traumatic events is always an entirely negative experience and that post-traumatic stress disorder is the only post-traumatic mental illness.

I do not share the authors' reassurance that the three-year follow-up rate was only 48% as it provides ammunition for those who will, I fear, continue to provide psychological debriefing. Perhaps it is cynical to question their motives but I am troubled by the almost pornographic nature of human experiences outwith the normal. There is a voyeurism and the potential vicariously to become part of a traumatic event, even of history, by intervening. Society's or is it the media's cry is 'something must be done', and despite the growing body of evidence that psychological debriefing does not work, or is harmful, I suspect such work will not be halted unless society changes from its 'psychologicalisation' of human distress. There is an old military adage that applies here: 'the only thing harder than trying to get a new idea into a military mind is trying to get the old one out'.

Perhaps Mayou *et al*'s paper reinforces the reality that there are no 'quick fixes' for human experiences. The provision of help should be directed towards those who are defined as affected by their experiences. Identifying these cases should be the challenge for psychiatry. Perhaps then the advice proffered by Salmon (1917) will be correctly applied, although such interventions are unlikely to be so simple.

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Psychosocial treatment programmes for personality disorders: service developments and research

Chiesa & Fonagy (2000) clearly demonstrate the beneficial effects of therapeutic community treatment for personality disorder, and more so in the treatment limb with less hospitalisation and more day care.

The logical extension of this is to offer these programmes with only day care. Several units around the country are now doing this, including new units in Aberdeen and Maidstone, as well as long-established units such as our own in Reading and the Red House in Salford.

The evidence from systematic reviews and meta-analyses for the effectiveness of therapeutic communities in treatment of personality disorders is strong (Lees & Manning, 1999) and, together with the Cassel study, demonstrates the need for new, creative ways of setting up effective treatment programmes.

A multi-centre research project funded by the National Lotteries Charities Board is now underway, which should help in this endeavour. It is using multi-level modelling and a path-analytic equation modelling technique to determine the impact of a number of features that therapeutic community programmes have. This research is more complex and sophisticated than a simple randomised controlled trial design, but for treatments that do not fit a drug model paradigm it will be much more helpful in designing effective programmes of therapy. The protocol is available at www.pettarchiv.org.uk/atc-protocol.htm.

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More disappointing treatment outcomes in late-life depression

Tuma (2000) reported disappointing outcomes in the treatment of late-life depression. Suicide rates are highest in the elderly in many countries (Shah & De, 1998), while treatment with drugs and electroconvulsive therapy consistently results in full recovery rates of less than 30% (Murphy, 1983). Some studies show slightly more optimistic findings, such as Baldwin & Jolley (1986) and Brodaty *et al* (1993) who demonstrated prognosis in later life approaching that in younger adults at one year. Yet others suggest that longer follow-up reveals a worse outcome (Forsell *et al*, 1994). These studies use standard physical treatments but make no mention of adjunctive psychological treatments of any kind.

There are still too few studies demonstrating the effects of psychological interventions in older people (O'Rourke & Hadjistravropoulos, 1997). More recently published data have shown improved outcome using a combination of drug and psychological treatments, including interpersonal therapy and cognitive–behavioural therapy (Reynolds *et al*, 1999). In addition, important research by Ong *et al* (1987) demonstrated relapse prevention for individuals attending a support group.

In a recent postal survey, I enquired of members of the Royal College of Psychiatrists' Faculty for the Psychiatry of Old Age whether elderly patients in their care had specifically requested psychotherapy. The overall response rate was 65%, of which 49% had experience of patients asking for psychotherapy. One can only assume that those already in receipt of such treatments would not ask for it. Patients rarely demand drug treatments as they are often already taking medication. The National Health Service (NHS) Executive (1996) review of psychotherapy services endorses the need for older patients to have access to similar service opportunities as the young.

Since elderly consumers of our service are asking for psychotherapy, and because there is some evidence (Roth & Fonagy, 1996) that it is a useful adjuvant in the war against late-life depression, why are we still producing research which appears to ignore this approach?

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