government policy on offenders with personality disorder (Nick Benefield). This book sets out to establish a role for psychoanalytic understanding in contemporary psychiatric services, particularly at the interface of psychiatry and the criminal justice system.

The chapters, a series of stand-alone essays most of which describe the authors' experiences of providing psychodynamic supervision to staff in a clinical setting, are generally grounded and relevant to day-to-day practice, a key aim of the editors. Different readers will probably value different chapters, depending on which are most relevant to their own work, but the pervading themes have general applicability and are consistent: the patients are complex and very disturbed; there is too little room in modern services for dynamic reflection – consequently, the anxieties of staff and patients are not acknowledged; and action (even if ill-considered) is valued much more than thought. At times, I felt uneasy about an apparent premise that all patients are highly disturbed even if this disturbance is not overt, and occasionally the current state (disturbance) of health services was denigrated too much. But for the most part, particularly when the focus was maintained on the dynamic between the patient, the clinician and the structures or institutions within which all operate, these assumptions served their purpose.

I was interested in those chapters that directly considered the assessment of risk, which sought to re-establish the importance of subjectivity and narrative to valid clinical risk management. The two chapters whetted my appetite and I wanted to read more. It was a shame that there was no consideration of prisons, where the dynamic between the offender/patient and the institution is brought into sharpest relief, and where sometimes it is hard for clinicians to maintain their clinical integrity.

This is a good and thought-provoking book and its subject matter is important. Receptive clinicians will find it useful in their daily clinical practice within existing services. Those involved in service development, whether in-patient or community-based, would do well to consider it too.

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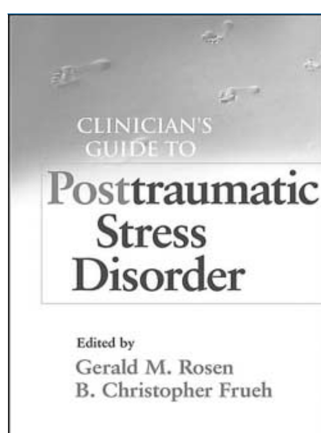

Clinician's Guide to Posttraumatic Stress Disorder

Edited by Gerald M. Rosen & B. Christopher Frueh.
Wiley. 2010.
£47.50 (hb). 320pp.
ISBN: 9780470450956

Contributors to this impressive collection include Robert Spitzer, one of the architects of DSM-III, and Jerome C. Wakefield and Allan V. Horwitz, authors of *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder* (Oxford University Press, 2007). In a paper entitled 'Saving PTSD from itself in DSM-V', Spitzer & Wakefield wrote that, 'Since its introduction into DSM-III in 1980, no other DSM diagnosis, with the exception of Dissociative Identity Disorder . . . has generated so much controversy in the field as to the boundaries of the disorder, diagnostic criteria, central assumptions, clinical utility, and prevalence in various populations' (p. 233).[1]

It is ironic that research spurred by the introduction of post-traumatic stress disorder (PTSD) has come to challenge almost every aspect of the construct's originating assumptions. These issues are carefully discussed: the idea of a specific aetiology; the distinctiveness of the supposed core symptoms; the loosening of the stressor criterion, which editor Gerald Rosen calls 'criterion creep'. He quotes Ben Shephard who, in *A War of Nerves: Soldiers and Psychiatrists in the 20th Century* (Harvard University Press, 2001), wrote: 'Any unit of classification that simultaneously encompasses the experience of surviving Auschwitz and that of being told rude jokes at work must, by any reasonable lay standard, be a nonsense, a patent absurdity'. Rosen notes that normal and even expected reactions to a traumatic experience, such as anger or uncertainties about the future, can now be referred to as 'symptoms', and that this labelling is encouraged by such terms as 'sub-syndromal', 'sub-threshold', 'partial' and (my favourite) 'delayed-onset' PTSD. Without a coherent position on the question of specific aetiology, the validity of PTSD rests largely on the distinctiveness of its clinical syndrome, yet its features overlap substantially with other psychiatric categories.

