were on the real thing may have unconsciously demonstrated their faith and loyalty by remaining well. They are unlikely to have excluded themselves from the trial by owning up, as the Scandinavian researchers expected.

But this does not explain the magical benefits we still see from lithium today, when it is just one treatment among many, used at levels which hardly produce side-effects. The 50-year old Cinderella should be allowed to go to the ball in peace; she has already outlived many of her critics.

BAASTRUP, P. C., POULSON, J. C., SCHOU, M. *et al* (1970) Prophylactic lithium double blind discontinuation in manic depressive disorders. *Lancet*, *ii*, 326–330.

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GP monitoring of lithium levels

SIR: Lithium has a well established place in the treatment of psychiatric disorders, but the most appropriate setting for lithium supervision has been a matter of debate. Given the increasing tendency for GPs to take responsibility for such matters, I undertook a study of lithium monitoring standards in GP and psychiatric out-patient settings.

The computerised record of all serum lithium estimations in south Manchester during a ten month period in 1994 was examined. Two groups of patients were compared; those who had two or more levels done by GPs and none in out-patients ($n=94$) and those who had two or more levels done in out-patients but none by GPs ($n=140$).

There were no significant differences between the groups in numbers of intervals between tests greater than 90 days (OPD 182/390 *v.* GP 112/264) or 180 days (OPD 30/390 *v.* GP 21/264). Although there was a non-significant trend towards higher lithium levels in the GP group (lithium $\geqslant 1{\cdot}1$mmol/l OPD 15/542 *v.* GP 19/363) the proportion of results above the therapeutic range was lower than both GP and hospital monitored patients in the studies of Masterton *et al* (1988) and Kehoe & Mander (1992).

GP monitoring of lithium levels is commonplace in south Manchester, and there is little evidence from examination of current practice to suggest this is inappropriate.

KEHOE, R. F. & MANDER, A. J. (1992) Lithium treatment: prescribing and monitoring habits in hospital and general practice. *British Medical Journal*, **304**, 552–554.

MASTERTON, G., WARNER, M. & ROXBURGH, B. (1988) Supervising lithium. A comparison of a lithium clinic, psychiatric out-patient clinics and general practice. *British Journal of Psychiatry*, **152**, 535–538.

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Long-term treatment with clozapine in schizophrenia

SIR: Avnon & Rabinowitz (1995) in an article on clozapine and neuroleptic resistant schizophrenia observe that "some patients experience a vacuum in the absence of delusions and hallucinations" and conclude that their success was due to a multi-family group to help with the patients' anxieties on entering the real world.

We have been running such a group for over five years and an audit on the families' perceptions of the changes since their relatives began clozapine produced some unexpected results. There was anxiety expressed by the families about their relative entering the real world with their lack of necessary skills, social and otherwise, and this has been alluded to in the popular press as awakening. But in addition the families recognised that clozapine had produced significant change in the degree of affective warmth and that a return to the pre-clozapine days would be a major blow. This change in affective warmth may be the key to why those of us with large cohorts of clozapine patients see progressive changes with time as both the patient and the family become conditioned to the changes and to why Lindstrom (1988) in this 13 year study had 39% of his 96 patients in employment.

AVNON, M. & RABINOWITZ, J. (1995) Effectiveness of clozapine in hospitalised people with chronic neuroleptic resistant schizophrenia. *British Journal of Psychiatry*, **167**, 760–764.

LINDSTROM, L. H. (1988) The effect of long term treatment with clozapine in schizophrenia: A retrospective study in 96 patients treated with clozapine for up to 13 years. *Acta Psychiatrica Scandinavica*, **77**, 524–529.

