Psychological Medicine 2001, **31**, 173–180. Printed in the United Kingdom

Book reviews

Psychological Debriefing: Theory, Practice and Evidence. Edited by B. Raphael and J. Wilson. (Pp.386; £37.95.) Cambridge University Press: Cambridge. 2000.

By the time you read this review, I will have given up being book review editor of *Psychological Medicine*. I have enjoyed it, but after nearly 10 years it is time to move on. I will miss it.

Many of the books that have passed over my desk have been instantly forgettable. Edited proceedings of conferences where the participants only learnt they were supposed to hand over a manuscript months after the event. Piles of paperbacks on counselling. Unclassifiable texts such as '*Horticultural Therapy for Older People*' (gardening to you and me). Glossy books with little content always intended as drug company gifts. Multiple choice question books. Anything with 'DSM' in the title.

But now and then a book comes along that I actually want to read. Perhaps it is written by someone with a masterful prose style – Paul McHugh comes to mind. Sometimes it is something with which I need to keep up to date – Stephen Stahl's books on psychopharmacology. Some are indispensable reference books – Lishman's '*Organic Psychiatry*'. And sometimes it is the subject that intrigues.

This book is one of the latter. It is about that modern phenomenon, psychological debriefing. Not only an intervention, but also a social movement. Debriefing is what is supposed to happen when those teams of 'trained counsellors' (and why is it always a 'trained counsellor'? We never talk about a 'trained pilot' or 'trained surgeon') descend on the hapless victims of yet another disaster. Before the blue lights have stopped flashing, those involved are expected to sit down, talk it through and be told what they ought to be feeling now and in the future. This procedure will in some unspecified way reduce psychological distress and prevent the development of illnesses such as post-traumatic stress disorder.

I used to be indifferent to the entire subject, until I became an editor of the Cochrane Review Group on Depression and Anxiety. In order to earn my meta-analytical spurs I had to carry out a review myself. With colleagues we chose the subject of debriefing, thinking that it would be a simple matter.

It wasn't. It turns out that debriefing, which sounds so innocent ('better out than in' says my mother) is actually far more complex and ambiguous. And when it came to the evidence in support of its efficacy, well, there wasn't any. And there still isn't several trials later. And even more alarming, the better trials were suggesting the procedure might do more harm than good.

It is interesting to see how the many contributors to this edited volume deal with this little local difficulty – the fact that nine trials and a meta-analysis have failed to find any evidence that the procedure actually does what it says it does. Sadly, the majority deal with it in the time-honoured academic fashion – they ignore it, or alternatively come up ever more elaborate reasons of why those trials were not a true test of the intervention. But fortunately others are more balanced, and some of those previously well-disposed towards the intervention are starting to sound a note of caution, and point out that even if all these trials are fatally flawed, where are the positive trials that might redress the balance?

So is it all a waste of time then? Actually not. The editors and some of the reflective contributors make a compelling case for why we should not be throwing out babies with bathwater. They are beginning to attempt to separate what may be iatrogenic from what can be beneficial. Most agree that the practice of compulsory debriefing must cease (although one still seems to think that this can be justified!). Those teams of trained counsellors descending on perfect strangers at the crisis of their lives and telling them to talk must also become a thing of the past. Many now acknowledge the multiplicity of reactions to trauma, and indeed the cultural relativity of the term trauma itself. Adversity can have benefits for some. Others are

unaffected by it, and simply need to be left well alone.

This is an excellent book – not least because of the standard of the editing. It is refreshing to see editors who not only have read each contribution (and this is not the time to name and shame a few editors who clearly have not performed even that simple process), but have provided a helpful commentary along side. The contributions reflect a wide range of opinions – some of which are close to my own and some of which certainly are not. But all shades of opinions are well represented, and given the opportunity to present their case.

I think that the epidemic of debriefing, for that is what it is, is now passing, I do not see how we can continue to justify this blanket intervention in the absence of evidence that it helps, and the presence of some evidence that it harms. 'First do no harm' counsel the editors, rightly. Yet the desire to help people in crisis remains understandable and laudable – one of the more attractive aspects of human nature. What we need now is a more mature, considered approach, one which is evident in some of the contributions from the military in this book, who of course have the longest interest in the subject.

