columns

It is primarily a practical guide; after a brief theoretical description, it moves on to describe strategies in family work. The book offers advice on setting up and running family groups; and discusses engagement, co-therapy, psycho-education, communication training, and dealing with the emotional responses of the relatives. Some of the commonly occurring problems in high expressed emotion families like anger, conflict, rejection, overinvolvement and grief and loss are also discussed and advice is offered on how to deal with them. At the end it talks about running a relatives group in parallel with the family work, and emphasises the importance of cultural difference.

Although it is meant to be a manual for family work, it will be of interest for professionals who come into regular contact with the families of people suffering from schizophrenia, since it can help colleagues in dealing with conflicts within family settings and their own conflicts with the family members. There are many transcripts from real life to explain the issues under discussion. Although there is an excellent chapter on improving communication among family members, it could be expanded, as this is the most vital part of family work.

Being a manual, the book does not describe and discuss in detail the theoretical background or the evidence base for family therapy for schizophrenia. But it does describe the family therapy techniques in an easy to understand way. Useful practical details and advice on commonly arising situations, e.g. what to do when the therapist is offered tea, coffee, or a cake during a family therapy session in a patient's home! But the most outstanding feature of this book is its brevity and conciseness – the kind of book you can read while waiting for your train.

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## Racial Identity, White Counsellors and Therapists

Tuckwell, G.
Buckingham: Open University Press, 2002, £16.99 hb, 188 pp., ISBN 0335-21021-X

This book, written by a school teacher turned counsellor, aims to address anxieties facing white counsellors and psychotherapists, working with clients from other racial groups. It explores issues and processes associated with race and racial identity and also offers a framework for extending the understanding of race on the sense of self. As such, it is one of the few books available to do so as most of the existing literature concentrates more on understanding the different cultural groups, the impact that their race has on them, their experience of society and the impact of racism on them. Fewer people from Black and other minority ethnic groups are known to be referred for talking therapies. Even less is known about how they respond to these treatments – whether it is from white therapists or from the small (but growing) band of black therapists. The publishing of this book is therefore timely.

This book discusses frankly the eurocentric model of white supremacy and domination, which influences important attitudes relating to superiority and inferiority. It proposes a broader and deeper understanding, which should take account of intra-psychic, interpersonal and socio-political factors. The author argues that practitioners need to recognise their own racial attitudes and counter-transference reactions in relation to clients, as collective beliefs about white supremacy can be damaging. The case for the role of supervision and training to help develop racially aware practice, is well-made and well accepted by all practitioners.

It is a shame that the style of the book could deter novices to this field as it coherently brings together world-wide expert views and current thinking in this complex field. A shame too, because it is a refreshingly honest attempt to grapple with much that is never openly spoken about, but that nevertheless exists. I particularly found the summing up section at the end of each chapter useful as this promotes reflective practices. This book will probably be avidly sought by experts in the field of counselling and psychotherapy rather than the majority of the readers of this journal because of its specialist stance.

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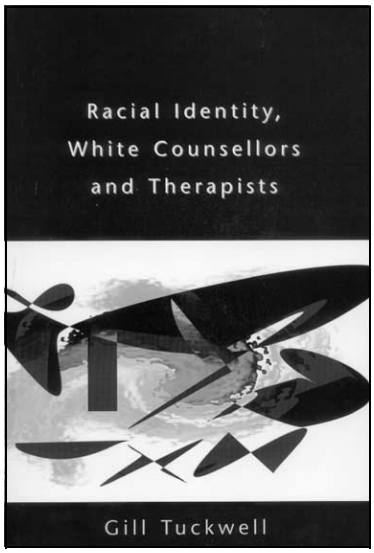
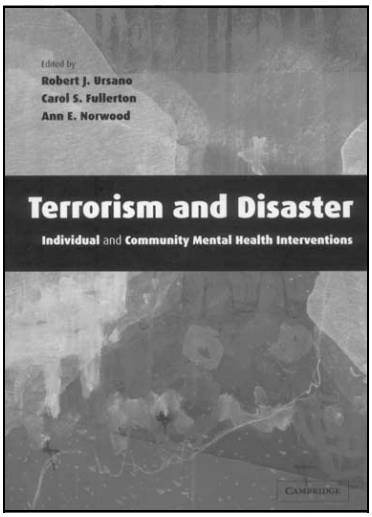



