Heart, Ron Zaczek, has also written his own account of a "veteran's triumph over combat trauma" in his book titled *Farewell Darkness.* Zaczek tells us in the opening chapter who he is: "I was a goddamned combat Marine crewchief! I saw as much bad shit as anyone and definitely more than any goddamned Saigon Warrior or Da Nang rear-echelon motherfucker. . . . My identity had been forged during the twelve months, 28 days, and two years of my war, and none of the labels I'd earned thereafter mattered."

The structure of Zaczek's book is the recounting of his Vietnam experiences to his therapist at a Vet Center. Because he describes his struggles in Vietnam in graphic detail, this book is not for the faint-hearted. For instance, "Marines as well as North Vietnamese are stacked heel-to-heel, head-to-toe, head-to-head, to shield the living against the firing and shrapnel that graze the ridge. . . . Their uniforms are punctured by bullets, shredded by shrapnel, but the pink flesh and the black flesh and the yellow flesh can no longer bleed." If one ever had doubts about why Vietnam veterans suffered posttraumatic stress disorder, Zaczek's war remembrances will dispell them rather quickly.

The book provides, if anything, too much detail about Vietnam for readers who are mainly interested in the psychotherapeutic process for combat trauma and posttraumatic stress disorder. The healing process is well portrayed, and perhaps it is to the author's credit that he does not back away from recounting his war experiences in detail so that the therapeutic process can become truly understandable for those who never served in Vietnam. Zaczek informs us, "I am inside the story, both as me and as me watching me, and I am strangely comfortable there. It is my element. But I am frightened."

Farewell Darkness is filled with pithy, on-point insights about the Vietnam War and why it induced trauma. For example, Zaczek says, "Something they never tell you, when you learn to kill the enemy, is that the enemy is only the enemy during the killing." Or, "Trying to separate Vietnam from your life is like trying to strip colors from a rainbow. If you were ever successful, whatever you had left certainly wouldn't be a rainbow."

This book can be recommended for anybody who wants to understand the interactions between horrendous trauma, posttraumatic stress disorder, and the psychotherapeutic process. For those who want to learn about the treatment of Vietnam veterans, but without the combat details, this is not the book.

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Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, and Educators

edited by B. Hudnall Stamm, Ph.D.; Lutherville, Maryland, Sidran Press, 280 pages, $18.95 paperbound

Malkah T. Notman, M.D.

Newspaper reports of rescue attempts after a recent airline crash described the distress of the rescue workers, who often had to stop their work because of their feelings when finding personal effects or body parts of the victims. Years ago, when listening to stories of Holocaust survivors who had come with medical problems to the hospital where I was a resident, I felt recurrently overwhelmed by the horror of what was described and the helplessness of the survivors.

In the past these reactions were not systematically recognized as responses to trauma. They are now identified and addressed in the relatively new field of secondary traumatic stress, defined as the effects on those witnessing trauma, hearing about trauma, or treating trauma victims. It includes the effects on family members as well as on therapists. *Secondary Traumatic Stress* is a collection of papers on various aspects of the subject, part of a growing literature in this area. All the invited contributors have experience and expertise in the field.

Recognition of secondary trauma as an important consequence of trauma is supported by the revision for *DSM-IV* of the definition of posttraumatic stress disorder (and the definition of the new category of acute stress disorder) that a person "experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others." The second element of the definition is that "the person's response involved intense fear, helplessness, or horror." The editor of this volume believes this definition marks a shift of focus to "the interaction between the person and the event," with expansion of concern to the caregiver as well as the victim.

The papers in this book are divided into four sections. Part 1, Setting the Stage, opens with a chapter on "compassion fatigue" by Figley, who introduced this term and is known for his work in the field. He presents a broad outline of the potential effects of trauma and the concepts of secondary traumatic stress and stress disorder, and he describes the effects of secondary trauma on the caregiver. The following two chapters review research on the emotional costs of doing trauma work.

