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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