weapons produces a variety of unpleasant emotions in many healthy Britons: fear, anger and despair are prominent. The intensity of emotion rises at first with knowledge of the subject and it is sometimes claimed that informing the public about the health risks is harmful and unethical. The BBC postponed the documentary 'A Guide to Armageddon' because it was deemed too alarming to show during the Falklands War.

We should be aware that the public pressure generated by non-morbid emotion is the mainspring of politics. If we are persuaded that our function is to reassure patients by encouraging delusions of safety then there are political consequences. We should not be complacent that psychiatric treatment of political heterodoxy cannot happen in Britain.

I would be grateful if colleagues would notify me of any examples of official encouragement to treat non-morbid fear of nuclear war.

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DEAR SIRS

I was interested in Dr Holmes' 'case study' of 'The Psychology of Nuclear Disarmament' (*Bulletin*, August 1982, **6**, 136–38). Like him, I also believed that it would be irrelevant or arrogant for psychiatrists to apply their individual expertise to sociological and international matters. Yet (as he demonstrates) the nuclear arms issue seems remarkably open to psychological analysis. The leading speakers in the present debate for nuclear disarmament (e.g. Dr Helen Caldicott) also liberally use the language of personal and interpersonal affairs to describe the international dynamics of nuclear arms. Although other factors are important—notably the economic empire built on the armament business—personal concepts allow the ordinary citizen (including the psychiatrist) more chance to understand and grapple with a problem which ultimately has to do with the personal matter of individual annihilation.

Dr Holmes emphasized the point that military and psychodynamic terminology have a lot in common. In an article on how Freudian terminology changed its use and meaning in the translation from Freud's ordinary German language to the specialized (and often reified) English vocabulary, Lewis Brandt (1961) demonstrated how Freud used well-known military analogies and terms which have different and more dynamic implications than have their translations—e.g. 'defence', 'cathexis', 'repression'.

So using psychodynamic terminology to understand military problems brings the wheel full circle.

NICK CHILD

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REFERENCE

BRANDT, L. W. (1961) Some notes on English Freudian terminology. *The Journal of the American Psychoanalytic Association*, **9**, 331–39.

Videotapes on psychiatric subjects

DEAR SIRS

Sheffield University Television Service has produced a number of videotapes on psychiatric subjects made in conjunction with the Department of Psychiatry. These are available for purchase (£50 + VAT) on either U-matic or VHS formats. Information may be obtained from Mrs Roslyn Hancock, Television Service, The University of Sheffield, Sheffield S10 2TN; telephone (0742) 78555, extn. 6063.

The following tapes are available:

I've Sprained My Knee Doctor (Colour, 22 mins): Two versions of a patient visiting her family doctor because of a sprained knee. A calm relaxed friendly doctor proves just as efficient and more acceptable than a brusque irritable one. The attitude of the doctor spreads to his receptionist.

Psychiatric Interview (Colour, 26 mins): The format of the psychiatric interview is demonstrated, emphasizing the need for a relaxed, empathic approach offering emotional support.

Parasuicide (Colour, 26 mins): An interview with a patient who has taken a small dose of tranquillizers and alcohol in response to a row with her boyfriend. After exclusion of a specific psychiatric disorder, alternative help is offered.

Giving ECT (Colour, 13 mins): A demonstration of the whole process of giving ECT including pre-treatment assessment, putting the patient at ease and allowing ample time for recovery.

Compulsive Gambling (Colour, 23 mins): An account of the way the wife of a compulsive gambler learns of the extent of his problems and the opportunities open for help.

Violence in Hospital (Colour, 26 mins): A case study—a patient in a surgical ward develops post-operative paranoid psychosis and attacks one of the nursing staff. The management of such problems in a general surgical ward is discussed by the nurses and doctor.

Accompanying notes are available with some of these tapes.

