

stimulus waveforms. There are, however, several statements in this report that are vague and potentially misleading.

These investigators summarize their findings by saying (p. 357), "It is suggested that the quantity of current, as well as the induction of a convulsion, is relevant to therapeutic outcome with ECT". This and a similar statement at the very end of their discussion may lead readers to conclude that the quantity of current or energy *per se* is partly responsible for ECT's therapeutic efficacy. Such a conclusion is supported neither by the convulsive therapy literature (Fink, 1979) nor by Robin and de Tissera's own data analyses. Regarding the latter, Robin and de Tissera did *not* report a positive correlation between electrical energy and anti-depressive efficacy, which would be required if one were to argue for a therapeutic effect directly related to electrical energy. If the therapeutic differences across Robin and de Tissera's three groups is not due to a difference in electrical energy, what is the critical variable influencing therapeutic outcome?

Seizures induced with ECT do not necessarily occur in an "all-or-none" fashion (Liberson, 1948). Clinical observations from several studies (discussed by Daniel and Crovitz, 1983, p. 3) suggest that low energy pulse electrical stimuli (as used in Robin and de Tissera's study) may produce *less generalized* seizures than those produced by higher energy electrical stimulations. These former seizures may be less effective in alleviating depression than the latter more highly generalized seizures (Ottosson, 1962a, 1962b; Cronholm and Ottosson, 1963; Fink, 1979).

While Robin and de Tissera measured and found no difference in *duration* of seizures among their three treatment groups, they apparently did not examine differences in clinical or EEG seizure *patterns* among the three ECT groups. These investigators cannot therefore rule out the possibility that a difference in seizure generalization (reflected in differing patterns) was responsible for the inter-group anti-depressive difference they found, a hypothesis Cronholm and Ottosson (1963) formulated to explain results in a similar study.

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DEAR SIR,

Robin and de Tissera conclude that low energy pulse ECT stimuli are not as therapeutic as high energy pulses or high energy modified sinusoidal waveforms. Their findings, however, do not allow such a general conclusion to be reached. The low energy pulse

stimulus used by these investigators has an ultrabrief pulse width (0.3 msec) which has already been shown to be less effective than stimuli with a wider pulse width (Cronholm and Ottosson, 1963; Pippard and Ellam, 1981). A brief pulse stimulus characterized by a pulse width in the range of 0.75 to 1.5 msec, (MECTA ECT device) on the other hand, has been shown to be equally as effective as an unmodified sine wave stimulus for both unilateral nondominant and bilateral electrode placement (Welch *et al.*, 1982; Weiner *et al.*, in press). This ongoing study involved random assignment to both stimulus waveform and electrode placement. Seizure duration, as monitored by EEG, was equivalent for all combinations, indicating that stimuli were probably equivalent with respect to seizure threshold.

By making a generalization about the efficacy of high and low energy ECT stimuli, Robin and de Tissera may be leading the reader to believe that all forms of brief pulse stimuli are not as effective as high energy stimuli, and that their use should, therefore, be avoided. Such a conclusion, however, is premature, not only for the reason delineated above, but also because there is evidence that higher energy stimuli may be associated with more adverse central nervous system effects (Weiner *et al.*, 1982; in press; Daniel *et al.*, 1983).

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EMPATHIC INTERVIEWING REVISITED

DEAR SIR,

We read with interest the recent comments of Peter Maguire (“Psychiatrists also need Interview Training” *Journal*, October 1982, 141, 423–24) concerning the training needs of both family practice (general internist) and psychiatric residents, specifically with regard to interviewing patients. This letter is to reaffirm some of his views and to report some of our own efforts in teaching interviewing techniques.

Each of the authors were third year psychiatric residents at the University of Pittsburgh when we undertook our community psychiatry placement at a local family practice residency program. The overall requirement was for us to become mental health consultants, and for two days per week for six months a year, learn the principles based on the work of Gerald Caplan and others. We went to rounds on an inpatient unit with the family practice residents, and the director of the residency, and advised in the outpatient clinic. The remainder of the time was used differently by each of us, on research projects, lectures, nurse’s groups, seminar attendance, etc.

On the inpatient unit we were present at the bedside for some of the first encounters between patient and resident, and one day a week, for both resident rounds and attending rounds. On all these occasions we were free to comment on the interview to the resident, and to ask questions for own medical knowledge, and to volunteer information to the resident. On rounds we

were also available for demonstration interviews. In the outpatient clinic, we were also available for first encounters, follow-ups, and for psychiatric resource purposes, i.e. pharmacotherapy, hypnotherapy, etc. Our consultation was supervised by a Board certified psychiatrist and a psychologist with specific expertise in mental health consultation.

The scheme of teaching included interviewing and the doctor-patient relationship, through Balint seminars, lectures, and supervised case management. This latter supervision is provided usually by a social worker as well as other staff family practitioners, while the Balint seminars are led by psychiatrists. Videotaped interviewing is rare and we are not yet fully equipped for its general use.

With regard to our role as teachers and observers, we noted the following, and have ranked them according to importance:

1. The different personalities of the residents (including how complexities of a case related personally to the residents) played an important part in determining how receptive residents were to our suggestions as well as the ease with which we were accepted into the room with the residents for the first encounter. Also, it was interesting to note that certain residents seemed to ask more insightful questions and were more open to suggestion. This pattern remained consistent over time and was not affected by the change in the teaching psychiatrist.
2. In general, first year residents were more receptive to suggestions, both psychiatric and medical, than the more senior residents.
3. It was easier for us to gain access to a room with a resident if his senior gave approval, and his sanction had different manifestations; the senior could give a suggestion to the resident that we accompany him, or could be asked to see a patient alone, or he could just be asked a general question in psychiatry.
4. The interrelationship of the behavioural aspects of a case was usually underplayed.
5. We, as psychiatrists, were continually amazed that the sensitivity to specific and often hidden behavioural issues seemingly acquired by clinical experience and demonstrated by several senior physicians, especially the residency director, could not really be taught. In addition, residents were more interested in emulating the medical knowledge than the behavioural science knowledge.

Residents and sometimes seniors are uncomfortable being watched, but we agree that the traditional method of sending the medical student or resident into a room and bringing back the data (the facts) is