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Correspondence

Contents: Psychological debriefing/Psychiatric morbidity in rural *v.* urban regions/ Lithium revisited/ Minor physical and factual anomalies/Reporting of psychosocial distress/Prenatal exposure to the 1957 influenza epidemic/Likelihood of hospital discharge.

Psychological debriefing

SIR: The term psychological debriefing (PD) was employed to describe the techniques used in the RAF for dealing with both short and long-term effects of traumatic stress. These techniques were derived from the methods described by Mitchell and Dyregrov with some cognitive-behavioural elaboration.

The term psychological debriefing was originally retained in order to emphasise that the process was limited to a recapitulation of the original stressful events and an attempt to deal with direct consequences of that experience. Such PD has been applied in a wide range of situations sometimes during the immediate aftermath but also after more prolonged experiences such as hostages or prisoners of war. It is clear that the scientific status of these interventions is still in doubt but the response of those involved and their subsequent reports indicate that those who participated felt that the experience was beneficial and their coping strategies were improved.

The paper by Busuttil *et al* (1995) describes a further elaboration of these techniques as a 'treatment' of established PTSD and the term PD was retained as a natural extension in which the basic principles were retained. Although an uncontrolled open outcome study, their results do suggest a marked beneficial effect which justifies further objective study. Until such scientifically impeccable studies have shown whether or not these methods are effective or some alternative efficacious remedy is identified it seems justifiable to continue the use of these methods after major trauma.

Whether or not the term Psychological Debriefing is appropriate (Leigh-Howarth & Baggaley, 1996) is open for debate but it matters little provided that the methods used are clearly stated. Although masterly inactivity can have its place in obstetrics it is rarely appropriate where emotional distress is concerned. Since many of us are convinced that intervention of the type described is beneficial following trauma and no clear alternative exists it would be difficult to justify in ethical terms the use of an untreated or placebo group.

BUSUTTIL, W., TURNBULL, L., 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.

LEIGH-HOWARTH, M. & BAGGALEY, M. R. (1996) Psychological debriefing techniques (letter). *British Journal of Psychiatry*, **168**, 383–384.

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SIR: I am writing as co-developer of the in-patient treatment programme for post-traumatic stress disorder (PTSD) which incorporates psychological debriefing techniques described by Busuttil *et al* (1995). I would defend their use of the term 'psychological debriefing' robustly. The fundamental components of psychological debriefing as described by Mitchell (Critical Incident Stress Debriefing) and Dyregov (Psychological Debriefing) are used in the initial phase of the treatment programme. The purpose is to bring to the surface the fullest possible recollection of the traumatic experiences of all of the participant group members. Our experience is that in all cases so far treated in this way a full description of the traumatic experience in both factual and emotional terms has never been achieved. The group format appears to grant mutual permission and to engender a situation of unprecedented safety for this to be the reality. The psychological debriefing is followed by cognitive-behavioural phases ('lines' and 'ladders') in a highly-structured manner which permit the processing of the traumatic memories, assimilation and the development of a planned progress into the future. None of this could be achieved without full exploration of the traumatic imprint in the spirit of Mitchell and Dyregov.

In most cases admitted to the programme the psychological debriefing represents an immediate component which was neglected after traumatic exposure which permits secure retrieval of memory information and which facilitates the processing of the same.

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.

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SIR: Comparisons between the group treatment approach described by Busuttil *et al* (1995) for war veterans and the well documented Koach project (Solomon *et al*, 1992) highlight important treatment and research issues. The Koach project was a residential group treatment approach for PTSD developed to treat Israeli war veterans. Based on a behavioural model of PTSD, a central treatment component involved confronting avoidance using a number of behavioural techniques but there was "a deliberate refusal . . . to allow working through of past war experiences" (Shalev *et al*, 1992; p. 214). While subjective appraisal by therapists and the 41 participants was highly positive and therapeutic gains were shown in reducing phobias and improving social functioning, no improvement was noted in the symptoms of PTSD and at two year follow up the treatment group had a worse outcome than a no-treatment control group.

The Busuttil study in comparison incorporated no behavioural procedures directly aimed at anxiety habituation and extinction and the focus of therapy was the "psychological debriefing" or information processing component. It is necessary to acknowledge possible group differences, the methodological flaws of the studies, the possibility that the Israeli study may not have ensured that habituation of anxiety accompanied exposure and that debriefing did allow for some habituation of anxiety. Nonetheless, the high success rate in reducing PTSD symptoms such that 85.3% no longer satisfied the criteria for diagnosis of PTSD is in marked contrast to the Israeli findings.

It has been questioned whether information-processing models of PTSD add anything to Pavlovian models of extinction (Hacker-Hughes & Thompson, 1994). Richards & Rose (1991) found in a study which looked at imaginal exposure and *in vivo* exposure, that "where *in vivo* exposure was tried first, it was either ineffective or only partially effective" (p. 839). In a study of an implosion treatment with rape survivors, Foa *et al* (1995) also present findings showing that successful outcome was associated with changes in subjects' rape narratives suggestive of information processing of the event. In the same article Foa quotes other authors who conclude that for trauma survivors, the need to make sense of their traumatic experience is of vital importance.

Much of the treatment literature in PTSD has a behavioural or cognitive-behavioural bias. Such approaches have proved valuable but other theoretical models may have the potential to enhance both the understanding of PTSD and therapeutic effectiveness.

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.

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Psychiatric morbidity in rural *v.* urban regions

SIR: Mumford *et al* (1996) showed that women in Chitral, Pakistan, suffered surprisingly more anxiety and depressive disorders than their counterparts in Western countries. This finding contradicts the common belief that people who live in remote rural areas of the globe, being exempt from the pressure of civilization, lead relatively stress-free lives. However, it is not so surprising when one considers that socioeconomic and political changes have negatively impinged on the livelihood of rural people and aggravated their powerlessness in many developing countries nowadays (Desjarlais *et al*, 1995).