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# *Correspondence*

**Contents:** Psychological debriefing/Life events and dementia/Community care in presenile Alzheimer's disease/Repeat prescription antidepressants and residential care/Clozapine-induced hypotension treated with moclobemide and Bovril/Extreme suicidality following serotonin syndrome/Brain damage and tardive dyskinesia/Psychosurgery for obsessional disorder/Treatment of obsessive-compulsive disorder/Clozapine-induced hypersalivation and the alpha2 adrenoceptor/Suspected congenital sertraline dependence/Behavioural toxicities of antidepressants.

## Psychological debriefing

SIR: Busuttil & Busuttil (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