There was no overall relationship between depressive symptomatology and serotonergic function across diagnoses. We conclude that a) depressive symptoms in major depression and organic depression are associated with reduced central 5-HT function, while those in schizophrenia are associated with increased 5-HT function; and b) depression may not have a common serotonergic neurobiological origin across diagnosis.

[1] Van Praag HM, Kahn RS, Asnis GM, et al (1987). Denosologization of biological psychiatry or the specificity of 5-HT disturbances in psychiatric disorders. J Affect Disord.; 13: 1–8.

LITHIUM AND SEROTONIN REUPTAKE INHIBITORS; THERAPEUTIC OR TOXIC?

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The aim of this presentation is to review all available data on the safety, tolerability and effectiveness of lithium in combination with serotonin specific reuptake inhibitors in the treatment of Major Depression.

All published reports, including case reports, uncontrolled series and controlled studies, regarding coadministration of lithium and SSRIs were identified for the purpose of the review. Reports made to CSM and to pharmaceutical manufacturers were also considered.

The data were not suitable for meta analysis. Although case reports suggest that toxicity may occur the data from systematic studies, although largely open and uncontrolled, indicate a benign adverse event profile with little risk of serious events. Based upon 90 evaluable cases, the most frequent adverse events appear to be tremor, nausea or vomiting and somnolence. Evidence for efficacy of the lithium add-on strategy rests upon one small placebo controlled study (n = 15). Data from the uncontrolled studies is not incompatible with this but must be interpreted cautiously.

The interpretation of the currently available data is, on balance, that i) lithium add on to SSRIs is an efficacious strategy for the treatment of refractory Major Depression, ii) the combination is associated with an increase in the number of adverse events but these are seldom severe or serious, iii) serious toxicity is an uncommon occurrence. There is sufficient data to justify a large placebo controlled study to evaluate efficacy and tolerability.

'SEROTONERGIC AUTORECEPTOR BLOCKADE IN THE REDUCTION OF ANTIDEPRESSANT LATENCY: A CONTROLLED TRIAL'

María B. Tomé, Rosarii Harte, Michael T. Isaac. *Lewisham and Guy's Mental Health NHS Trust, London, UK; Department of Psychological Medicine, UMDS (Guy's Campus), London, UK*

Objective: To study augmentation of the antidepressant paroxetine with pindolol, a $5HT_{1A}$ autoreceptor blocker. Open studies suggest that, for SSRI antidepressants, the two-to three-week latency of antidepressant effect may be reduced if pindolol is taken simultaneously.

Method: Double blind, randomised, placebo controlled trial. All patients (n = 80; mean age 36 [range 19–65]; asthma, diabetes, cardio-pulmonary disease *excluded*) met criteria for major depression and received paroxetine (20 mg *o.d.*) plus, randomly, either pindolol (2.5 mg *t.d.s.*) or placebo. Assessment: days 4, 7, 10, 14, 21, 28, 42, using clinical measures, the Montgomery-Åsberg Depression Rating Scale [MADRS] and the Beck Depression Inventory. Patients are followed up for six months, allowing assessment of long term safety, tolerability and optimal dosage regimes, and subsequent service usage.

Results: Compared with day 0, 20% of *all subjects* showed a fall in MADRS score > 50% by day 4. By day 7, 30%, and on day 10, 40% of the patients scored > 50%, rising to 48% at day 14. On days 21, 28 and 42, 52%, 56% and 70% of patients registered a fall in MADRS score > 50%. Other measures showed comparable changes.

Conclusions: The markedly reduced latency of antidepressant effects has considerable implications for the future management of depression, and may have an impact on admission for and suicide rates. Larger multi-centre trials are warranted if the breaking of the blind has shown that these results are due to pindolol augmentation of paroxetine.

