occasions when an event has so disturbed an individual's psyche that short term pharmacological intervention is required. Also, the knowledge that the debriefers have a senior mental health professional available to them is a source of confidence and reassurance to the them.

I believe that the best debriefers are those who come from within the 'at risk' organisation, who are both well respected, and experienced, and with whom those who receive debriefing can identity. In many ways these are the people who are role models within the organisation. Their acknowledgement of the normal human emotions after a traumatic event carries weight with the potentially traumatised.

The utilisation of external debriefers, no matter how well qualified, will suffer from a difficulty in acceptance from those undergoing the debriefing process. There is the added difficulty in that those being debriefed will view the process as a 'box ticking exercise', and not related to their specific needs. If they know the debriefers and hold them in high regard, it is more likely that they will take the process seriously and benefit from it.

Overall it has been my observation that those who have been debriefed, like it. They express the opinion that after a traumatic event, it is a recognition that the organisation cares about their emotional well-being. How many times have we all heard anger being projected at the authorities from a perception that they did not 'care'. It is possible that this is a contributing factor to the anger that is evident in many suffering from post traumatic stress disorder. It is for this reason more than any other, that I believe we should not ditch post traumatic debriefing, and that we use it wisely and with debriefers with whom people can identity.

Whether or not debriefing prevents post traumatic stress disorder, we will never know for sure. There are just too many variables to measure. So we can continue to expect conflicting results, and the debate as to its harms and benefits will run on and on.

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A case for transcranial magnetic stimulation

Sir – We read with interest the editorial by O'Keane in September issue of the *Irish Journal of Psychological Medicine*[1]. We have recently treated eight patients meeting ICD-10 criteria for major depression with slow repetitive transcranial magnetic stimulation (rTMS) to the right prefrontal cortex. They volunteered for rTMS in preference to electroconvulsive therapy.

The small sample derived from both inpatients and outpatients provided written informed consent. The treatment protocol used was a replication of the protocol applied in the Klein Study 1999.[2] Patients completed the Hospital Anxiety Depression Scale (HADS), the General Health Questionnaire-28 (GHQ-28) and the Symptom Checklist 90-R (SCL-90-R) on initial assessment. Progress was measured with the SCL-90-R.

Patients' medications remained constant and none was receiving ongoing psychotherapy at the time of treatment. Treatment was administered in ten daily sessions during a two-week period. A stimulation frequency of 1Hz was used over two minutes as it is thought that low frequency rTMS may be less likely to induce seizures.[3]

Four out of the eight patients had greater than a 33% reduction in their depression T-Scores on the SCL-90-R and showed clinical signs of improvement. One of the patients with a dual diagnosis of major depression and Parkinson's disease had an improvement in both her depression scores and a 50% reduction in her Parkinsonism, rated by the Webster Rating Scale.

Patient satisfaction level with the procedure was high. One patient withdrew midway through treatment due to feeling over stimulated and restless. With the exception of a headache in another patient, no other adverse side effects were described.

We agree with O'Keane that rTMS is "a valuable treatment option" and while it is not without risk it may be less stigmatising and pose fewer risks than electroconvulsive therapy. That being so it may find 'a clinical niche' in future.

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