output node), or that the training set should include over 30 000 cases.

The aim in training a classification ANN is to extract features from the training data that characterise the classes of interest. Since Zou *et al*'s ANN has well over 15 000 path options for the training set of 60 cases, the feature extraction properties of the ANN were redundant. The ANN was simply required to represent each training case in learning space. Classification of the test data would have proceeded by finding the closest match among the training data representations and adopting this diagnosis. Zou *et al*'s approach has, therefore, probably created a pattern matching system rather than a true ANN classification system. As such, it achieved a satisfactory result, but would be expected to be less successful when more diagnostic groups are added and the classification task is more complex.

ANNs have considerable promise in the classification of psychiatric disorders (Galletly *et al*, 1996). However, an ANN is not merely a black box. Attention must be given to the choice of appropriate architecture, input data, training and test data sets, classification thresholds and initial weights, all of which appear to be either less than optimal or unspecified in Zou *et al*'s paper.

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Lithium and ECT in combination

SIR: We read with interest the article by Jha *et al* (1996). The clinical implication suggested by the authors, "The combination of ECT and lithium may be justified in selected cases" needs to be viewed with caution. There are some reports to suggest increased risk of neurotoxicity associated with ECT and lithium in combination (Small *et al*, 1980; El-Mallakh, 1988). Potential risk of prolongation of depolarising muscle relaxant effects by lithium is possible (Hill *et al*, 1976). In any case, there are no confirmed trials showing therapeutic advantage of ECT and lithium in combination over ECT sans lithium.

It is therefore clinically prudent to withhold lithium during ECT. Lithium may be restarted, if indicated, after completion of a course of ECT. In our experience, such a strategy has not resulted in any symptom relapse during the period before therapeutic levels are achieved.

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False memory syndrome

SIR: I wish to clarify a comment about the False Memory Syndrome Foundation made by Brewin in his editorial (1996). He states:

> "Recently, however, doubt has been cast on the process whereby forgotten memories of child sexual abuse appear to be recovered within therapy, and it has been suggested that many if not all of these memories are the product of inappropriate therapeutic suggestion. This suggestion has been promulgated in particular by the False Memory Syndrome Foundation in the US..."

The False Memory Syndrome Foundation has no way of knowing whether or not "many" memories recovered in therapy are the product of inappropriate suggestion. Therapy sessions are confidential. There does, however, seem to be ample evidence that some memories recovered in therapy may be false. There is also evidence that some therapists practice techniques that carry a high risk of suggestion. Research by Poole *et al* (1994) indicates that