In a study of similar design (and hence with similar flaws) to that of Busuttil *et al* we (Bisson & Jones, 1995) reported a similar dramatic improvement at three month follow-up in a group of 18 military and non-military personnel with post-traumatic stress reactions. Nine of the subjects' symptoms related to experiences in the Gulf War. The treatment technique was that of taped imaginal exposure (TIE) which employs many elements of psychological debriefing. In TIE the personal account is audiotaped and then listened to as "homework". The average number of 60–90 minute out-patient therapy sessions in our study was 4.2 range 3–7).

Brief effective out-patient therapies will prove more attractive to patients and purchasers in the NHS. They are likely to be more cost-effective and to allow more PTSD sufferers to receive treatment than intensive residential programmes. Such programmes should be reserved as second line treatment for patients who have failed to improve with out-patient interventions.

BISSON, J. I. & JONES, N. (1995) Taped imaginal exposure as a treatment for post-traumatic stress reactions. *Journal of the Royal Army Medical Corps*, **141**, 20–25.

BUSUTTIL, W., TURNBULL, G. J., NEAL, L. A., *et al* (1995) Incorporating psychological debriefing techniques within a brief group psychotherapy programme for the treatment of post-traumatic stress disorder. *British Journal of Psychiatry*, **167**, 495–502.

FOA, E. B., OLASOV ROTHBAUM, B., RIGGS, D. S., *et al* (1991) Treatment of post traumatic stress disorder in rape victims: a comparison between cognitive–behavioural procedures and counselling. *Journal of Consulting and Clinical Psychology*, **59**, 715–723.

J. I. BISSON

University of Wales College of Medicine
Heath Park, Cardiff CF4 4XN

SSRI and sympathomimetic interaction

SIR: Interactions between specific serotonin re-uptake inhibitors and sympathomimetics, while a theoretical possibility, are apparently uncommon because the latter are rarely prescribed. Such interactions may, however, occur if patients self-administer sympathomimetics. We report two such cases caused by popular pharmacomythology.

Case 1

A 31-year-old man presented to a casualty department with symptoms he recognised as being those of a large amphetamine overdose. He was extremely restless and agitated, over-talkative, anxious, hyperventilating and described ideas of reference. These symptoms subsided over the course of five hours in the department, his mental state returning eventually to normal. His GP had prescribed fluoxetine 20 mg daily for depression, but he had been taking a dose of fluoxetine 60 mg daily until a week before his presentation. He had intentionally trebled his prescribed dose because associates and the media led him to believe that pleasant psychological effects might result.

Shortly before presentation he had taken a dose of amphetamines that was small by his usual standards, but which was presumably augmented by the high levels of fluoxetine still present in his circulation because of the very long half-life of the drug.

Case 2

A 32-year-old man was admitted to an adult general psychiatric ward presenting first rank symptoms of schizophrenia. As a result of a business failure, he became depressed, and attended his GP, who prescribed fluoxetine 20 mg daily. Four days prior to admission he took two doses of amphetamines. He became very energetic and complained of insomnia. He also reported hearing voices talking to him and believed that the TV and radio were sending him messages and signals indicating the directions he had to follow when driving his car. On admission the patient received a single dose of 100 mg of chlorpromazine and he was discharged free of abnormal perceptual experiences and psychotic symptoms three days later.

This patient did not experience psychotic symptoms on previous exposure to amphetamines. However, the combination of amphetamines and fluoxetine was associated with a brief, but severe psychotic episode which lasted for approximately three days.

Sympathomimetic–fluoxetine interaction has been described in a bulimic patient who combined a proprietary appetite suppressant with the drug (Walters, 1992). The interaction with illicit amphetamines is more dangerous, and is likely in a population that perceives fluoxetine to be a potentially rewarding drug of abuse. Clinicians should take this potential interaction into account when prescribing for depressed drug abusers.

WALTERS, A. M. (1992) Sympathomimetic–fluoxetine interaction. *Journal of the American Academy of Child and Adolescent Psychiatry*, **31**, 565–566.

J. BARRETT
O. MEEHAN
T. FAHY

Maudsley Hospital
Denmark Hill
London SE5 8AZ

https://doi.org/10.1192/bjp.168.2.253 Published online by Cambridge University Press