frequency, width, and train duration be fixed for all patients, and the current of pulses be varied between 350 and 750 mA, as a function of patient age, translates into an approximate 2-fold range in total stimulus charge (210–450 mC), despite the 40-fold range among patients in actual seizure threshold (Sackeim *et al*, 1993; 1994). Both the efficacy and cognitive side effects of ECT are dosage sensitive, and related to the extent to which electrical dosage exceeds threshold (Sackeim *et al*, 1993). In general, age accounts for only about 10% of the variance in threshold, and many older patients will have 'adequate seizures' with a charge of only 24 mC. Following the suggestions of Byrne and colleagues, we would be subjecting the older patients, i.e. those most vulnerable to excessive cognitive side effects, to the greatest excess in electrical dosage. Alternatively, following these recommendations, other patients with high thresholds will have seizures of adequate duration, but fail to respond due to inadequately suprathreshold dosing.

Byrne *et al*'s main concern was to simplify methods of ECT administration by suggesting a fixed set of parameters and allowing dosage manipulation only with respect to the current of pulses. As we pointed out, the principle of dosage titration is independent of the specific parameters used to manipulate stimulus intensity (Sackeim *et al*, 1994). Furthermore, basic research has yet to determine the strength–duration functions necessary to finalise choice of optimal ECT parameters. At present, it is unknown whether manipulation of pulse frequency, train duration, and/or current provides the most efficient form of stimulation. The choice of pulse current made by Byrne and colleagues was without scientific foundation. At the practical level, because of the great variability in seizure threshold, it is unlikely that dosage adjustments offered by an optimal ECT device could ever be restricted to a single electrical parameter. Clearly, very low levels of pulse current would be inefficient in triggering depolarisation, while very high levels may not only be inefficient, but also dangerous.

We disagree with a number of other specific suggestions. We have described how knowledge of the dynamic impedance during the passage of the ECT stimulus can be fundamental in determining whether failure to provoke a seizure is due to an increase in threshold or to poor electrode contact (Sackeim *et al*, 1994). Byrne and colleagues also recommended that, when confronted by seizures of inadequate duration, the practitioner should automatically increase stimulus intensity. This is contradicted by recent studies that demonstrate that high intensity stimulation results in shorter seizure duration compared to lower intensity stimulation. Byrne *et al* also discouraged the incorporation of EEG monitoring facilities in ECT devices. The detection of nonconvulsive prolonged seizures, tardive seizures, and status epilepticus is not a trivial issue. While relatively rare, the documentation of such events in the ECT literature as leading to significant morbidity and, in some cases, death, should prompt more rather than less caution. Further, there is increasing interest in the use of ictal EEG parameters as measures of treatment adequacy, since it is now known that seizures of adequate duration can be reliably produced at every treatment session but fully lack antidepressant effects.

SACKEIM, H. A., PRUDIC, J., DEVANAND, D. P., *et al* (1993) Effects of stimulus intensity and electrode placement on the efficacy and cognitive effects of electroconvulsive therapy. *New England Journal of Medicine*, **328**, 839–846.

—, LONG, J., LUBER, B., *et al* (1994) Physical properties and quantification of the ECT stimulus: I. Basic principles. *Convulsive Therapy*, **10**, 93–123.

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Sir: We are very pleased to have Professors Sackeim's and Malone's response to our article. We would like to make the following points:

1. The range of currents quoted and the doses these give, were designed to be illustrative rather than optimal. We apologise if we failed to make this sufficiently clear.

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2. The underlying tenet is precisely that of Professors Sackeim and Malone, ie. "... basic research has yet to determine the strength–duration functions necessary to finalise the choice of optimal ECT parameters".
3. We, therefore, challenge the use of the unit mC in ECT, as it assumes that all stimulating parameters are of equal importance and cannot be related to the patient's current threshold.
4. Research into EEG monitoring may soon provide useful information on ECT parameters as measures of treatment adequacy. At the moment it appears more often to give a spurious air of precision and scientific credence to a process which is poorly understood.

We recommend the abandonment of the use of the unit mC to describe the treatment dosage in ECT. We recommend that details of current, pulse width, frequency and train duration be recorded. Parameters which are varied during the treatment course to obtain the best results for that particular patient should be noted. The link between stimulation parameters, benefits and side effects may then become clearer.

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Sir: We write to draw attention to a Letter of Concern that has been circulating within the psychotherapy profession. The Letter arose from the invitation by the Association for Psychoanalytic Psychotherapy in the NHS to Professor Charles Socarides to give its Annual Lecture last April. Socarides, a psychoanalyst, is well known for continuing to argue against the decision of the American Psychiatric Association to declassify homosexuality as a mental illness in 1973. He has also campaigned against lesbian and gay rights on the grounds that homosexuality is a perversion that threatens to "turn the world upside down".

In writing the letter, we did not seek to have the lecture cancelled. It was threats of disruption from other quarters that caused this to happen. Our aim was to raise two crucial issues highlighted by the invitation that interlock and deserve serious public debate; these issues have been problematic for some time.

The first was the apparent discrimination (direct and indirect forms have been documented) against lesbian and gay men applicants for training at the Institute of Psycho-Analysis and other psychoanalytic psychotherapy organisations. The second concerned the undue preference given to the graduates of the Institute of Psycho-Analysis for appointments to posts at senior registrar and consultant level in psychotherapy (mainly in London and the South-East).

A private (and apparently homophobic) institution has a significant but unregulated role in public sector mental health provision. This does not occur elsewhere in the health service.

We are also concerned about the nature and quality of psychotherapy services available in the health service to lesbians and gay men.

The letter was signed by approximately 200 psychotherapists including professors of psychiatry, psychotherapy and psychology, consultant psychiatrists and psychotherapists and private sector psychotherapists from all schools. This response is, we believe, without precedent in the history of psychotherapy in this country.

As a major controversy, this attracted much media interest. This was, in the main, accurate and sympathetic. It culminated in extensive reporting of a public statement by the Parliamentary Under-Secretary of State for Health (John Bowis) condemning those mental health professionals, including psychoanalysts and psychiatrists, who continued to regard homosexuality as a mental illness or aberration.

Department of Health officials have given direct and written assurances that all the issues raised in the letter are being looked into.

The full text of the letter and list of signatories and further information are available from the address given below.

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