have been attributed to a temporary imbalance between cholinergic and dopaminergic activity (Leigh *et al*, 1987). This is supported by ocular movements under dopaminergic control (Rascol *et al*, 1989) benefiting from either anticholinergic or dopamine receptor blocking drugs (FitzGerald & Jankovic, 1989).

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References

LEIGH, R. J., FOLEY, J. M., REMLER, B. F. *et al* (1987) Oculogyric crisis: a syndrome of thought disorder and ocular deviation. *Annals of Neurology*, **22**, 13–17.

RASCOL, O., CLANET, M., MONTASTRUC, J. L. *et al* (1989) Abnormal ocular movements in Parkinson's disease: evidence for involvement of dopaminergic systems. *Brain*, **112**, 1193–1214.

FITZGERALD, P. M. & JANKOVIC, J. (1989) Tardive oculogyric crises. *Neurology*, **39**, 1434–1437.

Reviewing reviewers

SIR: I have read Ellenberger's book *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry* from cover to cover. Twice. Does this qualify me for some sort of record?

I was quite disappointed with MacDiarmid's reconsideration of the book (*Journal*, January 1990, **156**, 135–139), and taken aback that he considered it acceptable to admit he had not even read it all. I had thought that a *sine qua non* of reviewing was that the reviewer read the piece under review, be it never so long or tedious. It *is* long, but in my opinion not a page too long.

Perhaps because MacDiarmid is not familiar with the whole of the book, the impression I received from his review was not the same as that which I got from the book itself. Ellenberger's chapter on Janet is actually considerably longer than his chapter on Freud, yet approximately half of MacDiarmid's review deals directly with the latter.

I had found that this was one of the strengths of Ellenberger's book that he, as it were, put Freud into perspective, so that one could see what came before, after and at the same time, despite Freud's subsequent and now challenged pre-eminence. I don't think that this is reflected in MacDiarmid's review.

It may seem impertinent, but I don't think it unreasonable to request that people who review books should take the time to read them fully.

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Failure to convulse with ECT

SIR: Failure to convulse with electroconvulsive therapy (ECT) has been the subject of much recent discussion in your *Journal* (*Journal*, January 1988, **152**, 134–136; *Journal*, April 1988, **152**, 571; *Journal*, May 1988, **152**, 712–713). Reference has been made to a number of measures adopted to address this problem including vigorous pre-oxygenation, caffeine priming, reduction in methohexitone dosage, the use of chlorpromazine, cessation of benzodiazepines, the conversion from unilateral to bilateral electrode placement and the introduction of 'high energy' ECT machines. From a quality assurance perspective, it is disconcerting but important to reflect on the range of clinical activities derived from such measures. For this purpose, the psychiatrist's activities can be dissected, temporally, as follows: (a) what is done at the patient's bedside if there is no convulsion on application of the electrical stimulus; (b) what changes, if any, are made prior to the next ECT treatment session.

To the best of my knowledge, neither routine has been surveyed. Discussion with a number of colleagues working in different institutions suggests that an alarming variety of practices and protocols abound. To expound on (a), for example, some psychiatrists will not deliver a further stimulus if a patient does not convulse with the initial one. Other psychiatrists decide to give one, two or three further stimuli before either effecting a seizure or abandoning ECT for the day. Some administer a repeat stimulus immediately after failure of a preceding one. Others ensure that a designated period of time (usually up to a minute) elapses between administrations. Some psychiatrists will not change the original electrical settings for repeat stimuli. Others increase the duration but not the amplitude of the current. Others increase the amplitude but not the duration. Still others increase both the amplitude and duration. Increments in such parameters depend partly on the nature of the ECT machine but are, in any case, often randomly chosen. Some psychiatrists retain the initial electrode position, perhaps exerting more pressure on the patient's skin. Some convert from unilateral to bilateral placement. Many psychiatrists are hesitant or inconsistent in their routine. A familiar scenario may emerge – an electrical stimulus is delivered, a clinical fit doesn't ensue, the anaesthetist and psychiatrist look expectantly at one another, the attendant nurses look politely at the floor.

The described diversity of practice is, I suspect, not restricted to the Antipodes. It is lamentable. The administration of an electrical current to the head is not

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