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.

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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.

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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