What I have learnt from my military contacts, and I am pleased to see reflected in this book, is a belief that the key to debriefing is to make it seem as low key and normal as possible. It should be facilitated by those already known to, and familiar with, the participants, who share and understand the experience. We should encourage people who wish to talk (and the key word is wish) to do so as part of their pre-existing social group, and in a non-mental health context. We should be looking only for those who are already in distress and suffering, either acutely or chronically. For the rest, if we don't know what helps, we should do nothing.

Giving debriefing to each and everyone whose only thing in common is that they got on a train or a plane at the same time can no longer be justified. Let us see no more of the arrival of the counselling teams in the wake of the fire engines. Those whose motives are voyeuristic should watch the drama on TV with the rest of us. If we really want to help, we should now be making sure that these early interventions are given by those who are already part of the social group, and to those who really are in need. For the rest of us, when we have no evidence that what we do helps, and a sad record in our profession of ill-timed and ill-conceived interventions, our motto should be 'don't just do something, stand there'.

SIMON WESSELY

A Cursing Brain? The Histories of Tourette Syndrome. By H. I. Kushner. (Pp. 303.) Harvard University Press: London. 1999.

Do good books need a catchy title in order to be bought and read? In my opinion, this is not so in the case of 'classic' textbooks, but in the case of some books this may well be so, as an inducement to explore the contents of the subject of the book further. Let us examine the case.

It may be worthwhile to introduce the reader to Gilles de la Tourette Syndrome (TS), which is characterized by the combination of multiple waxing and waning motor tics plus one or more vocal tics lasting for longer than a year (World Health Organization, 1992; American Psychiatric Association, 1994). The tics commonly begin between the ages of 2 and 15 years. Coprolalia (the inappropriate involuntary uttering of obscenities) occurs in less than one-third of clinic populations, but in very few children or mildly affected cases. Copropraxia (inappropriate and involuntary obscene gestures) occurs in 1–21% of clinic samples, while echolalia (imitation of sounds or words of others) and echopraxia (imitation of actions or movements of others) occur in 11–44% of clinic patients. Palilalia (the repetition of the last word or phrase of others) occurs in 6–15% of patients. Characteristic associated behaviours and psychopathologies include obsessive–compulsive behaviours (OCB), attention deficit hyperactivity disorder (ADHD) and self-injurious behaviours (SIB) (Robertson, 1994), and in some cases, depression, anxiety and a wide variety of personality disorders (Robertson *et al*. 1997). It is not known whether these psychopathologies are representative of all TS individuals, or due to referral bias, originally described by Berkson (1946). TS is now recognized to be genetic, but to date the gene has been elusive (Alsobrook & Pauls, 1997).

The book reviewed here is *A Cursing Brain? The Histories of Tourette Syndrome* by the

