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Correspondence

Letters for publication in the Correspondence columns should not ordinarily be more than 500 words and should be addressed to:
The Editor, British Journal of Psychiatry, 17 Belgrave Square, London SW1X 8PG

SCHIZOPHRENIA IN FICTION

DEAR SIR,

In Dickens' *David Copperfield*, the following conversation takes place between David, the narrator, and Mr Dick, a friend of David's aunt:

> 'Do you recollect the date', said Mr Dick, looking earnestly at me, and taking up his pen to note it down, 'when King Charles the First had his head cut off?' I said I believed it happened in the next year sixteen hundred and forty nine. 'Well', returned Mr Dick, scratching his ear with his pen, and looking dubiously at me, 'So the books say; but I don't see how that can be. Because, if it was so long ago, how could the people about him have made that mistake of putting some of the trouble out of *his* head, after it was taken off, into *mine?*'

Schneider (1959) has said that one of the symptoms of first rank in the diagnosis of schizophrenia is the attribution of thoughts to other people, who intrude their thoughts upon the patient, and this would seem to apply here. Schneider's one caveat is that there is no physical illness present which might cause the symptom, and this may reasonably be inferred from the text; Mr Dick's symptom persisted in the context of otherwise good health for a period of fifteen to twenty years.

In *Jane Eyre* the following is a description of Mrs Rochester's behaviour:

> 'In the deep shade, at the further end of the room, a figure ran backwards and forwards. What it was, whether beast or human being, one could not, at first sight, tell: it grovelled, seemingly, on all fours; it snatched and growled like some strange wild animal; but it was covered with clothing; and a quantity of dark, grizzled hair, wild as a mane, hid its head and face; . . . the clothed hyena rose up and stood tall on its hind feet. . . . the maniac bellowed: she parted her shaggy locks from her visage, and gazed wildly at her visitors. The lunatic sprang and grappled his throat viciously, and laid her teeth to his cheek . . .'.

This rather metaphorical account defies diagnosis and it may have been based on lay concepts of madness rather than on observation.

Accuracy of observation sufficient to allow a diagnosis to be made has been noted previously in Dickens' work (Cecil-Loeb, 1971). The Pickwickian syndrome of somnolence and obesity illustrated by fat Joe in *The Pickwick Papers* has been thought to be an example of the cardio-respiratory failure of extreme obesity. It is in these medical descriptions that Dickens' detailed recording of observation may be validated, and perhaps this accuracy generalizes to other varieties of behaviour shown by his characters, which cannot be compared with precise standards. From a literary viewpoint, it might be argued that although accuracy is an asset in creating social realism, it is a disadvantage in the more romantic novel like *Jane Eyre*, depending for its effectiveness on a less obvious adherence to fact.

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Acknowledgement

I wish to thank Professor John Copeland for his advice.

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EPILEPTIC FIT AFTER CLOMIPRAMINE

DEAR SIR,

A 67-year-old woman was admitted to a psychiatric ward suffering from a depressive illness. The clomipramine 50 mg three times daily which she had been taking as an outpatient was not continued and 36 hours after admission she became unconscious; her respiration became audible, she slouched down in the

chair in which she had been sitting and there were clonic contractions of her arms and legs. She was conscious after a quarter of an hour, then in a few minutes she went to sleep for the night.

There was no improvement in her mental state following the convulsion. Her medication was restarted and she recovered over the next six weeks; the dose was then gradually reduced and there were no further convulsive episodes.

There was no family or personal history of convulsions, nor any history of conditions which might predispose to these. There was no history of drug or alcohol abuse. No abnormalities were found on physical examination or investigation, the latter having included an electrocardiograph, and electroencephalograph and a brain scan.

The absence of any disorder which could cause, or predispose to, a convulsion makes it possible that drug withdrawal was responsible for the episode. There have been two reports of convulsions following withdrawal of amitriptyline and imipramine (Committee on Safety of Medicines—personal communication) respectively, and thus is would seem that convulsions are a possible risk of abrupt withdrawal of this group of drugs.

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WARD ROUNDS

Dear Sir,

I was interested in the letter in the January 1978 issue of the *Journal* (**132,** p 111) from the lady who complained about ward rounds. I have met many fellow psychiatrists who have been unhappy, as I am, with the format of the usual ward round but have been unable to come up with any alternatives. It would be most interesting if you could publish descriptions from other psychiatrists who have successfully tried alternative methods.

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Dear Sir,

How timely it is that a patient should point out some of the faults inherent in psychiatric rounds (*Journal*, January 1978, **132,** 111-12). Perhaps he is also touching on a number of other issues which should concern us as doctors.

Firstly, the issue of patients' confidence that their case is being treated with due regard for their personal privacy. The author clearly feels that this is not the case and that his privacy was indeed intruded upon. It is a familiar psychoanalytical concept that patients find it hard to reveal highly affect-laden material, especially in the presence of an intrusive therapist. How much more applicable this must be to a 'team interview'.

Secondly, the cost benefit of the team round is, by implication, questioned. Many of us must frequently have wondered whether all of the ten or even fifteen persons present at a round might be more usefully occupied. Were such a round to last 2½ hours it would be equivalent to a full week's work for one person.

It is argued that such events are valuable learning experiences for the team members, but, even ignoring the confidentiality issue, this notion must be regarded with due scepticism. Perhaps the physiotherapist might agree.

We should conduct these clinical activities with greater regard for the ill-effects on our patients and for their cost, just as we do when prescribing drugs.

Or do we feel that our paramedical colleagues would be resentful at being excluded from the decision-making process? Do we now serve the team rather than the patient?

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KNOWLEDGE OF SIDE EFFECTS AND PERSEVERANCE WITH MEDICATION

Dear Sir,

In two earlier studies (Myers and Calvert 1973; 1976) we found that forewarning patients of possible side-effects of two antidepressant drugs (amitriptyline and dothiepin) did not affect the incidence of reported side-effects nor did it significantly influence the rate of discontinuance of medication.

Sixty-six patients with primary depressive illness were drawn from attenders at a psychiatric out-patient clinic between May 1974 and June 1976. They were randomly allocated to one of three groups. Patients in Group A were told they were being given a drug to cure their depression; those in Group B were told they were being given a drug to cure their depression and were also told the side-effects they might experience, in which event they were advised to continue the medication; patients in Group C were given identical verbal information to those in Group B and, in addition, the information was presented in written form for them to take away.