mental responsibility and one verdict which determines criminal liability. It allows that there are degrees of abnormality of mind, and degrees of mental responsibility, and that the more abnormal the less responsible. Finally, the terms found by the trial judge in R. v. Walden (1959) to express the matter before the jury, "... Well, really it may be he is not insane but he is on the borderline, poor fellow. He is not really fully responsible for what he has done ...", discourages the suggestion that either abnormality of mind or mental responsibility, or the relationship between them, can be quantified.

The states of mind which are crucial to the verdict are thought to be determinable by the common sense judgement and worldly experience of jurors. Whatever role the forensic psychiatrist plays, the only issue that is reserved to him as expert witness is the 'aetiology of the abnormality'. Whether the defendant exhibits abnormality of mind, and in particular the extent to which he exhibits abnormality of mind, is a question which the jury alone may decide. So heavy is this burden that juries do not often have to shoulder it. Susanne Dell (1982), in her analysis of how section 2 works in practice, points out:

> "... how rare jury trial is in such cases: 80 per cent are dealt with by guilt pleas. When the prosecution does challenge the defence, the defence is quite likely to fail: of 28 cases where this happened 18 (64 per cent) resulted in murder convictions."

The expert witness should always remind the court as to the limitations of his expertise, heeding Dell's cautionary note:

> "... although the presence or absence of mental responsibility is not a medical matter, doctors grapple with it; and in half the cases where they disagreed with each other on the issue of diminished responsibility, it was on the moral and not the psychiatric aspects of the case that they disagreed."

Dr Green doubts whether the process is a 'just' one. Depending on the circumstances, the killing of a human being may produce reactions ranging from applause to abhorrence and a desire for revenge. In times of peace the legal system is responsible for establishing the correct response within rules laid down by the parliaments. The essential structure of English law concerning unlawful killing is formed by the idea that personal responsibility can be diminished because of the psychological abnormality of the offender and consequently a verdict different from murder ought to be available to mark this special status. It is easy to be critical of the present formulation of the law. In cases where a plea of diminished responsibility is raised, the character of the defendant always poses difficulties yet the courts are required to come to decisions in particular cases within a short space of time. By means of a three stage process involving mental abnormality, mental responsibility and criminal liability, it is possible that the optimal balance has been arrived at.

As for forensic psychiatrists, provided that they avoid words which they do not understand, they should be able to make sense most of the time and assist the court occasionally.

RAYMOND TRAVERS

Scott Clinic
Rainhill Road, St Helens
Merseyside WA9 5DR

Reference

DELL, S. (1982) Diminished responsibility reconsidered. CLR, pp. 809–18

Psychotherapy Register

DEAR SIRS

I am writing in response to the information submitted by Michael Pokorny, Chairman of the United Kingdom Standing Conference for Psychotherapy (*Psychiatric Bulletin*, August 1992, **16**, 483–484). In discussing the UKSCP plan to have a Registration Board, he writes: "There is provision for an extra seat for the British Psycho-Analytical Society." I think this information might be misleading for the Membership.

In fact, the British Psycho-Analytical Society withdrew its membership from the UKSCP as it felt that, unless there was a governing body of senior established organisations in overall charge, then satisfactory monitoring of registration could not be achieved. As their proposal was not acceptable, the Council of the British Psycho-Analytical Society decided to withdraw the Society from the conference. Their view was further endorsed at a General Meeting of the Society. It should also be noted that the APP (Association for Psycho-Analytic Psychotherapy in the National Health Service) also withdrew from membership of the UKSCP for similar reasons.

I felt that the Membership of the Royal College of Psychiatrists should be aware of this.

RICHARD LUCAS
Chairman of External Relations
British Psycho-Analytical Society
The Institute of Psycho-Analysis
63 New Cavendish Street
London W1M 7RD

Reply

DEAR SIRS

I am grateful to Richard Lucas for adding to my article in the August *Psychiatric Bulletin*. He is quite

correct in stating that the British Psycho-Analytical Society has withdrawn from UKSCP.