Part 2, called Therapist Self-Care Models, contains three chapters proposing and describing ways of creating nurturant, supportive, and safe environments for therapists on an individual and group and community basis. The authors draw on the experience of two clinics known for employee-supportive programs. A par-

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ticularly useful point made in a number of the chapters is that individuals who do trauma work are often self-selected from among people with trauma histories. The ways in which their histories can affect classroom teaching and training programs, as well as strategies for responding to these issues, are described in part 3, called Beyond the Therapy Room.

A description in part 3 of an "Arctic community-based approach to trauma" is a sensitive and sophisticated account of an Alaska native community. It addresses the complexity of developing a community health program using native paraprofessionals, trained at a regional center to provide primary health care under the distant supervision of a physician. The problems posed by the multiple roles of these paraprofessionals and the approaches to dealing with them are applicable to many communities in less remote settings. One wonders about similar experiences of the "barefoot doctors" in China.

The final section, Ethical Issues in Self-Care, discusses a range of concerns involving the necessity to warn potential therapists of the risks of trauma work as well as larger philosophical issues of the prevalence of trauma and violence and the social changes needed to diminish them.

The book calls attention to the very important wide-ranging impact of trauma and the effects on the therapist and caretaker of work involving high degrees of distress and extreme situations. The papers vary in sophistication and in complexity, as one might expect in any collection. Sometimes the formulations are presented in an oversimplified manner. The concept of trauma seems to encompass everything without attention to variation in the nature of the trauma or in the meaning of the experience to the individual. The concept of countertransference is often not clearly addressed or understood. The chapter on "Communication and Self-Care: Foundational Issues" is perhaps the weakest and most limited in the book.

However, on the whole *Secondary Trauma* is a very valuable book for all clinicians and health planners, alerting them to the important problem of secondary trauma and offering the considerable experience of the contributors in developing solutions.

Management of Violence and Aggression in Health Care

edited by Brian Kidd, M.R.C.Psych., and Cameron Stark, M.P.H., M.R.C.Psych.; London, Gaskell (Royal College of Psychiatrists), 1995, 185 pages; distributed by American Psychiatric Press, $28.50 paperbound

Harold Carmel, M.D.

In a perfect world, a mental health organization would regularly train its clinical staff in verbal, as well as physical, means of de-escalating patient aggression. In a perfect world, staff would effectively contain episodes of aggression as they start to develop. In a perfect world, staff injured by patient aggression would be debriefed with care, and the psychological sequelae would be well managed. We do not live in a perfect world.

In the United States, the mental health professions are becoming more aware of the issues surrounding patient aggression (1). Yet it is safe to say that American practice de-emphasizes some aspects—for example, staff debriefing after violent episodes—in favor of other important priorities. These priorities are understandable and supportable, but they do carry their price. One may be a phenomenon that we are beginning to understand, the extent to which unresolved reactions to aggression experienced by staff lead to chronic disorders (2) that resonate in the working environment of a treatment unit. These reactions may contribute to staff behavior that unintentionally promotes aggression.

Comes now this volume from the United Kingdom. It helps to reflect on a shared problem from the perspective of a different culture. Reading this interesting book, I was struck by its greater emphasis, compared with an American text, on verbal de-escalation of aggressive behavior and on postincident care and support for assaulted staff. In contrast, issues of medical management and physical restraint are given less emphasis.

I suspect that American readers, if they are Anglophiles, will be bemused by the different legal and medical practices described in some of the chapters, but will find little there to challenge current standard practices in the United States. Much more valuable are the chapter on "Interviewing the Aggressive Client" by Jeremy Coid, the model of "De-escalating Aggressive Behaviour" presented by David Leadbetter and Brodie Paterson, and Erica Robb's chapter on "Post-Incident Care and Support for Assaulted Staff."

I finished this book with a greater appreciation of the need for a comprehensive approach to patient aggression. This approach would incorporate attention to the patient (proper diagnosis and treatment, verbal de-escalation, and, as indicated, physical intervention), to the staff (proper training in verbal and physical techniques, attention to the work atmosphere, debriefing after violent incidents and proper care for assaulted staff), and to the organization (organizational, often financial, support for the above). The British, it seems, pay more attention to some of these things than we do. We should attend to them also.

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