medical historian Howard Kushner. It is unreservedly excellent and ought to be read by all those interested in the history of neurology and psychiatry as well as TS. The author takes the reader along the route of many TS patients who have a 'difficult journey through a medical maze in search of a diagnosis', with years of misunderstanding and ostracization. He highlights the fact that TS is now considered to be more common than was previously thought, and cites a recent report suggesting that TS occurs in as many as 2·9% of mainstream schoolchildren (Mason *et al*. 1998). He points out that the precise aetiology is as yet unknown, but does discuss both the genetic predisposition to TS, and the recent, if more speculative, notion of PANDAS (paediatric auto-immune neuropsychiatric disorders associated with streptococcal infection) (Swedo *et al*. 1998). Kushner also discusses the alleged 'disputed illness' and takes us through the periods in history when the notions of TS have changed, and through the 'biblical' DSM-journey, in which the diagnostic criteria and age at onset seem to change with each revision. He talks us through which behaviours constitute TS and which do not – and which remain a longstanding source of disagreement among professionals. In the chapter 'The Case of the Cursing Marquise' (my favourite), Kushner devotes a whole chapter to the Marquise de Dampierre (1799–1884), who had 'eight decades of suffering' and whose story was first reported by Itard in 1825 and subsequently by Georges Gilles de la Tourette in 1885. He tells the reader about all the clinicians who saw her (or cited her), and also tells us about many other historical TS clinicians and TS patients, including, possibly Daniel Paul Schreber (who for years was the most famous patient ever with a diagnosis of schizophrenia (Freud's 1911 diagnosis)). Kushner also exposes the history of neurology and psychiatry, takes us through the undisputed 'organic' basis to TS, and familiarizes the reader with the intriguing psychoanalytical approaches to TS that dominated the 1930s and 1940s, with well-known exponents of the discipline such as Ferenczi (whose famous saying that tics were 'stereotyped equivalents of Onanism [masturbation]', which has been cited many a time), Mahler (a 'doyenne' of paediatric psychiatry whose views were held even into the 1980s) and Freud. He demonstrates how the French psychiatric world has ironically been dogged by a psychoanalytical approach to TS, even to date, and even in the face of obvious 'organicity', as recently as the 1990s. We are also exposed to the extraordinarily wide variety of treatments for TS, almost predictably being both psychological, medical and worse. Kushner also extends a personal invitation to his readers to attend the various conferences held on TS. The first international conference on tics ('The Tics and Allied Conditions') was in 1927 and organized by the British neurologist Kinnear Wilson at the British Medical Association's Annual meeting (with British, American and French delegates). He discusses in detail the 1985 international centenary conference held in Paris and shows how the battle between the Anglo-North American (organically orientated) and French psychiatrists (analytically orientated) was in almost full flight. Many international conferences have now taken place, with those organized by the USA Tourette Syndrome Association (TSA) in particular taking place in 1981 (New York), 1991 (Boston) and more recently in 1999 (New York). The book also contains many pictures of people, including the by-now-famous and ubiquitous photograph of Georges Gilles de la Tourette, as well as Margaret Mahler and the Shapiros, lending a visual appeal to the book and introducing these people to the reader who may not have known or met them. The title chapters are even clever. The French Resistance (chapter 9), which begins in 1941 in Nazi-occupied Paris, refers to the resistance by many French psychoanalytical psychiatrists to the suggestions of an organic basis and medical treatment of TS. At a personal level, thankfully, Britain has played some role in the TS story in the book. Kushner devotes substantial discussion to W. Russell Brain's article 'The treatment of tic (habit spasm)' in 1928. As said, Kinnear Wilson hosted a conference in 1927, Mildred Creak and colleagues from the Maudsley Hospital published an important paper in 1935, the Shapiro's first paper on haloperidol apparently could not find a home in the psychoanalytically dominated American medical press and was finally published in the *British Journal of Psychiatry* in 1968. Finally, he also cites two fairly recent British studies in school children, suggesting

that TS is more common than was previously thought (Mason *et al*. 1998), especially in children with learning difficulties (Eapen *et al*. 1997).

My only difficulty with the book is the title, which highlights the obscene nature of TS. Does a book as good as this need a catchy title? Coprolalia is one of the more intriguing symptoms of TS but, as said, it is not common. Many, mistakenly still believe that coprolalia is required for the diagnosis of TS to be made. Swearing is, of course, fairly common in many cultures (including USA and UK) and what many clinicians do is to incorrectly call this 'ordinary swearing' coprolalia. When a symptom is as curious and fascinating as this, it is no wonder perhaps that people capitalize on it. A current 'popular' book may well have to rely on its catchy title before its academic, appealing, and scholarly stature is finally recognized.

Other books dealing with TS include the many textbooks (e.g. the most recent textbook edited by Leckman & Cohen, 1999), which carry their acknowledged expertise in the field, and size (a 584 page magnum opus) as their selling points; they do not have to rely at all on a title. We (Robertson & Baron Cohen, 1998) wrote a small book (110 pages) on TS, essentially for the lay public, but which could also be useful for clinicians who have TS patients; it belongs to 'The Facts' series. It gives three case vignettes, factual information about TS, includes a bibliography (listed in sections – under diagnostic criteria, history, epidemiology, clinical characteristics, etc.) and gives a comprehensive list of TS associations and contacts around the world.

