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.

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The diagnosis of depression was based on the usual clinical criteria for depressive illness. Dothiepin was prescribed in 35 cases, clomipramine in 11 cases, and various other antidepressants in the remaining 20 cases. The only other drugs prescribed were flurazepam as an hypnotic and diazepam or lorazepam as sedatives. Patients were reviewed 2, 4 and 6 weeks after the initial prescription, and were first asked 'What effect did the tablets have on you?' If the answer did not indicate side-effects, they were then asked 'Did the tablets have any adverse effect on you or make you feel bad in any way?' Each patient was also asked 'Did you take the tablets for the full two weeks?' The justification for using interrogation as the method of determining compliance is discussed by Myers and Calvert (1973; 1976).

There were no statistically significant differences in age and sex or in prescription of the various antidepressants, or in distribution of the 9 defaulters between the groups.

Side-effects were reported by 87 per cent of the sample, with no significant difference between the groups, but the rate of discontinuance of medication differed significantly (see Table), being much less when written information was provided.

Ley *et al* (1976) have emphasized the importance of the patient understanding the instructions given him, and written information may help or perhaps increase the 'attention-placebo' effect (Haynes, 1976). We suggest that written information about side-effects should always be given both in clinical practice and in drug trials.

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TABLE

Knowledge of side-effects and continuance with medication in patients who experienced side-effects

	Group A No information	Group B Verbal information	Group C Verbal and written information
Continued	7	13	19
Discontinued	4	6	0

	X^2	df	p
Overall	8·06	2	$< 0·02$
A v B	0·0018	1	$< 0·80$
A v C	5·14	1	$< 0·05$
B v C	4·95	1	$< 0·05$

LIST OF BOOKS SUITABLE FOR A PSYCHIATRIC LIBRARY

DEAR SIR,

Dr Bowlby's Sub-Committee accept responsibility for design and contents of the *List of Books Suitable for a Psychiatric Library* recently published by the Royal College of Psychiatrists. As stated in the Preface, their aim is not completeness, but balance. We must refer to an extraordinary imbalance, which is much to the disadvantage of trainees.

Section R9, titled 'Family Psychiatry', suffers a curious omission: no book specifically on Family Psychiatry! The section is overburdened with works which are remotely connected with Family Psychiatry or whose theme is Family Therapy, an import from the U.S.A. only recently practised in this country and, of course, only a part of Family Psychiatry. The latter —a British innovation—is extensively covered in all its aspects (theory, psychopathology, diagnosis and therapy) in a seminal work, *Family Psychiatry* (1963), and later in *Theory and Practice of Family Psychiatry* (1968) and *Principles of Family Psychiatry* (1975), all three by Dr J. G. Howells.

It is unfortunate that trainees looking for guidance in the List will be denied the benefit of these fundamental volumes, which are indeed the only works titled 'family psychiatry'.

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