the method of funding, of the old service in Northern Ireland, which Dr Forrest favours. There are, however, other ways of developing a unified service, not based on the medical model as we have known it in the past but respecting the multi-disciplinary approach, which is now generally accepted as being the most appropriate one.

On the other hand, the approach of Dr Kushlick and his colleagues is based upon the principles embodied in *Better Services for the Mentally Handicapped* (which are also contained, with detailed modification, in the Scottish equivalent, *Services for the Mentally Handicapped*). There is, it seems to me, a valuable thread of agreement here, even between somewhat polarized extremes, and it is most important in the present turbulent state that this possibility for the development of an articulate and unified voice for this vulnerable sector should be pursued.

It appears to some of us that one major cause of the emotive dissonance that has characterized this field in recent years is the lack of understanding between various professionals. It has been the experience of the Association of Professionals for the Mentally Handicapped that if such professions undergo even a short educational experience together they gain much more insight into the roles of their colleagues in other disciplines.

What is urgently needed in the United Kingdom is an academic centre, or centres, for the training of professionals in mental handicap. There appear to be many areas of overlap in parts of existing courses which are at present taken in isolation by nurses, social workers, educationalists, para-medicals, psychologists and the students in the various medical sub-specialties. There are also areas in which no one seems to receive adequate training. If the mental handicap aspects of these courses could be received in the same setting with students from other disciplines: (1) a better perspective and a more balanced approach would be promoted among professionals; (2) the content of the courses could be considerably refined, especially with regard to their relevance to the ultimate professional tasks; and (3) a centre (or centres) of excellence would be created which would attract the comparatively few skilled people who are around in this field to work together in a balanced multi-disciplinary setting from which some original ideas and research could hardly fail to materialize. It is, of course, essential that such an 'Institute' should be located in a situation, both functionally and geographically, that does not give it, directly or by implication, a unidisciplinary slant. It might be possible, for example, to attach it to a University but not necessarily through the Departmental structure, and it should not be difficult—with funding—to direct it at Professorial level.

It has been my sad experience in recent years to see an increasing polarization of the views upon the services for the mentally handicapped. The result of this has been to prevent the effective development of new ideas on any worthwhile scale. The causes are complex—political, economic, psychosocial, technological developments in medicine, etc. The faith of *Better Services* (40)(xiii) in the reorganization of the NHS does not seem to those of us actually involved in the service to have been justified. I suggest that our task now is to co-operate within ourselves and with our colleagues in all the related disciplines in the setting up of a truly 'Better Service' that compounds experience, insight, and above all, better professional skills, knowledge and attitudes.

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UNILATERAL ECT

DEAR SIR,

We are surprised that Dr Halliday *et al* (*Journal*, October 1975, **127**, 416) did not refer to pulse ECT when discussing the prevention of memory disturbance after ECT. We agree that there are three considerations in achieving this—the use of unilateral non-dominant electrode placement, correct assessment of laterality and employment of the minimum dose required to produce grand mal. With regard to the third, we believe that they have overlooked an efficient and widely available method, namely the use of bidirectional pulses, 750V peak-to-peak with a repetition rate of 21·5 per second. The wave form thus differs radically from that of sinusoidal ECT. Pulse ECT has been adequately described (Cronholme and Ottosson, 1963: Carney and Sheffield, 1974) and it has been shown in controlled comparative studies to be as beneficial as sinusoidal ECT by Valentine, Keddie and Dunne (1968) who also showed that it reduced to a significantly greater extent than sinusoidal ECT, post-electroplexy malaise and memory disturbance.

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CONTROLLED TRIALS OF IMIPRAMINE

DEAR SIR,

Drs Rogers and Clay (*Journal*, December 1975, 127, 599) suggest that further drug-placebo trials in endogenous depression are not justified as imipramine is of indisputable benefit in such patients who have not become institutionalized. The data presented are open to other interpretations, and the effectiveness of imipramine for the treatment of depression has still not been established beyond doubt. A suitably designed trial comparing antidepressants with placebo might still help to clarify the problem. Many psychiatrists would expect most patients (certainly over 50 per cent) with endogenous depression to get better in due course without treatment because of the natural history of the disorder. There is no indication of the length of time for which any of the patients were treated. We think the distinction between endogenous and other depressions is not so readily made as implied in the table. The great variation in percentage improvement rates in both imipramine and placebo groups of endogenous depressions needs some explanation. The criteria for rating improvement are not mentioned, and the sample sizes vary from 6 in one trial to 140 in another.

The trials analysed by Rogers and Clay form only a small proportion of the published trials on antidepressants. The method of statistical analysis does not allow for all trials to be tabulated. There are many trials in which placebo has achieved a better result than an antidepressant, and these have not been included. Also, only two trials carried out since 1966 are mentioned and it is in the first years of a drug's commercial life that favourable reports tend to be published. Some of these points concerning antidepressants have been made previously by Leyburn (1967) and by Porter (1971). It would be unfortunate if the results of this particular statistical review were accepted uncritically as evidence that imipramine is in fact so therapeutically effective.

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A MARRIAGE THAT OUGHT TO ENDURE

DEAR SIR,

In his pamphlet *The Future of Psychiatry* Professor Eysenck advocates an amicable divorce between the disciplines of Psychiatry and Clinical Psychology. It is our opinion that this would not be in the best interest of the psychoneurotic patient. By arguing that psychoneurosis is behaviour largely determined by conditioning, deconditioning or failure to learn or condition, Eysenck (p 6) is stretching his stimulus-response theories just as far as he claims many psychiatrists are stretching the disease model. Recent work (Beech, H. R. and Perigault, J., 1974; Crowe, M. J. *et al*, 1972) suggests that both acquisition and extinction of morbid fears and obsessions constitute a very complex process—'it is obvious that multiple conditions are involved which interact with one another, so a satisfactory model cannot be simple', comments Marks (1975). 'Unusual states of arousal' and 'right cognitive set' are postulated, but elude precise qualitative definition. Thus the door once again opens to concepts such as idiosyncratic meaning and conflict. Many behaviour therapists, contrary to Eysenck's view, emphasize the role of cognitive factors in the cause and treatment of psychoneurosis. At this point there is a great deal of overlap between behaviour therapy and psychotherapy.

A significant proportion of our patients resist exploration so that basic drives remain unrevealed: the obstacles of denial, dissociation, projection and displacement of feeling can be formidable, and it is the psychotherapist's often slow and arduous task to evaluate and disentangle them. Such obstacles do not necessarily constitute complexes in the classical sense (Eysenck, p 17), but may represent interpersonal emotions or phobias hidden from conscious awareness and therefore not accessible to treatment until the patient can be brought into direct contact with the phobic object or situation: but if the latter remains unrevealed, unrecognized or unknown, what precisely do we help the patient to confront?

The danger of neglecting covert factors is not so much symptom replacement as resistance to treatment or only very partial improvement. In a series of agoraphobic patients, psychological gain appeared to have prevented success with deconditioning therapies in 56 per cent of cases (Shafar, 1975); psychodynamic gains operated, but many were relinquished with

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