evident in this paper due to the fact that all ratings were made only by the subjects themselves.

As the laterality of foci is not stated it is difficult to see how the findings can be regarded as support for an association between psychopathology and a left temporal lobe focus, though this is stated in the discussion.

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DEAR SIR,

We would like to reply briefly to Dr Roberts' 3 basic points. Firstly, complex seizures were a feature in all our patients with focal epilepsy, although, as we state in our paper, not all seizures were of temporal origin. Unlike Dr Roberts, we do not think that the available evidence, including the two review papers that he cites (Stevens, 1975; Stevens and Hermann, 1981), suggest significant differences in interictal psychopathology between patients with temporal and non-temporal seizures, if other factors, especially major cerebral pathology are excluded. Additional generalized seizures can be an aggravating factor, but as these were present in only 6 of the 47 patients with focal epilepsy, it is unlikely that they could have substantially affected the mean score of this subgroup of patients. Secondly, the study by Bear and Fedio (1977) is an interesting one, but based on a rather small number of patients (a total of 27) who were furthermore selected without regard to their psychiatric history—always a potential major complicating factor. Their finding of differences in psychopathology and response-style in temporal lobe epileptics related to laterality of the focus remains unconfirmed. Thirdly, we nowhere claim to have assessed laterality effects. The sentence in the discussion concerning the effect of a left temporal lobe focus merely refers to an additional finding in the study by Stores (1978), which we cited.

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AMITRIPTYLINE FOR DEPRESSED WOMEN WITH YOUNG CHILDREN IN GENERAL PRACTICE

DEAR SIR,

We feel that your readers would be interested to hear the results of a small controlled trial of amitriptyline in women who were identified as suffering from minor psychiatric illness in a general practice survey carried out in Harrogate, North Yorkshire. Symptoms of depression and anxiety which commonly affect women in the general population are related to adverse social factors (Moss and Plewis, 1977; Brown and Harris, 1978; Richman, 1978). Perhaps this is why it is often assumed that counselling of some sort is the most appropriate form of management in this sort of disturbance. However, we have some evidence that amitriptyline can reduce depressive symptoms under these circumstances and that improvement is still present after a year.

All the patients on the general practice list of one of us (J.H.) who were women with children aged two to 15 were approached and asked to complete the Leeds Scales (Snaith *et al,* 1976; Forrest and Berg, 1982) with a view to identifying those who had minor psychiatric illness. About 80 per cent responded. High scorers (scores of 7 or more) were interviewed a few weeks later and were offered treatment in a double-blind, randomly-allocated, placebo-controlled trial of a slow release amitriptyline preparation if the family doctor considered them sufficiently disturbed and there was no likelihood of pregnancy or severe physical illness. Twenty-five women, about a third of those interviewed, were included and successfully completed the trial. Progress was monitored using the Leeds Scales. The doctor made his own rating of symptoms and did not know what the questionnaire scores were. In retrospect it was found that his assessments of depression, apathy and diurnal vartiation of symptoms were significantly associated with Leeds D Scale scores ($P < .05$). The active drug group received 25 mg of amitriptyline for a week and then 50 mg in one evening dose. Blood levels of drug were estimated at four and