C. P. SEAGER

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DEAR SIRS

The survey on the use of electroconvulsive therapy by Pippard and Ellam has shown that there is a great need for a training videotape which would enable young psychiatrists responsible for giving ECT to learn how the treatment is given. The Department of Psychiatry at the University of

Manchester has had considerable experience in the preparation of self-teaching videotapes and we have therefore prepared a special videotape as part of our work for the AUTP Working Party on the Applied Uses of Television.

Dr John Johnson has now prepared a suitable videotape in association with one of our senior registrars, Dr Susan Benbow, and this tape is available for distribution to other interested hospitals. The videotape includes sections on indications and contraindications for the treatment, obtaining consent from the patient, preparation of the patient before treatment, and details of the treatment itself. It demonstrates how to test the ECT machine itself, and shows both unilateral and bilateral electrode placement. The hazards to the patient of using an unnecessarily large stimulus current are explained, and the viewer is shown how to recognize a well modified fit.

The programme, which is 18 minutes long, can be copied on to your own blank VHS or Soni-U-Matic cassette at a charge of £25.00.

DAVID GOLDBERG

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Care and maintenance of ECT electrodes

DEAR SIRS

Following a period of unsatisfactory performance of our Ectron machine, we referred the matter to our Principal Medical Physics Technician, David Gaffrey. He found that the cable to one of the electrodes had come adrift but also that the metal surfaces of the electrodes were badly caked with dried electrolyte solution under their gauze covers. He pointed out that this would impair the efficiency of the apparatus for the production of seizures and recommended that the electrodes should be serviced every week. This seems such an obvious point and one which is probably so widely overlooked that I request these points on the care and maintenance of ECT electrodes should be brought to wider attention.

R. P. SNAITH

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Leeds

ECT electrode maintenance when using an electrolyte solution

(1) Remove the gauze electrode covers.
(2) Remove the metal electrodes from the screw threads by rotating anti-clockwise.
(3) Examine the metal electrodes and the screws on which the electrodes are secured for white, dry electrolyte solution.
(4) Clean the metal electrodes and screw threads thoroughly, removing all deposits of dried electrolyte using a small tooth brush and soft soap solution.
(5) Dry the metal electrodes and the screw threads.
(6) When dry, re-assemble the metal electrodes to the screw threads.
(7) Replace the gauze electrode covers with new covers.

Note: If the metal electrode is badly pitted and the metal is flaking from the electrode, replace this electrode with a new one.

General notes:

(1) Ensure that the electrode solution is kept away from the electrode handles while treatment is in progress. This solution is a conductive medium and could cause the operator to receive an electric shock. If this solution does come into contact with the electrode handles, it should be removed and the handles dried before treatment can commence.
(2) Ensure that the cables to the ECT electrodes do not become kinked or twisted as this will place a strain on the wires inside the cables and could cause the wires to break.
(3) Always have a spare set of ECT electrodes available with the ECT machine. It is nearly always the cables that fail first.

Objectives in training

DEAR SIRS

It was heartening for me, as a trainee, to read Chris Thompson's article on educational objectives in psychiatric training (*Bulletin*, August 1982, **6**, 141). However, I would disagree with the logic of his conclusion that because the process of setting objectives for both trainees and trainers would be difficult—requiring rigorous debate between the strands of opinion within psychiatry and inevitable compromise—then it should be abandoned.

I would also suggest that it would be useful for Clinical Tutors and Consultants to examine each job within a psychiatric rotation to determine what they hope their junior staff will get from that job, other than that vague term 'experience'.

Far too often education is seen as being provided for by means of seminars and tutorials. In fact we learn most from our patients. Enquiring minds are not encouraged by slavish reading of the journals, but by a critical use of the literature and the basic sciences to answer the clinical challenges posed by our patients. This in turn can only occur in the context of close and considered supervision of a trainee's clinical experience.

FRANK HOLLOWAY

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Psychiatric experts and expertise

DEAR SIRS

Diana Brahams' article (*Bulletin*, July 1982, **6**, 121–22) gives the misleading impression that a psychologist, Mr Barrie Irving, was masquerading as a psychiatrist in the witness box. As she herself states, his description as 'the doctor' was that of her learned colleague for the Crown—an