my review (*Journal*, April 1978, **132**, 416). Since I do not wish to exchange puerile insults with Dr Harding, and as my old friend Dr Marks is in firm possession of the wrong end of the stick, I will content myself with commenting on their disingenuous suggestion that nurse therapists might be responsible to that old work horse, the 'multidisciplinary team'.

In a primary care setting, such a team is headed by the general practitioner, and contains social workers and receptionists, as well as an array of specialized nurses. Should one of Dr Marks' specialized nurses require advice concerning a problem arising in therapy, he or she would need to refer the patient—