Correspondence

EDITED BY MATTHEW HOTOPF

Fear reduction by psychotherapies: a response

Dr Snaith (2000) misquotes us (Marks & Dar, 2000) on an important point. We do not conclude that "all elements . . . have therapeutic potential and that any assertion of superiority of one approach over another is unwarranted". We specifically state that non-applied relaxation, avoidance (anti-exposure instructions), diary keeping, treatment set, giving a rationale, and regular homework assignments are not particularly therapeutic *per se*. Several approaches are less helpful than others.

We are grateful to Dr Snaith for reminding us of his results with anxiety control training (ACT). His paper (Snaith, 1974) noted that several ACT patients did imaginal or live exposure, which is covered by our discussion on exposure. He described his 1982 trial (Constantopoulos *et al*, 1982) of ACT briefly in a non-peer-reviewed chapter. Just 12 patients were randomised to either experience anxiety scenes or just cope with anxiety without exposure. His papers (Constantopoulos *et al*, 1982; Snaith, 1998) give too little detail to judge how much each treatment used imaginal exposure (implosion) or irrelevant fear exposure (stress immunisation). The reports give no mean ratings and standard deviations before and after treatment, preventing judgement of how much each group improved. Though both groups improved with no significant differences between them, the study lacked power – a very big difference would be needed to yield significance when comparing two cells containing just six patients each. Dr Snaith's results with "just coping with anxiety" may echo those with irrelevant fear exposure and support our idea that stress immunisation (irrelevant fear exposure) may reduce anxiety. Snaith *et al*'s (1992) paper did not describe randomisation to ACT or a contrasting procedure.

Our call for psychotherapists to work towards a common psychotherapy language that defines each procedure in a standard accepted terminology is bolstered by examining Dr Snaith's terms. What he calls "meditation" has relatively little in common with Kabat-Zinn's (1996) mindfulness meditation, and his ACT, for example, includes components which are not specified regarding relevant *v.* irrelevant exposure. If psychotherapists agreed to call the same procedures by the same names, that would be a huge step forward. European and American associations in the field (the European Association for Behavioural and Cognitive Therapy (EABCT) and the Association for Advancement of Behavioural Therapy (AABT)) have appointed a joint task force to develop a common psychotherapy language.

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Psychological debriefing: historical military perspective

May I offer a historical military perspective on the paper by Mayou *et al* (2000). Proponents of psychological debriefing have misused the military experience from the Russo-Japanese War 1904/5 onwards to justify early psychological intervention using PIES – proximity (close to the scene – in safety), immediacy (as soon as possible), expectancy (that individuals will return to duty – not to prevent ensuing psychological illness) and simplicity (respite, rest, recollection, rehabilitation and return to duty). Proponents conveniently forget that PIES was only ever applied to those who were deemed to be suffering and was conducted by individuals who shared and understood their experience.

There may be many reasons why Mayou *et al* arrived at their conclusions but the same caveats apply as are appended to Bisson *et al* (1997), Kraus (1997) and Turnbull *et al* (1997), among others. Perhaps we (psychiatrists) are at fault in trying to categorise human responses to unpleasant events into medical conditions and are naïve to think that one intervention could prevent post-traumatic stress reactions and illnesses that are multi-factorial and complex in genesis.

In trying to understand and manage post-traumatic stress reactions there are a number of useful metaphors. Garb *et al* (1987) find the grieving process particularly useful as both post-traumatic and grieving are responses to loss events. Although an unfashionable term, psychological defence mechanisms exist to protect the individual (at least initially); to interfere with such mechanisms carelessly courts disaster. Perhaps psychological debriefing does just this. In both post-traumatic reactions and grief there is a period of introspection during which individuals do not wish to talk. Such needs should be respected, and usually are in the case of grief. Why should traumatic events be different?

This period is followed by a time when assistance and advice is welcome, even sought, and in post-traumatic situations, as in grief, this should first be sought from the social support network. If this does not work, then professional help may be required, but we as professionals must question the seemingly ubiquitous societal belief that exposure to

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