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Correspondence

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British Doctors and Dentists Group

SIR: I am a member of the British Doctors and Dentists Group that Brook (*BJP*, February 1995, **166,** 149–153) mentions, and wish to inform colleagues of the activities of that group.

The B.D.D.G. started 20 years ago in London. From an initial single meeting in London at that time we have now grown to 14 groups spread throughout England, Wales, Northern Ireland and a group in Dublin. Membership consists of doctors and dentists in recovery from chemical dependency and alcoholism. Groups meet on a regular basis in confidential surroundings to share experiences and to provide support for each other.

For some years our dental colleagues in the B.D.D.G. have successfully run a scheme to allow them to intervene and assist a sick dentist in response to a request from that dentist or a spouse or partner. That scheme has been supported by a locum scheme and access to funding for treatment facilities. We doctors are now, in response to growing concern about the welfare and consequences of addicted doctors, looking at the ways in which we can respond.

We have a national committee which is looking at the organisation and provision of assistance for addicted doctors. We have a network of doctors, themselves established in recovery from addictive illnesses, who are willing and able to respond to and assist a suffering colleague. This network may be accessed via the Medical Council on Alcoholism (as described by Brook) or directly on 01252-316976 via Dr Ian Joyner. We are happy to receive requests for advice or assistance from doctors who are concerned that they have or may have an addiction problem or from their spouses or partners. We promise absolute confidentiality. (In order to avoid conflict of loyalties it would be our practice to avoid putting an enquirer in direct contact with somebody who might be an immediate colleague of a sick doctor.) Through the local groups we may be able to offer advice regarding specific treatment opportunities as well as advice on obtaining funding. We also have a families network whereby it is possible for us to put the spouse of an addicted doctor in contact with other spouses in order to provide support and advice in that way.

As an organisation we have no official links or obligations to the G.M.C. or any other statutory or regulating body. We have over the years, however, enjoyed a good relationship with the G.M.C. and have worked successfully with them in assisting individuals who had already been brought to their attention.

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Psychological debriefing

SIR: Bisson & Deahl (*BJP*, December 1994, **165,** 717–720) question whether empirical evidence exists to justify use of psychological debriefing (PD) in the prevention of post-traumatic stress disorder (PTSD).

PD was described by Dyregov (1989) but is only one of four similar techniques incorporated under the term 'critical incident stress debriefing' originally described by Mitchell (1983). Studies tend not to distinguish which technique is being evaluated.

PD was devised for groups of emergency workers and recommended for use within 48 hours of traumatisation. Recently, PD has been applied to individuals as opposed to groups and used with primary not secondary victims. It has also been used as a treatment measure, not just in prevention. Conclusions about the efficacy of the technique cannot be made without addressing differences in application.

PD allows individuals meeting in a structured group format, who have been exposed to the same

trauma, the opportunity to piece together what happened. This cannot occur in the same way if PD is used individually. Therapeutic group support factors are also missing. PD within 48 hours for primary victims may be inappropriate given that numbing and dissociative symptoms may predominate. Reactions and needs of primary and secondary victims may not evolve in the same way.

Within PD, a number of therapeutic factors may operate: social support, information processing, facilitation of constructive coping and education about the stress response syndrome. Which factor or combination of factors are necessary to prevent PTSD?

Distinction must be made in relation to the nature of the trauma. PD may be useful after exposure to a single circumscribed event. It may not be appropriate as a single 'end of trauma' session after exposure to an event/s which has been ongoing over a period of weeks. For example, no benefit from the technique was apparent in a controlled study conducted in soldier body handlers who had also been traumatised over a prolonged period during the Gulf conflict and who were offered a single PD session some weeks after traumatic exposure (Deahl *et al*, 1994). In contrast, in an important study not mentioned by Bisson & Deahl, Alexander (1993) reported that police body handlers who received interventions including daily PD showed no increase in psychiatric morbidity three years later. Ongoing debriefing for ongoing trauma may be necessary.

Psychological debriefing is rarely considered in a theoretical context. The possibility of iatrogenic effects is overlooked. The presentation of traumatic material without allowing sufficient time for the habituation of anxiety may serve as a re-traumatisation experience for some. Group studies may mask this effect.

ALEXANDER, D. A. (1993) Stress among police body handlers. A long-term follow up. *British Journal of Psychiatry*, **163**, 806–808.

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.

DYREGOV, A. (1989) Caring for helpers in disaster situations: psychological debriefing. *Disaster Management*, **2**, 25–30.

MITCHELL, J. T. (1983) When disaster strikes. The critical incident stress debriefing process. *Journal of Emergency Medical Services*, **8**, 36–39.

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Charles Bonnet syndrome

SIR: Teunisse *et al* (*BJP*, February 1995, **166**, 251–253), report a large series of patients who are reported to have the Charles Bonnet syndrome emanating from an ophthalmological clinic.

The major value of the investigation of the Charles Bonnet syndrome is the light that it sheds upon the pathogenesis of visual hallucinations in the absence of other psychopathology. The definitions used in this paper are derived from the work of Gold & Rabins (1989). Despite early authors stressing the lack of cognitive impairment in their patients neither Gold & Rabins (1989) nor the authors of this paper include this in their definitions. Even if few of the patients fall into the putatively cognitively impaired range (as is the case in this paper) this is important to note. Holroyd *et al* (1994) using a telephone interview technique that does not depend on visual cues demonstrated that the hallucinators in their population have significantly lower cognitive scores ($P<0.001$) than the non-hallucinators. Howard & Levy (1994) demonstrated a similar finding in late paraphrenics with 'Charles Bonnet-plus' hallucinations despite excluding all with a Mini-Mental State score below 24.

Several authors record complex visual hallucinations as the precursor of dementing illnesses. Given the numerous reports of brain lesions in those with Charles Bonnet syndrome without cognitive impairment, the cognitive state of both the individual patient and that of the population from which the subject is drawn needs to be described in some detail.

The lax use of the term Charles Bonnet syndrome has been criticised (Berrios & Brook, 1982) and should be reserved only for those who exhibit no cognitive impairment. Terms such as Charles Bonnet-plus or complex visual hallucinosis should perhaps be used when studies are being attempted across diagnostic categories or when cognitive status is not investigated in detail.

BERRIOS, G. E. & BROOK, P. (1982) The Charles Bonnet syndrome and visual perceptual disorders of the elderly. Age & Ageing, **11**, 17–23.

GOLD, K. & RABINS, P. V. (1989) Isolated visual hallucinations and the Charles Bonnet syndrome: A review of the literature and presentation of six cases. *Comprehensive Psychiatry*, **30**, 90–98.