Secondly, Drs Bamrah & MacKay did not make it clear if they restricted their review to psychoses associated with all karyotypic types of TS or to 45 XO only. In addition to the seven cases they found in the literature, I am aware of three others: Beumont & Mayou (1971); Kolb & Heaton (1975); and Money & Mittenthal (1970). Two of these cases were mosaics and may not have been included for that reason.

Thirdly, the literature also contains four cases of TS associated with affective disorder of psychotic proportions: psychotic depressive reaction, endogenous depression and two cases of manic-depressive illness (Fishbain & Vilasuso, 1981). Some of these cases were also mosaics.

Finally, if psychotic reactions are uncommon among TS patients, then the prevalence of TS within schizophrenic females or females in mental institutions should be lower than that in a pool of newborn girls, where the prevalence of negative sex chromation is 0.05% (Akesson & Olanders, 1969). Two studies found *no* TS in large numbers of mental hospitals (MacLean *et al*, 1968) or chronic psychotic females (Anders *et al*, 1968). Another two studies (Akesson & Olanders, 1969; Kaplan & Cotton, 1968) found 0.03% and 0.4% prevalence of TS among mental hospital and schizophrenic women respectively. The one TS patient identified by Akesson & Olanders was an XO while all three identified by Kaplan & Cotton were mosaics. These studies indirectly support Drs Bamrah & MacKay's contention that the "absence of an X chromosome would confer some immunity from major psychiatric illness". However, it appears that immunity may not be conferred on a TS mosaic. This is the reason why the issue of mosaicism is important to this research area.

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Aggressiveness, anxiety and drugs

SIR: The brief article by Kirov on this topic (*Journal*, December 1989, **155**, 846) draws attention to a link between aggressive behaviour and anxiety, and derives a general principle that anxiolytic drugs may be expected to have an anti-aggressive effect. An early review of the effect of drugs on violent behaviour (Goldstein, 1974) found little encouragement for the use of anxiolytic or tranquillising drugs. I have had the opportunity to review more recent literature (Conacher, 1988) in which favourable results have been reported for some classes of drugs, that are not, however, all noted to possess a direct anxiolytic effect. A hypothesis has been advanced that the effect of these drugs is mediated through a serotoninergic system (Editorial, 1987).

Paradoxical reactions to tranquillisers have long been recognised, but there is too little known about these to confidently assert that they arise out of 'an abnormal terrain' such as a previously damaged central nervous system. In institutional environments where crowded conditions prevail, benzodiazepines should probably be regarded as contra-indicated in the treatment of aggression. Clinical experience supports empirical evidence that other drugs can be more effective in selected cases.

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Auditory hallucinations during oculogyric crises

SIR: Auditory hallucinations during oculogyric crises, reported by Chiu & Rogers (*Journal*, July 1989, **155**, 110–113 and October 1989, **155**, 569–570),

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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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