## Terrorism and Disaster. Individual and Community Mental Health Interventions.

Ursano, R. J., Fullerton, C. S. & Norwood A. E. (eds)
Cambridge: Cambridge University Press, 2003, £40 pb, 364 pp., ISBN 0-521-53345-7




The events of 11 September 2001 changed our world for ever. The world has become a more dangerous and uncertain place, and no-one is safe or immune from the threat of terror. In an instant the lives of victims and their families are irreparably transformed; leaving for some an enduring scar blighting lives with disability as great as any physical injury.

How best to respond to these needs is not obvious and there is little evidence to tell us what exactly we should be doing, when and to whom. Conducting methodologically robust trials of any intervention in the chaos and confusion that follows a disaster is almost impossible and the evidence, such as there is, is limited. What is clear however, is that inappropriate or ill-timed early interventions can do considerable harm. Responding to traumatic events therefore requires a cautious pragmatic approach building on the experience and lessons learned from those who have first hand experience of dealing with disaster.

Spawned in the wake of 9/11, *Terrorism and Disaster*, accompanied by a CD-Rom, makes compelling reading. Recent terrorist atrocities, their aftermath and the response of mental health services are described. The efficacy of early interventions is reviewed, as well as the pre-exposure screening of high risk groups such as soldiers and emergency service workers. Particular problems associated with more unusual traumatic events such as body handling, radiation exposure and contamination are described in addition to a review of wider public mental health



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columns

issues and problems associated with relocation stress.

This is an excellent book and required reading for anyone involved in disaster planning. Disaster is a unique experience for most mental health professionals: considering any of us could be called upon to advise and assist, this is a field with very few 'experts'. It is therefore crucial that we learn from the experiences and lessons of colleagues who have had first-hand experience; *Terrorism and Disaster* allows this opportunity.

The war on terror has barely begun and there will be many more innocent victims. Considering that conflict is taking place in more than 100 countries and terrorism in many more besides, the needs of victims constitute a public health problem of global proportions and a major challenge for psychiatry in these troubled times.

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## Psychiatric services to accident and emergency departments

### Council Report CR118, February 2004, Royal College of Psychiatrists and British Association for Accident and Emergency Medicine, £10, 96 pp.

This report supersedes the previous joint report (CR43) from the Royal College of Psychiatrists and the British Association for Accident and Emergency Medicine. Since the publication of the original report, new demands have been placed on both mental health services and accident and emergency (A&E) departments. The requirement that 90% of patients, rising to 100% by the end of this year, must have been discharged from A&E departments within 4 hours of arrival (Department of Health, 2001) will have a major impact on the interaction between mental health services and A&E departments.

The main report examines the common mental health scenarios that occur in the A&E department, issues affecting patients from ethnic minorities, specific problems in the A&E department, personnel issues and the organisation of services.

The principal recommendations in this report are as follows:

### Summary of recommendations

- There is a joint responsibility for commissioners, mental health service managers, and acute service managers to ensure that the input of mental health services to A&E departments is not overlooked in negotiations.
- A consultant psychiatrist should be named as the senior member of staff in the local mental health services responsible for liaison with the A&E department.
- A&E department personnel should have adequate knowledge of mental health issues, and feel confident in making an initial assessment of people with mental health problems.
- Mental health problems should be included in the triage process.
- A&E department staff training should include the recognition of common mental health problems, and the appropriate responses to that recognition.
- Mental health staff training should include training from A&E department staff regarding what is helpful. Conversely, A&E department staff require training from the mental health staff about what is practicable.
- Common training initiatives involving both staff groups address not only training issues, but also can lead to major operational benefits.
- local policies should be agreed regarding common mental health problems that arise in the A&E department.
- The A&E department should include facilities and resources for the assessment of patients with mental health problems. This should include an interview room with adequate safety features.
- Staff training should include safety issues.
- A liaison group, with representatives from the A&E department and from mental health services, should review issues of joint working between the two services, establish joint working protocols, and ensure that the recommendations contained within this report are considered and implemented.
- The liaison group should be authorised by, and have agreed reporting structures to, the respective Trust boards.



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