Other chapters concern early intervention in the aftermath of trauma, cross-cultural perspectives, and the spectacular role PTSD has come to play in the courtroom and to the compensation industry. Of treatment-seeking US veterans, 94% also seek compensation and Rosen argues that financial incentives have promoted exaggerated claims and unduly protracted sick roles, as well as undermining the academic integrity of the PTSD knowledge base. I have seen the same things happen in the UK.

This book interrogates the construction of PTSD and can serve as a case example of the way to critique the construction of psychiatric knowledge across the whole field. Such knowledge comes to assume a taken-for-granted status, as if it can be ignored that non-organic psychiatric categories are not nature carved at its joints. They emerge as committee decisions based on symptom clusters – clustered by humans, not by nature. Meanwhile, the DSM-5 version of PTSD may turn out to be even more friendly to indiscriminate practice than the current version is.

1 Spitzer RL, First MB, Wakefield JC. Saving PTSD from itself in DSM-V. *J Anxiety Disord* 2007; **21**: 233–41.

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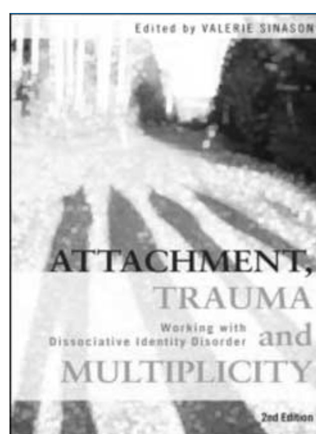

Attachment, Trauma and Multiplicity: Working with Dissociative Identity Disorder (2nd edn)

Edited by Valerie Sinason.
Routledge. 2011.
£22.99 (pb), 240pp.
ISBN: 9780415491815

This volume contains an introduction and one chapter by Ms Sinason, a message, short pieces with dedications by two

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mothers with dissociative identity disorder for their daughters, and a patient's statement on her marriage, followed by 16 chapters by different authors, for each of whom a biographical note is provided. They range from Peter Fonagy, PhD FBA, Freud Memorial Professor of Psychoanalysis, University College London, as well as Director of the Sub-Department there of Clinical Health Psychology; and Dr Felicity De Zulueta, an Honorary Consultant Psychiatrist in Psychotherapy, Maudsley Hospital; to a Detective Chief Inspector Clive Driscoll, who has completed 29 years of service in the Metropolitan Police, during which time he worked within a variety of units, including a child protection team and general Criminal Investigation Department studies. There are also two Professors of Psychology besides four members or fellows of the Royal College of Psychiatrists, including Dr De Zulueta. The headings include 'Multiple voices versus metacognition: an attachment theory perspective', by Professor Fonagy; 'Traumatic stress disorder and dissociation: traumatic stress service in the Maudsley Hospital', by Professor De Zulueta; 'The shoemaker and the elves', by Ms Sinason.

This volume is entirely devoted to a sometimes childlike presentation (by the patients) of purported dissociative states. The 'abuse family' is described by Adah Sachs, an analytic psychotherapist who 'lectures widely on trauma and dissociation, and maintains a small private practice'. The chapter of Dr Joan Goodwin of Galveston, Texas is titled 'Snow-White and the seven diagnoses'. There is throughout an uncritical acceptance of the validity of dissociative identity disorder.

I was distressed to learn from a healthy list of clinical and support links that 'The largest mental health charity, Mind, has a helpful booklet on "dissociation" for patients and their friends and families'. No one cites among the references any critical statement by a professional society, such as the Royal College of Psychiatrists, with respect to recovered memories, although belief in the latter is incorporated throughout the volume. Sydney Brandon's name is singularly absent, along with the almost equally forthright statements of the Canadian Psychiatric Association and the Australian Psychological Association, or any discussion of the critical views of current theories of dissociation. Perish the thought – all that critical stuff has been substantially ignored.

The legal risks of false accusations and the disastrous outcomes of treatment in many high-income countries, especially in the USA, are not to be found in the book, although there are three pages by Phil Mollon, PhD, on memory and dissociative identity disorder, and a passing mention of false memory in three other places. The evidence for outcomes with 'dissociative identity disorder treatment' fails to come to grips with any of the serious flaws in the dissociation theory and 'dissociative identity disorder', or for that matter with the very poor results of its treatment compared with normal management of similar patients under other diagnoses.

It is a book for believers only.

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