language, influence of past on future experiences, and gender differences. This is followed by a focus on alloparents (individuals other than parents who take on a parental role) and adolescence. The book ends by considering the impact that early experiences have on later-life trajectories.

The chapter on biology and the brain catches attention, not least because of its attractive rough sketches which illustrate the points being made in a very memorable fashion. Following a logical thread, the conclusion is that, at least to some extent, the brain remains plastic throughout life and that there is always reason for optimism in the face of adversity.

Resilience and good feelings are very much in the news at the moment and this chapter provides a summary of some of the evidence base for promoting both. The quality of care that a child receives has an impact on their internal characteristics with a consequent impact on their resilience. However, the very negative effects of child maltreatment are seldom escaped and the author makes the point that 'loading' of factors such as poverty, birth order, parental unemployment and poor health must be considered alongside genetic determinants.

The introduction to the book includes a section about the importance of evaluating research findings very carefully. This warning must be borne in mind when reading the whole book as assertions and conclusions reached by the author must be actively evaluated by the reader.

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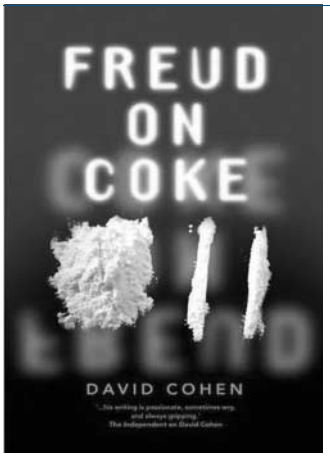

Freud on Coke

By David Cohen.
Cutting Edge Press. 2011.
£9.50 (hb). 309pp.
ISBN: 9780956544506

Cohen lets us know early on that his work is part history (exploring Freud's drug use) and part polemic on the current place of drugs within society. Perhaps with this in mind he warns us that we 'are now entering a war zone'.

The central story begins in the conversational manner of a late-night bar, developing some drama through damaging letters between Freud and Wilhelm Fleiss, which Freud managed to suppress during his lifetime through the help of a princess (Marie Bonaparte) rather than a super injunction. The ultimate survival of the letters, owing to the princess/patient's refusal of her analyst's wish that she destroy them, helps Cohen depict Freud's ambitious, and sometimes disastrous, experiments with cocaine during a time of more general European enthusiasm for this drug (Merck's European import increased from 58 000 leaves in 1881 to 18 396 000 in 1885). Despite his energetic pursuit of success, Freud overlooked the significance of cocaine's anaesthetic properties and while his colleague, Karl Koller, blazed a trail for ophthalmic and dental surgery with the use of cocaine-anaesthetic across two continents, Freud pursued the ultimately less rewarding path of 'naso-sexual neuroses'. The Fleiss letters provide testimony of the dreadful injury inflicted on Freud's 'neurotic' patient Emma Eckstein along with Freud's continued heavy cocaine use during his eventual breakthrough with the published, edited analysis of his dreams.

But Cohen also shows us Freud as part of an important tradition of serious, introspective experiment in psychotropic drugs, continued here through Albert Hofmann (the bicycling, Swiss discoverer of lysergic acid diethylamide) and Aldous Huxley's wonderful account of his Californian mescaline experience. Within late capitalism this tradition of exploration has lapsed and the search for transcendence through psychedelics has given way to a search for the firmer, clearer ego boundaries of a growing range of 'neuro-enhancers' that promise to help us work harder rather than enabling us to 'open the doors of experience'.

Although Cohen often finds his target, there is a good deal of collateral damage, particularly when examining professional involvement in psychotropic drugs. Psychiatrists challenging the very debatable findings of an Irving Kirsch meta-analysis are dismissed as a 'pro-pharma shrink duo' (the biographer E. M. Thornton fares little better as an 'outraged spinster-librarian'). These *ad hominem* attacks appear as shorthand in Cohen's polemic but do not help establish its credibility, which is further undermined by a poor understanding of basic medical science – as when we are told that a Glasgow Coma Scale of 15 indicates 'at least minor brain damage'.

An engaging history – as long as you tread carefully between the landmines.

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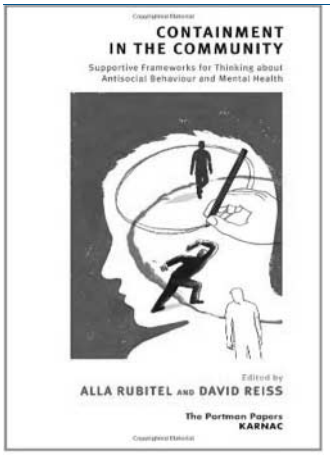

Containment in the Community: Supportive Frameworks for Thinking about Antisocial Behaviour and Mental Health

Edited by Alla Rubitel & David Reiss.
Karnac Books. 2011.
£22.99 (pb). 296pp.
ISBN: 9781855758483

For some, psychiatry has wilted in recent years, under the converging pressures of evidence-based medicine, managerialist politics and the political emphasis on public protection. The individual has been subordinated to the group, the validity of narrative and understanding to the reliability of outcome data, and therapeutic continuity to functionalised crisis management. In this stark environment for clinical practice the patient represents risk to the clinician, leading to anxiety, defensive practice, and a dichotomised clinical position of denial of risk or responsibility on the one hand and an overly interventionist approach on the other.

On reading *Containment in the Community*, one is immediately struck by the juxtaposition of forewords by a psychoanalyst whose writing is familiar to most psychiatrists (Professor R. D. Hinshelwood) and a civil servant with responsibility for

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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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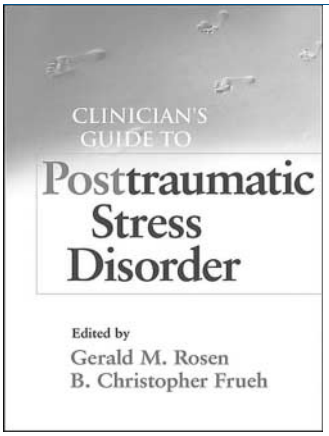

Clinician's Guide to Posttraumatic Stress Disorder

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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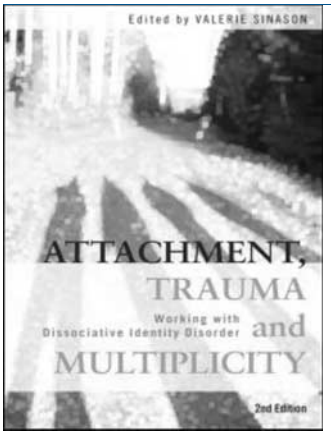

Attachment, Trauma and Multiplicity: Working with Dissociative Identity Disorder (2nd edn)

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