It is sad that they chose to leave before their proposals could be discussed. We would welcome them back into UKSCP. For the time being, a place on the forthcoming Registration Board is available for them.

MICHAEL R. POKORNY
Chairman

UKSCP
Regents College
Inner Circle, Regents Park
London NW1 4NS

Seizure duration and clinical efficacy in patients receiving ECT

DEAR SIRS

I read with interest the article by Dr Joyce, 'Short duration induced seizures and therapeutic outcome at electroconvulsive therapy applications' (*Psychiatric Bulletin*, July 1992, **16**, 408–410). The conclusion gives the misleading impression that the psychiatrist/anaesthetist only needs to be aware of the effects of benzodiazepines and propofol in relation to reductions of seizure duration in patients receiving ECT.

A seizure duration of 25s (Cronholm & Ottosson, 1960) and a cumulative seizure duration of 210s (Maletzky, 1978) are both considered to be central to the therapeutic efficacy of ECT. Many factors are known to affect the duration of seizure and these must also be given consideration, in addition to the effects of psychoactive and anaesthetic drugs. No mention is made of these in Dr Joyce's article. Seizure threshold increases (and seizure duration decreases) with increasing age and the cumulative number of treatments. Seizure thresholds are also higher in men and in those receiving bilateral ECT (Sackheim *et al* 1987). In addition, the seizure threshold is also influenced by a large number of different drugs including diazepam and propofol, and also drugs as diverse as caffeine and propranolol.

Greater awareness of these factors by junior psychiatrists, who are mainly responsible for administering ECT, is long overdue. Individual seizures that are unduly short will result in the total number of ECTs having to be increased to reach the necessary cumulative seizure duration for therapeutic efficacy. If individual seizure durations are of adequate length this will have three major benefits. First, it will reduce the cost of treatment by reducing to a minimum the number of ECT treatments required and secondly it would be possible to treat more patients with the available resources. Finally, but most importantly, it would lessen the anaesthetic risk to the patient by minimising the number of anaesthetics.

S. CURRAN

Rosemary Day Hospital
St James's University Hospital
Leeds LS9 7TF

References

CRONHOLM, B. & OTTOSSON, J. (1960) Experimental studies of the therapeutic action of electro-convulsive therapy in endogenous depression. *Acta Psychiatrica Scandinavica*, suppl., **146**, 60–101.

MALETSKY, B. M. (1978) Seizure duration and clinical effect in electroconvulsive therapy. *Comparative Psychiatry*, **19**, 541–550.

SACKEIM, H. A., DECINA, P., PROHOVNIK, I. & MALITZ, S. (1987) Seizure threshold in electroconvulsive therapy: effects of sex, age and electrode placement, and number of treatments. *Archives of General Psychiatry*, **44**, 355–360.

DEAR SIRS

I am grateful to you for giving me the opportunity to comment on Dr Curran's letter.

Dr Curran rightly points to some of the many factors known to affect seizure duration and threshold, and possibly also the efficacy of ECT. How convenient it would be if there were simple measures to indicate that particular applications of ECT were "adequate"! Unfortunately, crude and simple measures such as the adoption of a 25 second minimum seizure length and/or a cumulative seizure time of 210 seconds have insufficient empirical evidence to support their use, nor are they at all closely related to the clinical outcome of treatment. For example, near threshold unilateral ECT reliably induces bilateral seizures which tend to be more prolonged than those resulting from bilateral suprathreshold stimulation yet have less therapeutic efficacy. Short seizures, lasting less than about 15 seconds, should always prompt review of possible causes, importantly but not only drugs, anaesthetic agents and dosages, but it must not be assumed that longer seizures are necessarily adequate nor that short seizures cannot be efficacious.

There is no substitute for careful clinical assessment of the patient and the treatment process throughout the treatment and for close involvement of experienced psychiatrists and anaesthetists, specifically trained in ECT, in administering the treatment and in training and supervising others in giving it; it is no longer possible to justify having "junior psychiatrists ... mainly responsible for administering ECT."

JOHN PIPPARD

9 Princes Avenue
Woodford Green IG8 0LL