years a member of its Council and Treasurer for a number of years.

Pat's clinical work was of a very high quality. His notes were comprehensive, usually lengthy and always legible. He was an excellent clinician and was in great demand from all departments of the Hospital for consultation. His patients liked and trusted him and he was a very effective psychotherapist. He was popular among the students and an effective teacher; he used to lecture walking up and down and used to say that a moving target was more difficult to hit.

Pat was a devote Channel Islander, always spending his holidays there, and felt something of an exile in London. His first wife died tragically in childbirth while he was in the Navy when his eldest son (who also later trained at The London) was born and there are two girls and a boy from his second marriage. His retirement in 1976 was marked by one of the largest gatherings of the kind that can be remembered at The London but it was not long afterwards that the illness from which he ultimately died made its appearance. No-one could overstate the loving care he received from his wife Diane in his last years.

SIC
JE

---

*Psychiatric Bulletin* (1991), **15**, 717–718

# Video news

## *Tape reviews*

### Post Traumatic Stress Disorder

Although entitled *Post Traumatic Stress Disorder*, this videotape examines the broad range of normal and pathological psychological reactions to disaster. The full syndrome of post traumatic stress disorder, involving prolonged intrusive re-experiencing phenomena, avoidance behaviours, and autonomic arousal occurs in a minority of the primary victims of major traumatic incidents, their relatives and bystanders, and the professional workers who rescue or look after them; but partial symptomatic presentations are commonplace and, indeed, natural in the early weeks following the disaster.

This programme focuses on material from two contrasting traumatic incidents, the Clapham train crash and the Falklands war. A hospital chaplain, an accident department nurse, and a naval psychiatrist give admirably lucid and comprehensive accounts of the initial, short term, and more prolonged psychological reactions in those exposed to these events.

The first part of the programme examines the emotional reactions of those directly experiencing the incident. Commonly the victim displays an initial denial and numbness, often quickly replaced by a euphoria derived from having survived the disaster. Typically this gives way within two or three days to a constellation of early traumatic stress reactions including tearfulness, anxiety, sleeplessness and often anger. This tape emphasises the distinction, which is important for early management, between the sadness and emptiness which is a normal, expected part of the victim's early reaction, and clinical depression. We are also reminded that traumatic events re-awaken the residues of earlier psychological trauma, which may need to be addressed too. Early management centres on support, giving information about natural reactions to stress, and promoting the victim's repeated description of his experience. Where possible, and this is certainly important in military psychiatry, victims are encouraged to talk about their experiences in a group context with others who have survived the ordeal. Such proactive early intervention probably diminishes the later incidence of complications; but specific treatments will be required for the minority who develop frank psychiatric illness, including acute psychotic reactions. We are reminded that traumatic stress reactions may be prolonged, and that their onset may be significantly delayed. Victims are helped to come to terms with their experience by the social rituals which can follow disaster, such as the commemoration service and anniversary remembrance.

The second part of the tape looks at traumatic stress reactions in professional carers. Frontline staff work at a high pitch of arousal and effectiveness during the rescue and initial response phase. Commonly these workers experience subsequent tiredness, doubt and demoralisation; and this can lead on to anger, competitiveness, a profound awareness of personal fallibility, or the range of post traumatic stress symptoms. Negative reactions are diminished by a number of well recognised procedures, including the initial prioritisation of tasks, adequate refreshment and rest, and an initial informal debriefing when the workers stand down from the emergency. As with the primary victims, it is useful to emphasise that emotional reactions are a normal part of stress. Peer

group meetings can promote mutual support and the emotional processing of the traumatic experience. Those who are more deeply affected, showing adverse reactions, may require active counselling or other specific treatment.

This tape emphasises that stress is a normal and expected part of certain occupations. Planning and preparation for the psychological management of traumatic incidents is both possible and necessary. Adequate preparation can reduce the possibility of conflict between the management of the victim's physical needs ("saving life and limb") and management of the associated psychological reactions; and it can safeguard the effectiveness and well-being of front-line staff.

This is a useful tape, which avoids the sensationalism which is all too common in this field. It could have been improved by interviews with disaster victims and more front-line staff. As always, videotape material needs to be linked with active teaching sessions.

MIKE HOBBS

**Concepts of mental illness**

It sounded a good idea: 4½ hours' worth of video culled from a 1989 conference in Newcastle-upon-Tyne at which central issues to the aetiological understanding of the psychoses were discussed, such as the one-disease-or-two debate. Most of the major British figures with data and/or opinions in this field were there – including Crow, Hirsch, Kendell, Murray and Roth; we were even promised (apologetically) by Rawnsley in his introduction that proceedings would be dialectical if not adversarial – always a good way to bring out the crucial points of agreement and disagreement.

However, from the evidence of the 30 minute sampler tape, this potential has not been fulfilled. Either the conference turned out to be an unremarkable event at which well-known positions were merely restated, or else the brief clips shown here manage to miss entirely the essence of each talk and the lively debate and repartee which may have followed. The fact that more than one speaker begins with it's-been-a-long-day or how-tired-everyone-must-be does not suggest that the viewer would sit riveted through the uncut version.

Based upon these excerpts, 4½ hours could be more productively spent by reading about the issues from the recent reviews which most of the participants have written.

PAUL HARRISON

## *Tape details*

| **Ratings** | **audience** |
|---|---|
| *** highly recommended | P psychiatrists |
| ** recommented | M multidisciplinary |
| * worthing looking at | UG undergraduate |
| 0 no rating | PG postgraduate |

*Post Traumatic Stress Disorder*

| | |
|---|---|
| Production: | Turnip Video |
| Distributor: | Turnip Video, 193 Queen's Road, Wimbledon, London SW19 8NX |
| Details: | Video; 33 mins; 1991. £20. |
| Rating/audience: | **, M, UG and PG |

*Concepts of Mental Disorder*

| | |
|---|---|
| Production: | Audio Visual Centre Newcastle upon Tyne |
| Distributor: | Audio Visual Centre, University of Newcastle upon Tyne, The Medical School, Framlington Place, Newcastle upon Tyne NE2 4HH |
| Details: | 3 Video tapes totalling 4½ hours; 1991. £150+VAT. 30 min preview tape available on free loan |
| Rating/audience: | 0, P, PG. |

https://doi.org/10.1192/pb.15.11.717 Published online by Cambridge University Press