PROSPECTIVE STUDY OF THE EFFECTS OF INTERRUPTING ANTIDEPRESSANTS

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Antidepressant withdrawal symptoms, following discontinuation of antidepressants, include general somatic distress (flu-like syndromes, gastro-intestinal disturbances,), anxiety, sleep disturbances, movement disorder and manic reactions. Since most of the data come from case reports and retrospective study, it appeared to us of interest to assess, in a prospective manner, the effects of the withdrawal from tricyclic antidepressants and selective serotonin reuptake inhibitiors (SSRIs) in 16 patients answering to DSM-III-R criteria of major depressive episode.

All patients were hospitalized and a change of antidepressant treatment had been decided. Patients were assessed twice, just before the drug interruption and three days later. Clinical instruments were MADRS, Hamilton Anxiety Rating Scale, and the Scale for evaluation of benzodiazepine withdrawal symptoms which had been modified for the purpose of this study. We added two questions about gastro-intestinal symptoms often present in the case reports of antidepressant withdrawal.

87.5% of the patients presented symptoms following the withdrawal. Most frequent signs were anxiety (31%), irritability and jitteriness (25%), sleep disorders (19%), pain and contractions (20%), arousal and decrease in anergia (19%). Our results do not permit to establish a comparison between the rates of withdrawal syndrome induced by SSRIs and tricyclic antidepressants. They confirm the high frequency of withdrawal manifestations when antidepressant therapy is interrupted. Our results also stress the importance of the prevention of the withdrawal syndrome by a slow tapering of antidepressant dosage.

EVALUATION OF STRATEGIES IN THERAPY-RESISTANT DEPRESSION

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An evaluation of the first 73 patients who had attended our outpatient-clinic for therapy resistant depression revealed that only 41% (N = 30) fulfilled criteria for therapy resistant depression. 27 of these patients were followed up 3 months later and efficacy of therapy strategies were evaluated with HAMD and CGI.

6 patients were considered to be full responder (HAMD $\leq$ 6), 8 partial responder and 13 non responder.

There was no statistical significant difference between non responder and responder/partial responder before start of treatment strategies in age, sex, diagnosis, comorbidity on axis 1 or 2 (DSM-

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III-R), chronicity, frequency of melancholic subtype, HAMD-score or CGI-score. Treatment strategies were optimization of current treatment (N = 14, successful in 9 cases), change to other type of antidepressant medication (N = 3, successful in 1 case), augmentation-treatment (N = 5, successful in 1 case), combination treatment of 2 antidepressants (N = 4, successful in 2 cases), ECT (N = 1, successful), sleep deprivation (N = 3, successful in 2 cases), light therapy (N = 1, not successful), cognitive behavior therapy (N = 4, successful in 3 cases).

'COMPARISON OF SEROTONIN LEVELS IN DEPRESSION TREATED BY NEW AND STANDARD ANTIDEPRESSANT REGIMES'

María B. Tomé, Michael T. Isaac. *Lewisham and Guy's Mental Health NHS Trust, London, UK; Department of Psychological Medicine, UMDS (Guy's Campus), London, UK*

Objective: We test the hypothesis that augmentation of paroxetine, a selective serotonergic re-uptake inhibitor, with pindolol, a specific 5-HTI_A blocker, increases levels of serotonin in the brain, as measured in the periphery, during the early phase of treatment. Open studies indicate that this combination may reduce the traditional latency of onset of substantive antidepressant action.

Method: Using high-performance liquid chromatography, we measured blood serotonin levels on days 0 and +7 of the 42-day trial period in 20 subjects from a randomised, placebo controlled, double blind evaluation of the pindolol/paroxetine combination. All subjects (n = 80; mean age 36 [range 19–65]) met criteria for major depression and received paroxetine (20 mg *o.d.*) plus, randomly, either pindolol (2.5 mg *t.d.s.*) or placebo.

