More specific treatments require evaluation and for this depend upon an adequate means of diagnosis and follow-up. Since this is not yet available, there is no reliable data to support specific therapy. Immunosuppressive medication has been shown to be either beneficial or deleterious. Clinical studies suggest that it may be unhelpful early in acute myocarditis, but beneficial in the later stages[14]. In follow-up, early improvement of left-ventricular ejection fraction is the best single determinant of prognosis (83% survival at 3 years[15]), but such functional improvement fails to correlate well with the histological improvement that is seen after immunosuppressive therapy. Therefore immunosuppression in myocarditis remains another unresolved issue. A multicentre myocarditis treatment trial in progress in the USA may soon provide answers.

New antiviral agents such as interferon or ribavirin, and monoclonal anti-T-cell antibodies have proven beneficial in animal models, with the prospect of highly specific therapy for myocarditis in the future.

There are many unanswered questions about myocarditis; what is it, how is it detected, and how is it treated? We can only answer the last question if we have answers to the other two, which we do not at present. There is no means of assessing specific therapies with any certainty. Rest and supportive measures are not only the mainstay of treatment, but remain the only rational treatment of myocarditis today.

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Therapeutic flexibility in the post disaster response

Immediately following a disaster, individuals and health and social service organizations may find their coping capacities overwhelmed. Disasters may directly threaten life and induce feelings of horror and helplessness.

An acute response is usually mounted by organizations such as the emergency services. However, there is a growing recognition of the need for longer term services that are aimed at dealing with the psychological impact of the disaster on its victims.

Many reports of disaster response work have shown similar symptomatology in people affected by different mass disasters. Nonetheless, this symptomatology requires and demands a variety of therapeutic approaches.

At an early stage of disaster response whether headed by social services, health services or voluntary agencies, inter-departmental and inter-professional coordination is essential. This enables accurate assessments of the pressing practical needs of victims. Immediate post-disaster work is often centred on a crisis intervention model of practical advocacy and listening rather than the more directive or interpretative approaches of later stages.

Disaster victims may later go on to take up further services with other agencies. After the Clapham train crash in 1988 many survivors took up a psychotherapy service under Dr Carolyn Selley at the Royal South Hampshire Hospital. Therapeutic techniques used with these survivors were wide ranging including the use of in vivo desensitization for dealing with transport phobias, the use of newspaper cuttings and

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other reportage to make the event real, and dream rehearsal with modified endings to assist with intrusive nightmare imagery.

Professor Yule has provided services for children affected by disaster since the sinking of the Herald of Free Enterprise in 1987. He has found it a useful therapeutic approach to combine adult techniques of conversation about the event with play approaches in which the incident and its repercussions are re-enacted in games and drawing. It is pertinent to mention Dr Morgan O'Connell's work with post-traumatic survivors within the services which encourages people to work with montage, to develop personal diaries and artistic material representing their experience and subsequent reactions. It is a striking example of the variety of therapeutic approaches to post-traumatic reactions that while children are discussing the incident within an adult therapeutic model, adults may be painting and drawing representations of their experiences.

After the King's Cross fire in 1987, the Department of Psychiatry, University College and Middlesex School of Medicine, coordinated a response with Camden Social Services and local voluntary agencies. Therapists in our team offered a therapy contract of eight one-hour sessions over eight weeks but it soon became clear that there were issues specific to these patients which disrupted these normal therapeutic boundaries and demanded a more flexible approach.

Requests for legal reports assessing post-traumatic stress disorder (PTSD) disrupted therapy and complicated therapeutic contracts. The fact that patients have access to their therapists' legal reports means that their preparation requires care if contamination of the therapeutic alliance is to be avoided.

The inevitably high media and public profile of disaster responses also raises new challenges for therapeutic work. Patients may be involved in media productions and academic or public symposia alongside practitioners. Practitioners who are involved in consulting with pressure groups may find themselves having to reconcile the therapist/client relationship with other interactions in many different contexts.

Balancing service provision as part of a research project, with the collection of sufficient data for advancement of the field, is difficult. Disaster victims often experience problems accepting the patient role and one has to guard against over-investigation at the risk of losing patients in need of the service. It has been a constant challenge to the researcher in this area to find state of the art assessments which also run in grain with the therapeutic intent of the intervention.

As well as these pressures on the standard psychotherapy structures the nature of the distress itself has prompted changes in therapeutic approaches. Many therapists have begun to develop a longer first session in an attempt to create an initial debriefing session enabling therapist and client to embark on a comprehensive account of the incident. This would mark out the offer of help from previous interventions, from agencies like the police or the legal profession, who may evoke all the patient's emotional responses to the incident by asking for an account but would not necessarily offer the patient the chance to focus on emotions and thoughts aroused. This technique also addresses the primacy of the issues of engagement by providing a substantial first contact and the development of a sound foundation for further meetings.

Traditional medical models of approach utilizing inpatient care have been generally avoided in recent post-disaster responses. Some people suffering from PTSD have been admitted to hospital but this route has not proved generally successful. Such patients are often difficult to contain and resist the role of psychiatric inpatient.

However the use of residential programmes in which a group of PTSD patients stay together, often with family members involved at certain times, have been successful. This emphasizes the communality of people's experience and provides a therapeutically positive environment for promoting self help.

Post-traumatic patients are very rarely given any standard psychiatric medication. Antidepressants are reported to be helpful for depressive symptoms and intrusive recollections in a small percentage of patients. There may also be a role for medication in sleep manipulation. Generally though the treatment of PTSD has concentrated on psychotherapy using for example, cognitive and behavioural strategies for depression and avoidance, respectively.

A continual theme in the development of this work, in all its different circumstances, and with all its different therapeutic emphases, is the need to alter the understanding of both post-traumatic reactions and the role of the psychiatrist in providing treatment for this distress and disorder.

To inform people who have been in traumatic events of the usual post-traumatic symptomatology emphasizing how common such reactions are, can be a very positive therapeutic starting point. However, it is important that this reassurance does not give an impression of diminishing their distress.

It is now widely accepted that phase two disaster response work requires services to work proactively and the responsibility rests with those in charge of such services to find a methodology for approaching those who may be at risk of post-traumatic distress. This calls for a truly multidisciplinary approach.

This uniquely challenging work has demanded and effected change not only in our organizations and their roles but also in our very modes of response and treatment. It is to be hoped that this therapeutic flexibility will catalyse new thoughts and approaches in establishing a wide range of research and service interventions.

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