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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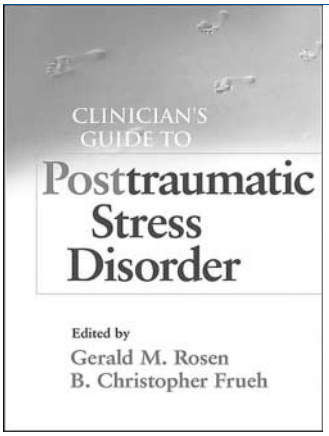

Clinician's Guide to Posttraumatic Stress Disorder

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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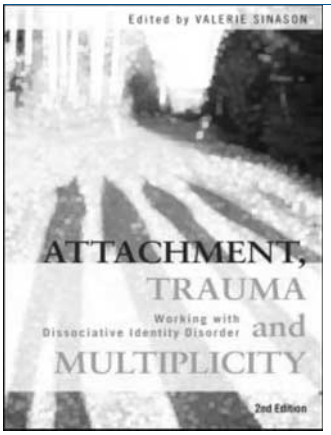

Attachment, Trauma and Multiplicity: Working with Dissociative Identity Disorder (2nd edn)

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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