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Psychological debriefing techniques

SIR: We were surprised that Busuttil *et al* (1995) chose to use the term psychological debriefing to describe some of the techniques used in their

in-patient group programme for post-traumatic stress disorder (PTSD). Psychological debriefing is a term associated with Jeffrey Mitchell and Atle Dyregrov who each developed the technique to be used as an intervention for emergency workers shortly after a traumatic event to help prevent PTSD. We believe that to use this term for the treatment of established PTSDs, in some cases many years after the event, is confusing. It is clear that the programme includes a number of cognitive behavioural techniques including imaginal exposure which have been demonstrated to be effective in PTSD.

No one has as yet established that techniques based on the models of Mitchell and Dyregrov are effective in the treatment of PTSD (Raphael *et al*, 1995). Indeed, there are reports of the psychological debriefing process in its proper context increasing rather than decreasing subsequent morbidity (Deahl *et al*, 1994). The basic assumption, therefore, that psychological debriefing works, is in our view unsafe and to extend it in the way such as has been postulated by Busuttil *et al* (1995) serves only to add to the ever increasing fog that surrounds the whole area of traumatic stress and its treatment.

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**, 495–503.

DEAHL, M. P., GILLHAM, A. B., THOMAS, J., *et al* (1994) Psychological sequelae following the Gulf War: factors associated with subsequent morbidity and the effectiveness of psychological debriefing. *British Journal of Psychiatry*, **165**, 60–65.

RAPHAEL, B., MELDRUM, *et al* (1995) Does debriefing after psychological trauma work? *British Medical Journal*, **310**, 1478–1479.

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Brief psychotic episodes in puberty

SIR: Abe & Ohta's report of brief psychotic episodes in puberty (1995) is seriously flawed.

The sample was small and included significant confounding aetiologies; Prader-Willi Syndrome, current neuroleptic treatment and an EEG suggesting epilepsy. Similarly, mental retardation was not considered an exclusion criterion. Symptoms suggested as characteristic of this group are poorly defined, e.g. "jitters", or possibly unrelated to psychopathology (pallor and enuresis). That none of the cases met ICD–10 durational criteria for 'recurrent depressive episode' is not remarkable when symptoms lasting beyond 15 days led to exclusion from the study. Also, insomnia which may have marked the onset of illness was considered to have preceded it in some cases, artificially lowering the episodes' recorded duration.

Omitting laboratory screening for illicit drugs and indicators of alcohol abuse invalidates a study of brief psychotic illness, particularly in an adolescent population. Ascribing successful outcome to sulpiride or lithium is questionable as by definition subjects had illnesses which remitted within 15 days without treatment.

This paper suggests that these individuals with similar symptomatology represent a single syndrome or diagnosis. There are however numerous aetiological possibilities and potential diagnoses in this very heterogeneous group.

ABE, K. & OHTA, M. (1995) Recurrent brief episodes with psychotic features in adolescence: periodic psychosis of puberty revisited. *British Journal of Psychiatry*, **167**, 507–513.

CUTTING, J. C., CLARE, A. W. & MANN, A. H. (1978) Cycloid psychosis – An investigation of the diagnostic concept. *Psychological Medicine*, **8**, 637–648.

BROCKINGTON, I. F., PERRIS, C., KENDELL, R. E., *et al* (1982) The course and outcome of cycloid psychosis. *Psychological Medicine*, **12**, 97–105.

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Non-Alzheimer dementias in young patients

SIR: We feel that both Williams (1995) in his editorial and Newens *et al* (1995) in their paper have to some extent missed one of the major characteristics of the population of younger dementia sufferers. Both authors have concentrated on Alzheimer's disease (AD), and have not considered patients with non-Alzheimer dementias.

In our experience of providing both a local and national referral service for younger people with dementia, only a half of demented patients under the age of 65 years have AD. In a recent audit of 283 patients seen in our clinic, 261 were confirmed as having a progressive dementia, of which only 130 fulfilled clinical criteria for Alzheimer's disease. Seventy-one patients were found to have an asymmetric focal cortical atrophy associated with clinical diagnoses of Pick's disease, frontal lobe