reduced from 200 to 100 mg. and phenelzine, 15 mg. daily substituted. Perhaps maximum dosage of an antidepressant, whether singly or in combination, should be determined on the state of play existing between side effects and target effects: if the latter have not yet been reached, can one safely put up the dose, or are there already side effects which will prevent one doing so? It is my own impression that the best response to combination therapy occurs shortly after a course of ECT, even if the latter has not appreciably helped. Perhaps in some ways ECT 'softens up' the CNS to respond to combined drug therapy. There is, of course, no reason why ECT cannot be given concomitantly with combined therapy, although from Dr. Shaw's letter it appears that they gave the two in sequence. In our refractory case on high doses of antidepressants, the administration of 15 ECT alongside drug treatment was felt to be a necessary but not sufficient ingredient in her response.

Yet another method of treatment not referred to in Dr. Shaw's letter is continuous sleep therapy (4). One of the indications for this treatment is when all else has failed, and a decision regarding psychosurgery has not yet been made. Under narcosis it can be beneficial to repeat ECT even though its previous effect has been sub-optimal.

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'TRUE AND FALSE EXPERIENCE'

DEAR SIR,

In his review of my book *True and False Experience* (*Journal*, 1973, *123*, 600) Dr. Michael Fordham criticizes the examples of psychotherapeutic work that I give because 'they say too little about when and to which patients such communications are beneficial and so make little contribution to knowledge'. I have some sympathy with him, as I have wondered myself whether they really do make a contribution, and, if so, in what way. But I would like to reply to his comment because I think it touches on a fundamental issue.

Psychotherapy consists, as does ordinary living, of a mixture of the spontaneous (in which the therapist relates to his patient as a unique, unpredictable, whole person) and the technical (in which the therapist manages his patient by means of fixed rules thought to be useful when dealing with certain kinds of people and situations). Although these two modes cannot be entirely separated in practice (and perhaps not even in theory) the person at the receiving end usually knows roughly which mode is in the ascendant. One of the points I was trying to make in my book was that psychotherapists (mistakenly in my view) usually take it for granted in their writings that the technical approach should be paramount: for instance, they say too much about when and to which patients various kinds of communication should be made.

It is more difficult, I feel, to pass on psychotherapeutic experience to others than is usually recognized. Roger Poole puts the problem succinctly in his recent book *Towards Deep Subjectivity*: 'Subjective method is the patient unravelling of the contradictions inherent in the idea of *two* objectivities in one society: one objectivity excluding the human being from the totality and the other insisting that he should be included in it.'

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PASSING NASAL TUBE IN PSYCHOTICS

DEAR SIR,

Not infrequently we have patients who refuse oral feeds and have to be fed and medicated by a nasal tube. At times it is very difficult to pass a tube, even under sedation. This is particularly true of negativistic patients or patients with catatonic schizophrenia. I have tried the following method in such patients, with 100 per cent success.

I give the patient ECT (he is usually in need of it and his stomach, bowels and bladder are likely to be empty). As soon as the convulsions stop and the patient is in a flaccid state, I pass the tube and it goes in easily and smoothly.

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