and not significant for the (initial) phobia (+ ·03) and anxiety (+ ·04) ratings.

Although I had according to my judgement excluded cases suffering primarily from depressive illness, it is possible that cases were included whom others might have regarded as 'pseudo-neurotic depressives'. At any rate it appears that most improvement in these cases might be expected in patients with associated depressive symptoms at their first presentation.

This result is in accordance with expectation, imipramine being an antidepressant drug. I could not detect in my clinical observations or in the statistical results any significant 'anti-anxiety' effect as claimed by Klein (3).

Certainly my results were not as good as those of Kelly *et al.*, and it may be that their treatment, composed of a combination of drugs of which MAOIs were the chief ingredient, carries significant advantages over imipramine. What is certainly required is that further controlled studies should be carried out in this field.

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CONSCIENCE AND DEPRESSIVE DISORDERS

Dear Sir,

I should like to make two comments upon the paper by Drs. Amdur and Harrow in the March 1972 issue of the *Journal* (**120**, pp. 259–64).

(1) It was demonstrated that patients with depressive illnesses have stricter consciences, according to the criteria used, than schizophrenic patients or subjects with personality disorders. It might possibly have been predicted that the latter two groups had laxer consciences than mentally healthy individuals, so that it has not been shown that subjects susceptible to depression have stricter consciences than do healthy subjects. The authors fail to comment upon the similarity of scores on the various scales recorded for depressed and 'other' patients (excluding schizophrenics and those with personality disorders). Those 'other' patients had various other diagnoses which were not specified, and the companion article 'Guilt and depressive disorders' in *Archives of General Psychiatry* does not clarify this matter. Surely a healthy control group is required before any conclusions can be drawn about the strictness or otherwise of the consciences of the depressed patients.

(2) Stricter conscience as measured by the authors is shown to be positively correlated with increasing age, and various possible explanations are considered. Could it be that the subjects gave responses socially acceptable to their own age group irrespective of the rigidity of their own consciences? Thus the younger patients might have replied in a vein in keeping with the morals of the 'permissive society', whereas the older patients might have responded in a manner suitable to a more authoritarian approach.

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THE FORMATION OF THE CLINICAL NEUROLOGY INFORMATION CENTER AT THE UNIVERSITY OF NEBRASKA

Dear Sir,

In March 1972, the Clinical Neurology Information Center (CNIC) was established at the University of Nebraska College of Medicine under the auspices of the National Institute of Neurological Diseases and Stroke. This is the third of a series of information centres in the NINDS Neurological Information Network; Brain Information Service is at UCLA and the Information Center for Hearing, Speech and Disorders of Human Communication is at Johns Hopkins.

The initial activities of CNIC will be the publication of State-of-the-Art papers; these will be critical reviews of topics of interest to neurologists, neurosurgeons and other clinical neuroscientists.

Information concerning CNIC may be obtained by addressing inquiries to: Director, Clinical Neurology Information Center, Medical Library, University of Nebraska College of Medicine, Omaha, Nebraska, 68105, U.S.A.

Walter J. Friedlander,
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