TS books by lay people have also appeared on the market and can be very valuable to sufferers, their families and even clinicians. The titles, in fact, do tell us something about the books. Schimberg (1995) herself has TS, as have two of her children; her book title *Living with Tourette Syndrome* is what the book is about – living with Tourette syndrome. It is well written and tells her own story as well as that of her children, woven discretely into much well-researched factual information about TS. She reveals the personal 'painful years', shows how TS can be exhausting for all concerned, highlights the neurological nature of TS, expels 'myths' about TS, and deals well with the 'information explosion' that has surrounded TS. She presents an extremely balanced view, and, in my opinion, this is the 'best book for the layman by a layman'.

The title of Fowler's (1996) personal account is *The Unwelcome Companion; an Insider's View of Tourette Syndrome*. He also highlights the neurological basis, and describes how TS (a 'misunderstood disorder') can range from 'mere aggravation to complete debilitation'. He gives a good rendition of coprolalia, discusses TS being 'incurable yet treatable' and gives a reasonable factual account of TS. His book is, however, more moving than that. Throughout, TS is personified as a demon, an intruder, an enemy in a constant tug-of-war with the victim or sufferer. The symptoms torture, humiliate, persecute and torment the incumbent. The book is thus an interesting combination of the personal struggle against TS and factual information (in my opinion somewhat biased at times). There is also a heartfelt chapter on how people with TS deal with society, and he tells (as do others) of the 'horrors' of treatments (e.g. ECT, lobotomies, exorcism). Some patients 'swear by' this book, which they see as the ultimate in 'sufferer empowerment'.

The final comment on a book's title is Sue Grafton's '*H is for Homicide*' (Grafton, 1992). Grafton writes thrillers – *A is for Alibi*, *B is for Burglar*, *C is for Corpse*, etc. There is no doubt it is a good read for those into crime. It is well-written and somewhat compulsive – to see in fact 'who dunnit'. Sadly (from my point of view), one of the key figures in the book is a man who clearly has TS, but who also clearly has (and it is acknowledged, a sociopathic personality disorder – charged with murder, theft, fraud, larceny etc.). My fear is that readers will remember the TS; it is mentioned often, the symptoms are well described and it has that unique appeal, that 'curiousity' value. The psychopathic aspect may be forgotten. In fairness, however, Grafton has done her homework well, and has introduced TS to another audience.

In exploring with the reader the range of books dealing with the various aspects of TS, I would submit that in fact a title does intrigue a reader. TS is a fascinating disorder, with many aspects to it. Books about it should not need a catchy title, but they invariably have one.

Many of the patients in real life and as depicted in the books reviewed have been

misunderstood and tormented both by their symptoms and society for many years. Themes that run through the books include the intriguing history, the fascinating symptoms, the awful and inappropriate treatments, and the 'organic *versus* psychological' aetiological theories. Factual information about TS is important, but to give the clinician a 'true feel' for the disorder, it is suggested that they also read this exquisitely written history of TS by Howard Kushner, sample the factual upbeat assertive account of Schimberg (who also uses the word 'demon' for TS, incidentally), read of the pain of TS (Fowler) and read of the individuals with TS who have really succeeded in life (see in Schimberg and Robertson & Baron-Cohen). Those who want to read a 'good thriller' should read Grafton's book, maybe they will also learn something about TS. Interestingly, Grafton acknowledges both Adam and Muriel Seligman (the latter of the USA TSA), and Kushner also writes about Adam!

MARY M. ROBERTSON

REFERENCES

Alsobrook, J. P. & Pauls, D. L. (1997). The genetics of Tourette syndrome. *Neurologic Clinics* **15**, 381–392.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders, 4th edn (DSM-IV)*. American Psychiatric Association: Washington, DC.

Berkson, J. (1946). Limitations of the application of fourfold table analysis to hospital data. *Biometrics* **2**, 47–51.

Brain, W. R. (1928). The treatment of tic (habit spasm). *Lancet* (23 June), 1295–1296.