Results: We observed accelerated antidepressant response in significant numbers of our patients, where 20% showed a fall in Montgomery-Åsberg Depression Rating Scale [MADRS] score > 50% by day 4 of the study; 30% by day 7; 40% by day 10 and 48% by day 14. We have attempted to correlate these clinical measures, and whether the subject was taking pindolol or placebo, with blood serotonin levels.

Conclusions: Central changes in serotonin, reflected in the periphery, may aid monitoring of antidepressant therapy.

SUPERIORITY OF LITHIUM OVER VERAPAMIL IN MANIA: A RANDOMISED CONTROLLED TRIAL

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Both case reports and small controlled studies suggest the efficacy of verapamil in the treatment of mania. Forty patients with DSM-4 mania were studied in a 28 day randomised controlled trial of either lithium or verapamil. The patients receiving lithium showed a significant improvement on all rating scales, Brief Psychiatric Rating Scale (BPRS), Mania Rating Scale (MRS), Global Assessment of Functioning (GAF) and Clinical Global Impression (CGI) compared to those receiving verapamil. The mean MRS score at day 28 in the lithium group was significantly lower than in the verapamil group (16.6 vs 23.2 respectively, p = 0.024, F = 5.57, d.f. = 1). A similar pattern was seen with the BPRS (11.9 vs 20.4, p = 0.002, F = 11.05, d.f. = 1), CGI (2.16 vs 3.22, p = 0.016, F = 6.40, d.f. = 1) and the GAF (45.5 vs 54.4, p = 0.049, F = 4.16, d.f. = 1). This study suggests that lithium is superior to verapamil in the management of acute mania.

NR17. Short communications: psychotherapy

Chairman: S Davidson

PSYCHOGENIC TRAUMA AND TRANSIENT PSYCHOSIS

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The hypothesis is advanced that the concept of psychotic reaction to overwhelming stress (brief psychotic disorder DSM4; psychogenic reactive psychosis ICD9) is accepted and widely used in continental psychiatry but largely rejected by English-speaking psychiatrists.

The history of the disorder in the 20th century is discussed and examples of transient psychoses in mythology, drama and literature and as a consequence of catastrophies (Hiroshima, Concentration Camp) are presented.

The transient psychosis is defined in terms of symptomatology and psychodynamics and differentiated from conditions such as Post Traumatic Stress Disorder, Depressive Stupor, Conversion Reaction and two case histories are quoted. Results based on a survey of 3000 papers in psychiatric journals reveals the scarcity of relevant publications in Anglo-American literature and data based on psychiatric admissions to two psychiatric wards of general hospitals, a private psychiatric hospital and a large public psychiatric institution over a one year period show an extremely low discharge diagnosis of the disorder, supporting the study's specific objective.

TREATING PHYSICIANS WITH PSYCHOTHERAPY

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This paper represents one dimension of the author's twenty two year experience in treating over 750 medical students and physicians for a range of psychiatric problems. Observations include: resistance in physicians to accepting the patient role; denial and minimization of symptoms including self-neglect; fear of harboring major psychiatric illness; anxiety about breaches of confidentiality and reporting to licensing authorities; living with feelings of stigmatization and shame; guilt about letting others down (especially their families, patients, and colleagues); and avoidance of examining underlying or associated psychodynamic factors in their symptom genesis. Common transference dynamics include: avoidance; acting out; fears of dependency and giving up of control; and gender-related conflicts. Countertransference dynamics include: anxiety about treating physicians (including fears of "contagion"); underdiagnosing; overdiagnosing; intellectualization; painful identification with the vulnerability of physician-patients; boundary blurring and mishaps; and gender-based issues.

CONSULTING TO MENTAL HEALTH ORGANISATIONS

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The Tavistock Clinic, founded in 1920 on multidisciplinary lines, has many years of experience consulting to organisations in the health and mental health field, as well as in public sector and voluntary organisations.

Clear patterns of staff behaviour in response to the pressures arising from work with mentally ill patients manifest themselves both within members of staff, within the staff group as such, and

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