WHAT CLOTHES SHOULD PSYCHIATRISTS WEAR FOR WORK?

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Aims: The aims of this study were to identify patients' and psychiatrists' attitudes about what styles of dress are appropriate for a psychiatrist to wear for work.

Method: Questionnaire sent to all junior and senior psychiatrists at three hospitals. This questionnaire consisted of 6 colour photographs of the same male or same female doctor (male photosets were sent to male doctors, female photosets to female doctors) in clothes of varying formality ranging from suit to T-shirt with jeans. In one photo the doctor wore a white coat. A questionnaire using the same photo set was offered to all psychiatric inpatients in one teaching hospital. Doctors and patients were asked to state which one photograph was most suitable for consultants to wear for work, and which was most suitable for junior psychiatrists.

Results: Of the 86 psychiatrists sent the questionnaire, 69 (80%) replied of whom 49% were consultants and 51% trainees. Sixty-seven percent of the sample felt consultant psychiatrists should wear a suit, 23% preferred a shirt and tie with smart trousers for men and a blouse and smart skirt for women, 7% chose a shirt without a tie for men or a blouse with trousers for women and 3% favoured T-shirts. None preferred white coats. The preferred style of dress of trainees was shirt and tie with smart trousers for men and blouse and smart skirt for women (69%). Sixteen percent favoured a shirt without a tie for men or blouse and trousers for women. Only 7% of doctors felt junior staff should wear a suit for work and none preferred white coats. There were no significant differences in attitudes in terms of sex or rank of the doctor.

Of the 63 eligible inpatients, 49 (78%) agreed to be interviewed (mean age = 40, 63% female). For consultants, 37% of patients preferred a suit, 27% preferred a white coat, 14% chose a shirt and tie or formal blouse and 12% stated that a T-shirt was the most appropriate dress. For junior psychiatrists, 35% of patients preferred a shirt and tie with smart trousers for men and blouse and smart skirt for women, 27% chose white coats, 22% favoured a shirt without a tie for men or blouse and trousers for women and 12% preferred a T-shirt. Only 4% wanted junior psychiatrists to wear a suit for work.

Conclusions: The psychiatrists we sampled had conservative standards of dress, although our observation is that this is not always maintained in reality. Most patients want their doctors, especially consultants, to dress smartly but do not want junior doctors to wear suits. A striking proportion of patients preferred white coats.

BODY-ORIENTED THERAPY IN PSYCHIATRY: AN EMPIRICAL STUDY ON 70 IN-PATIENTS

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Objective: Body-orientated therapy has by now been accepted and implemented as part of a multidimensional therapeutical concept in many psychiatric clinics. However, the increasing number of theoretical concepts and clinical practice contrast with a relative lack of empirical data proving its benefits. The aim of our study is to investigate the effects of body-orientated therapy in psychiatric in-patients.

Method: 70 consecutive in-patients were investigated on admission and after four weeks of therapy with five standardized questionnaires assessing a) general aspects of mood, feeling of vitality, somatic complaints etc, b) specific attitudes and beliefs with regard to their body and its functioning, and c) psychopathology. The patients taking part in concomitant body-orientated therapy (n = 38) were compared with those not taking part (n = 32).

Results: The two groups did not differ with regard to sex (48 women, 22 men), age (mean age 42 years), and main diagnosis (37 patients with depressive and 27 with neurotic disorders according to ICD 10). Almost all patients (n = 63) received psychopharmacological treatment. The patients taking part in concomitant body-oriented therapy demonstrated a significantly better therapeutical course than those not taking part ($p < 0.05$). The general aspects of mood, feeling of vitality, and somatic complaints were influenced to a greater extent than the specific attitudes towards their body. All patients showed a significant improvement of psychopathology ($p < 0.001$). Differences between depressive and neurotic patients were neglectable.

Conclusion: Our findings point towards a beneficial effect of concomitant body-oriented therapy in psychiatric in-patients. However, with regard to the design of our study, the results cannot be interpreted in a monocausal way. The question why general aspects are more affected than the specific body-related topics especially needs to be raised. In conclusion, our study supports a broad indication of body-orientated therapy in a multi-dimensional psychiatric concept and should stimulate further studies to elucidate the specific effects of this therapy.

A PILOT STUDY TO COMPARE COMPLIANCE AGAINST SIDE EFFECTS, DRUGS AND ATTITUDE

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Compliance of medication has been a cause for major concern in psychiatric patients. Non-compliance of medication in psychiatric patients could range from 15–63%. This is a matter of importance as it has implications on the quality and the cost of continued care. A group of 66 patients, who fulfilled the criteria for a psychiatric disorder according to the ICD-10 classification were analysed in this study. A subgroup of 42 patients who suffered from an affective disorder were analysed independently.

Compliance of medication ensures patients well being and prevention of frequent admissions. However compliance has been shown to be affected by attitude of patients towards the medication although this study failed to replicate this. It has also been suggested that compliance is not affected by patient's understanding of medication but the subjective attitude of patients. The study compared the compliance in the whole group as well as in the subgroup who suffered an affective disorder (depression).

Analysis of the results using chi square tests showed significance within the affective disorder subgroup where patient compliance with medication was found to be independent of the number of drugs prescribed. Statistical significance in other factors listed above may not have been reached due to the small sample size. Therefore a study with a larger sample size is now being planned.