Eapen, V., Robertson, M. M., Zeitlin, H. & Kurlan, R. (1997). Gilles de la Tourette's syndrome in special education schools: a United Kingdom study. *Journal of Neurology* **244**, 378–382.

Fowler, R. (1996). *The Unwelcome Companion; An Insider's View of Tourette Syndrome*. Silver Run Publications: Athens, GA.

Grafton, S. (1992). *H is for Homicide*. Pan Books (Macmillan General Books): London.

Leckman, J. F. & Cohen, D. J. (1999). *Tourette's Syndrome: Tics, Obsessions and Compulsions*. John Wiley and Sons Inc.: New York.

Mason, A., Banerjee, S., Eapen, V., Zeitlin, H. & Robertson, M. M. (1998). The prevalence of Tourette Syndrome in a mainstream school population. *Developmental Medicine and Child Neurology* **40**, 292–296.

Robertson, M. M. (1994). Annotation: Gilles de la Tourette syndrome – an update. *Journal of Child Psychology and Psychiatry* **35**, 597–611.

Robertson, M. M. & Baron-Cohen, S. (1998). *Tourette Syndrome: The Facts*. Oxford University Press: Oxford.

Robertson, M. M., Banerjee, S., Fox-Hiley, P. J. & Tannock, C. (1997). Personality disorder and psychopathology in Tourette's syndrome: a controlled study. *British Journal of Psychiatry* **171**, 283–286.

Schimberg, E. F. (1995). *Living with Tourette Syndrome*. Fireside Book, Simon & Schuster: New York.

Swedo, S. E., Leonard, H. L., Garvey, M, *et al*. (1998). Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections; clinical description of the first 50 cases. *American Journal of Psychiatry* **155**, 264–271.

World Health Organization (1992). *International Classification of Diseases and Health Related Problems – Tenth Revision*, World Health Organization: Geneva.

Common Mental Disorders in Primary Care: Essays in Honour of Sir David Goldberg. Edited by M. Tansella and G. Thornicroft (Pp. 253.) Routledge: London. 1999.

This book was written in honour of Professor Sir David Paul Goldberg who has stepped down from the chair at the Institute of Psychiatry in London. In brief, D.P.G. is a Londoner who has spent his life there apart from time at Oxford; a quarter of a century in the northern fastness of Manchester; time spent on sabbaticals and at many international scientific meetings in all parts of the world; and at his beloved cottages in Wales and Sussex.

There has been a plethora of talent in psychiatry in the UK during this century. There was the pre-World War II Mapother period leading to the post-war Aubrey Lewis generation. This produced, during the early years of the National Health Service, a flowering of talent, especially at the Joint Hospitals and the Institute of Psychiatry in London. Lewis, a seminal figure, made sure that all the subspecialities in psychiatry were catered to. So his acolytes came on stream with such people, for example, as Michael Shepherd. In turn D.P.G. was an acolyte of Shepherd. Sometimes it is amusing to find out the trail of the royal blood. We know that Adolph Meyer went to Johns Hopkins from Switzerland pre-World War I and advocated the concept of the bio-psycho-social approach to psychiatric disorders. His last chief resident was said to be Ernest Gruenberg, the first professor of psychiatric epidemiology in the world. Michael Shepherd spent time training with Gruenberg in the US and went on to become the first professor of psychiatric epidemiology in the British Commonwealth. D.P.G., and the rest of us in the General Practice Research Unit directed by Shepherd from the 1960s until the 1980s at the Institute of Psychiatry, London could reasonably argue that we had the royal jelly/blood or whatever it takes. Whether entirely accurate or not it makes a good story. D.P.G. was particularly definitive

in this respect, since he took up this line of work, that is psychiatric epidemiology as studied in the British general practice setting, and continued to do so for the rest of his distinguished professional career.

The best these days seem to get a *festschrift* between the Hall of Fame and Valhalla. It is asked 'what manner of man is he or has been?'. Well, Sir David Goldberg is the *enfant terrible* of general practice research. He has explored it further than anybody else. He has been knighted and is recognized with a raft of prizes. What of the man? He is a principled man and not always popular as a result. He is compassionate, which is not always realized. He is not always easy to access. He is very committed to his family. To quote a friend 'he is a fascinating mixture of tetchiness, loquacity, jollity and verbal and intellectual brilliance'.

