

## References

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## Depersonalisation and Self-Perception

SIR: I found Mellor's discussion (*Journal*, July 1988, 153, Suppl. 2, 15–19) of the phenomenological philosophy of depersonalisation both interesting and disturbing. Having pointed out how some great men, such as Schilder and Schneider, may fail to agree on certain fundamental aspects of interpretation, he goes on to offer a "tentative proposal that two forms of depersonalisation exist", a malignant, dysphoric variety, and a benign, possibly protective type. Surely this proposal fails to take the reactions of the subject into account? I have seen patients who have been given morphine react differently, with euphoria or with dysphoria, depending on a number of circumstances, not the least of which was the presence or absence of pain respectively. This reaction is also modified by the duration of exposure to opiates (O'Shea & Falvey, 1988).

If a subject experiences dizziness as a result of a brain tumour or because of beta-blocking drugs, is the experience qualitatively different of necessity? Again, surely, one factor determining those other-than-lost emotional reactions (Schneider, 1959) is the patient's interpretation of the significance of the phenomenon? My own viewpoint, be the setting delusional or otherwise, is that of Mayer-Gross (1935) and some more recent observers (for example Cohen, 1988): i.e. that the experience is probably a physiological event, complicated by factors such as genetics, personality, biochemistry, structural change, environmental circumstances, and so on. Philosophy and psychoanalysis fail to provide uniform explanations simply because of this complexity.

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## Lithium-Induced Carpal Tunnel Syndrome

SIR: With reference to the article by Deahl (*Journal*, August 1988, 153, 250–251), we should like to point out that this is not the first report of lithium-induced carpal tunnel syndrome, as stated. We reported just such a case in these very correspondence columns two years ago (*Journal*, September 1986, 149, 386–387).

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## The Truth About ECT

SIR: At the end of their interesting review on the use of electricity in the treatment of mental illness, Drs Beveridge & Renvoize (*Journal*, August 1988, 153, 157–162) bring in the practice of ECT. Strictly this is irrelevant to their subject and simply serves yet again to perpetuate misunderstanding of the nature of ECT. ECT is in no sense electrical *treatment* or electrotherapy, but only the use of an electrical stimulus instead of a pharmacological one (subcutaneous insulin, intravenous metrazol, or inhaled flurothyl) to set off an epileptiform disturbance in the brain; it is this disturbance which is therapeutic. We do not talk of the motor car as an electro-automobile because it has spark plugs, or of electro-central heating because an electric pump shifts the hot water. We do not pit the mysterious force of electricity against (mysterious) mental illnesses, as a hostile lay public may believe, nor (with muscle relaxants) should there be any convulsion (unpleasant word). So electroconvulsive therapy as a name has all the wrong associations and helps to perpetuate the bad image of the treatment. A more accurate name would be relaxant ictal therapy (RIT), which would be better for public relations. As for shock treatment, it does not mean, as some suppose, electric shock treatment like the painful tingling from a shocking coil or worse from the mains, nor surgical shock, nor emotional or physical shock (as given to the mentally ill in the past with the whip, the ducking stool, or the release of snakes in the dark). The word shock was introduced by Sakel to express the fairly fast action and non-specific nature of the effects of insulin therapy, and got carried over into pharmacological treatment.

Many authors writing briefly about the origins of ECT link it as Drs Beveridge and Renvoize do with the history of electrobiology, or with old practices of frigit and torture. But the roots of its discovery are