A STUDY OF KHAT INDUCED PSYCHOSIS

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Aims: This study aims to highlight epidemiology, clinical outline and prognosis of Khat induced psychosis.

Methods: Khat is a plant legally purchased through major European capitals from East African communities where the plant originates. In the literature there are 12 cases of Khat induced psychosis that have been reported in scientific references and journals. We report four new cases which were treated in our hospital and then studied and analysed the total 16 case reports.

Results:

- Epidemiology
  Origin — 65% African Somalian, 25% African, 18% other
  Sex — 94% males, 6% females
  Age — 20 to 36 year olds
  Past Psychiatric History — 12.5%
  Family History — Unknown.
- Prognosis
  Sever Khat abuse prior to episode — 94%
  Rapid resolution — 88%
  Recurrence of illness with Khat abuse — 62.5%
  Treated with neuroleptic and recovered — 75%
  Spontaneous recovery — 25%
- Clinical Picture
  Orientation & Consciousness — 62.5% N/R 37.5%
  Aggressive Symptoms — 68.75%
  Manic Symptoms — 56.25%
  Paranoid Delusions — 68.75%
  Grandiose Delusions — 31.25%
  1st Rank Symptoms — 25.00%
  Auditory Hallucinations — 43.75%
  Tactile Hallucinations — 6.25%
  Olfactory Hallucinations — 6.25%

Conclusion: Khat induced psychosis — prominent in African ethnic groups and males in their twenties.

More likely for heavy abusers to acquire psychotic symptoms and become hostile. Most patients respond to neuroleptic treatment within two weeks and others recover spontaneously if they stop abusing Khat.

ECOLOGY OF PSYCHOTHERAPY. A VIEW FROM THE PROVINCES OF RUSSIA

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In my report I would like to discuss the influence of professional activity on the quality of life of a psychotherapist in the Russian provinces.

I would also like to look at some models of psychotherapy, such as:

Healthy psychotherapist–healthy client;
Healthy psychotherapist–sick client;
Sick psychotherapist–healthy client;
Sick psychotherapist–sick client.

I would like to answer the following questions:

- How should one solve the problems of the client: either for the client, apart from the client, at the expense of the client, or together with the client?
- How can a psychotherapist work without getting burned out?
- What are the peculiarities of working with transfer and countertransfer in the Russian conditions?
- Is psychotherapy in Russia a science, an art or an occupation?
- How long should one study, for how long should one get treatment?
- Happiness and psychotherapy — is it possible?

P5. Schizophrenia, antipsychotics and neuroimaging

PHENOTYPIC AND FUNCTIONAL CHANGES OF IMMUNE REACTIVITY IN SCHIZOPHRENIA AND DEPRESSION

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There is growing evidence that psychoneuroimmunological interactions contribute to the pathogenesis of depression and schizophrenia. We have initiated a comprehensive study of phenotypic and functional determinants of immune reactivity in 60 patients with these conditions and 30 normal control subjects. The study involved screening of the subpopulation of immunocompetent ($CD3^+$ T, $CD15^+B$, $CD4^+$ and CDB^+T) cell subsets, NK cells and monocytes. Further, we determined the level of proinflammatory cytokines (IL-1, TNF-α, IL-6), and a marker of T-cell activation (soluble IL-2 receptor) in the serum, and analysed the production of immunoregulatory cytokines (IL-2, IL-4, TGF-β) in unstimulated and in vitro Con A stimulated lymphoid cells. Initial evaluation revealed significantly increased monocyte counts and serum levels of soluble IL-2 receptor in the patient group ($p < 0.01$). These findings support the notion of enhanced monocyte and T cell reactivity indicating the role of altered cell-mediated immune reactions in schizophrenia and depression. More detailed analyses of the relationships between well defined clinical types of these disorders and measured immunological parameters are undertaken and the results will be presented.

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MAGNESIUM DEFICIENCY IN PATIENTS WITH SCHIZOPHRENIA

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Objective: To compare blood serum concentrations of magnesium, copper and zinc in schizophrenic patients and in healthy subjects.

Methods: We evaluated serum Mg, Zn and Cu concentrations in 24 strictly selected drug-free patients (diagnosis were made according to DSM IV™ mean age 36.8 ± 12.1) and in 23 healthy controls (mean age 30.8 ± 5.4). In eight patients treated with oral haloperidol additional blood samples were available after therapy.

Results: Mean Mg, Zn, and Cu levels at baseline are illustrated in the table:

Trace element	Controls (n = 23)	Patients (n = 24)	Man-Whitney-T.
Mg (mmol/l)	0.91 ± 0.07	0.86 ± 0.07	$p < 0.05$
Zn (µg/dl)	107.2 ± 18.7	96.2 ± 13.4	$p < 0.07$, ns
Cu (µg/dl)	126.1 ± 31.5	121.1 ± 23.9	$p < 0.90$, ns

Multivariate analysis (MANCOVA) including the factors of diagnosis and sex with age as a covariate demonstrated that schizophrenia was independently associated with low Mg levels ($p < 0.01$). There was a trend toward higher serum Zn levels in male compared to female subjects. Neuroleptic therapy was associated with asignificant