David and I shared a room at the Institute when doing our M.D.s. We had a moment of panic once when the Monroe calculator was thought to have gone wrong. This machine was noisy and a kind of card sorter (we are dated, dear reader). It seemed to be smoking and we had to rerun all of our calculations. However, we survived. Thus, the General Health Questionnaire (GHQ) was saved for posterity. Other general practice researchers in Shepherd's department from the 1960s went onto other topics, mainly geriatrics. D.P.G., therefore, finished up carrying the torch. What did he do between going to Manchester in 1969 as Senior Lecturer and retiring in 1999 as Professor Sir David Goldberg? This book edited by Michele Tansella and Graham Thornicroft, sets out to describe something of the outcome.

The book starts with a picture of D.P.G. His stare is stern but more quizzical than harsh. Not a bad picture to have on the wall. He used to have the portrait of Sir Aubrey Lewis on his wall staring rather balefully at him. Going back to the book, his entry onto centre stage is heralded by fanfares from two epidemiologists, Rachel Jenkins and Scott Henderson. Rachel's foreword is a rave and even Scott, a man from the Granite City, gives almost equal measure. Thus: 'The science and social science citation indexes taken together tell that Goldberg's work has been cited in more than 6,000 publications by other researchers. Few individuals have had an impact of that magnitude'. We then move on to a cluster of international contributors from parts of the UK, Holland, Spain, Switzerland, the USA, Australia and India. I guess these are some of the places that D.P.G. touched. It is not clear whether these are geographically-bound or person-bound. It is interesting here to draw comparison with the *festschrift* for D.P.G.'s mentor Michael Shepherd, which was delightfully reviewed by Professor Lee Robins 10 years ago. Most of the contributors were familiar colleagues or students. In a sense their pieces were 'catch ups' on what had happened in their field since they worked with the great man. This is less than apparent when looking at the D.P.G. *festschrift* contributors.

The book contents are divided into five parts: the nature of the problem; team work in primary care; improving management; training in mental health schools and primary care; and, finally, the interface between primary care and specialist mental health services. The authors appear to genuflect to D.P.G. and then get on with a discussion of their own research. In other words, D.P.G. is seen as the touchstone but not necessarily the mentor. However, judging by the references, D.P.G. himself has published very consistently. These include *Mentall Illness in General Practice* (1980); *A User's Guide to the GHQ* (1988); *Common Mental Disorders. A Biosocial Model* (1992); *The GP, the Psychiatrist and the Burden of Mental Health Care. Maudsley Discussion Paper No.* 1 (1997); plus of course many papers, especially with others. It is surely the mark of a scientist like D.P.G. that he can work in teams; particularly with the same team over time. The book contributors with whom I am most familiar are epidemiologists like Anthony Mann, Gavin Andrews, Norman Sartorius and Michele Tansella. Anthony Mann, who always writes in a solid, economic style, puts together a useful chapter. He is probably *non pareil* among writers in his field. He makes two interesting points: 'Psychiatrists, who have researched primary care, have not contributed much to help the general practitioners with their older subjects with mental illness'; and, 'Depression has been claimed to be rare in old age. However, if other diagnostic terms are included – "minor depression", "sub-threshold syndrome" or "depressive thresholds" – the total rate of depression is, in fact, higher than in younger age groups'.

Gavin Andrews and colleague Caroline Hunt tell us that while 20% of Australians have a psychiatric disorder there is a need for general practitioners to improve their 'case detection skills'. This, of course, is what D.P.G. has been trying to do for the last 30 years. What, then, is the next move? Has general practice based epidemiology had an impact on general practice medicine or not?

Norman Sartorius, a former president of the WPA and close friend of D.P.G. talks about the limits of mental health care in general medical services. As expected his remarks are thoughtful and global. Suffice to say that 'An analysis of the reasons for the slow introduction of mental health care into general health services shows that limiting factors belong to the personal, technical, social, administrative and professional domains.' Each of these he tidily examines.

