

## Correspondence

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### Psychological debriefing

**SIR:** Busuttill & Busuttill (1995) draw attention to the problems inherent in the concept of psychological debriefing and of the difficulty of drawing conclusions from contrasting studies. The organisational difficulty of providing mental health professionals to perform psychological debriefing to large numbers of potentially traumatised people is enormous, and on current evidence this seems difficult to justify.

Following the national ambulance strike in 1990 a questionnaire study was performed to determine the prevalence and degree of distress among military personnel employed in providing the emergency ambulance service in London (Gillham & Abraham, 1992). This confirmed that military personnel did report they had been distressed by their experiences but the majority had discussed their experiences with someone and did not welcome the opportunity for further discussion. A minority welcomed the opportunity for further discussion and had significantly higher scores on the Impact of Events Scale (IES) and the General Health Questionnaire (GHQ-28). By the simple intervention of asking, a group of more distressed individuals was identified and it was possible to provide them with an appointment with the community psychiatric nurse (CPN) without organisational difficulty.

In a follow-up study 4 months later, of the 17 subjects who requested an opportunity for further

discussion, 11 replied – six had kept their appointment and five had not. The group that kept their appointments had a greater mean improvement in GHQ-28 and IES scores than the group that did not (mean improvement for GHQ-28: 5.8 v. 1.6, and for IES: 22.5 v. 4.2). This suggests that the CPN intervention was helpful to the group who received it, but why did the other group not keep their appointments?

There is a complex relationship between trauma, the individual, the group and help-seeking with which we are beginning to grapple. It would seem that the best advice at present is for the emergency and military services to practice routine debriefing (without the epithet 'psychological') following potentially traumatic experiences, among themselves in their small working teams, as a routine standard operating procedure in which appropriate help-seeking is encouraged. Mental health professionals can support and encourage this practice but should not get involved routinely in debriefing except as a part of training: they can then use their time and skills for those individuals identified as needing help within the hopefully more supportive and understanding milieu of the services' organisation.

BUSUTTIL, A. & BUSUTTIL, W. (1995) Psychological debriefing (letter). *British Journal of Psychiatry*, **166**, 676–677.

GILLHAM, A. B. & ABRAHAM, P. (1992) Operation Orderly – Prevalence and degree of distress among military personnel following their ambulance experiences in London District. *Journal of Royal Army Medical Corps*, **138**, 23–26.

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### Life events and dementia

**SIR:** Orrell & Bebbington (1995) describe a study which broadly reflects our clinical practice. Demented patients referred to the psychogeriatric service run by one of us (DB) who have either depressive illness or depressive symptoms frequently have been bereaved recently. Bereavement is a major threatening life event. Our practice is to

provide guided mourning to these patients to aid the process of grieving with the aim of treating their depression with or without the use of antidepressants. Orrell & Bebbington conclude that demented patients respond to the stress of life events just as cognitively intact individuals do; our strategy for management acts on the belief that they respond to the same intervention as cognitively intact individuals. Sometimes relatives, in believing they are acting in the best interest, do not tell their demented relative about a death in the family thereby denying them the chance to grieve.

Further work is needed on the effect of bereavement on dementia sufferers; this has theoretical, ethical and clinical implications.

ORRELL, M. & BEBBINGTON, P. (1995) Life events and senile dementia. Affective symptoms. *British Journal of Psychiatry*, **166**, 613–620.

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#### Community care in presenile Alzheimer's disease

SIR: Newens *et al.* (1995) discuss the use of community and support services by carers, and comment that sufferers are managed for a considerable period at home if they have a living relative, despite a severe degree of dementia and loss of independence. While in no way minimising the love and care shown by relatives, it must be allowed that one of the reasons for continuing to care at home is financial. Consider the following case study.

BB, a self-employed professional man, retired early due to memory problems. His two children are young teenagers, with many years of schooling ahead, his wife does not work. He receives attendance allowance and a private pension, together with income from earlier investments. He is now severely demented, incontinent, has disturbed sleep, and is often physically aggressive towards his sons, possibly because he does not recognise them. They no longer invite friends to the house, their school work is suffering. His wife is supported by six days of day care (in two facilities) and extended respite (in a third) to cover as much of the school holidays as possible.

If this unfortunate man were placed in a specialist nursing home his quality of life would probably improve as he would have consistent care on one site with visits from his caring family no longer under such stress. However his wife would have to register for income support and his children leave their private school as his income and savings would be taken for his care. Her lawyer has advised she file for divorce as this would enable her to claim half his savings, and the house, together with "alimony" to support herself and the children! She does not wish to do this. Application for him to be considered a "special case" for NHS funding has been unsuccessful.

The wider politics of paying for one's care in old age are frequently discussed, but until this problem for families of those with presenile dementia is more widely recognised, they will also "pay".

NEWENS, A. J., FORSTER, D. P. & KAY, D. W. K. (1995) Dependency and community care in presenile Alzheimer's disease. *British Journal of Psychiatry*, **166**, 777–782.

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#### Repeat prescription antidepressants and residential care

SIR: *Defeat Depression* provided valuable information on the detection of depression and the role of antidepressant medication (Department of Health, 1993). However the guidelines on continuing management are not so clear.

Even with primary care becoming more proactive it is still being reported that patients in residential care are being treated for long periods without careful follow-up (Gosney *et al.*, 1991). This group tend not to attend surgeries and it is usually a professional carer that requests their repeat prescription. Being a predominantly elderly group they are at increased risk of morbidity due to drug side-effects and interactions.

A survey of patients of a West Midlands GP surgery was undertaken providing data on those in residential homes on monthly repeat prescriptions of tricyclic antidepressants. Excluding those under regular review from psychiatric services gave a study group of 17. Two were men and 15 were women, with an age range of 68–91.

Duration of treatment to the date of the study varied from 8–918 weeks of continuous treatment (mean 190 weeks). The upper end of the range is alarming as is the lowest as one patient had been