Finally, we come to the editors. Their chapter is entitled 'Coordinating Primary Care with Community Mental Health Services'. Here the mandate is drawn together. They argue in effect for the utility of the National Health Service (NHS) model. This permits studies, such as those of D.P.G., which talk about filters, i.e. screening for levels of psychiatric disorder through various orders of psychiatric care. This was fine until the structure of the health services began to collapse, mainly for financial reasons. Just as those in former communist countries are looking back nostalgically to the discipline and order of communist regimes, so UK and perhaps European researchers look back to the sampling frame of the NHS. In the US, however, the concept of the general practitioner (GP) or primary care doctor never really gained sway. So the family doctor does not serve constantly and universally as the important screen for mental illness any longer anywhere. Is that surprising? No. Psychiatry is the most socially influenced of the medical specialities, and subject to political and cultural fads. So did D.P.G.'s service research last or do less well than basic/laboratory/clinical research? D.P.G. did not find the cause of schizophrenia or the gene for bipolar affective disorder. Such is the modern gold standard. He did not set out to do that. He is rather of the lineage which looked at the bio-psycho-social stuff, referred to earlier and kept its options open by concentrating on services. D.P.G. belongs to this service/epidemiology group. That is fine. Every generation contains and treats the mentally ill, hopefully as effectively as possible. This is the doctor's primary role. Aetiology, efficacy and efficiency come later. So D.P.G. gave a challenge. Lots of community mental illness described and, hopefully, to be delivered to the right medical authorities. Not much validity, but that will come later. As will containment of costs, morbidity and mortality limitation. Thank you, David, for your commitment in telling us about these people and their trials and tribulations.

This volume then is one of a number of tributes to D.P.G. as a psychiatrist/public health man. Just as we revere those who gave us clean water, we equally respect those who have taught us about the chronic non-communicable diseases like psychiatric disorders. It will not have been missed that the WHO has informed us that in the coming years five out of the top ten worldwide disabilities will be psychiatric disorders. Major depressive disorder is number one. So D.P.G.'s time in history, particularly in the worldwide context, has been just right.

ROBIN EASTWOOD

Ageing and Male Sexuality By R. C. Schiavi (Pp. 264; £27.95.) Cambridge University Press: Cambridge. 1999.

This new book is a comprehensive review outlining the current knowledge (while emphasizing how limited this remains) on the neglected area of sexuality in ageing males.

Professor Schiavi writes, that as a result of the demographic shift expected over the coming decades and as newer cohorts entering old age may possess a more consumerist philosophy a greater response to sexuality in older people will be expected from mental health services and professionals working in the field of mental health.

At present, sexuality in younger populations receives a high profile, and indeed our media can seem almost inundated with surveys and profiles of sexual behaviour in younger adults. Yet our understanding of sexual behaviour in the elderly is uncertain and is only being explored in more recent studies.

However, as Schiavi points out, a review of medically based research has thus far tended to

concentrate on organic aspects of sexual functioning and has neglected the wider context of sexuality – how people derive pleasure in new and different ways as they become older, how and why they may lose interest in previously pleasurable behaviours, and what exactly constitutes the behaviours being practised by current elderly cohorts.

Unfortunately, while Professor Schiavi continues to highlight this paucity of research, this book does not provide us with a new understanding of sexuality for the elderly. It is a comprehensive review of all the available evidence and indeed it is impressive that the reference list is not insular, citing not merely American authors but also extending to the most respected studies published by British researchers. But, though one can only be impressed by the depth of references, one is also struck by the inherent 'biological' emphasis within existing studies, which do not ask questions that would increase the breadth of our knowledge of sexuality in ageing populations.

Nevertheless, for those working with the elderly, this proves an invaluable guide. It is written in an authoritative easy readable manner. It never recourses to jargon or opinion (although one cannot help but regret at times that Schiavi does not speculate more often and resort more to description that is based on more intuitive and empirical knowledge rather than reference to more 'scientific evidence'). This book provides the first comprehensive review, available for those working with the elderly, piecing together all the available evidence thus far concerning sexuality and its disorders among elderly males.

TONY BEIRNE