The rapid expansion of and growing interest in motivational interviewing across different aspects of mental health problems has been dramatic. This book of expert contributions co-edited by William Miller, the originator of motivational interviewing, is a very welcome text. It looks at the use of motivational interviewing in anxiety disorders, post-traumatic stress disorders, depression, suicide, eating disorders, gambling disorders, medication adherence, and other aspects of psychosis. The chapters are structured in a very readable fashion, providing a basic introduction and rationale to how and why motivational interviewing might be used in combination with existing approaches. A range of clinical examples are used to discuss and highlight specific points and these clinical cases provide a good discussion of the key messages in the chapters. The research evidence for efficacy is presented, with a clear, critical and well-informed approach and recognition of the limits of the existing evidence.

Motivational interviewing is a complex and subtle intervention, a mixture of art and science. The terminology used is that of developing empathy and the core is very much inspired by Rogerian non-directive approaches. However, motivational interviewing is slightly different in that it recognises ambivalence and resistance to change and aims to develop a reflective listening approach that actively promotes change within the individual.

Working with ambivalence and resistance to change is at the heart of many day-to-day clinical problems. Developing skills that enable doctors to structure their responses to such clinical challenges is welcome and in theory should readily integrate with the broader range of interventions.

The chapter on eating disorders is a very fine example of the application of motivational interviewing. The authors report that it has been a hit with both staff and patients and that it has been readily incorporated into the broader management strategy of anorexia. They present some data on randomised controlled trials and comment that motivational interviewing has a place across most aspects of eating disorders but the evidence is currently the strongest for anorexia.

I suppose the question that arises is how specific the treatment is that can be applied across a wide range of disorders and integrated with other forms of interventions. Is this simply improving the communication skills and the capacity for understanding, empathy and connectedness that should be at the heart of any talking therapy? The skills used are those of decent therapists and likely to have been used without articulation in many settings before the concept of motivational interviewing was formulated.

However, despite such commentary, this book outlines some clear and convincing evidence that the present-day eclectic therapist would do well to pay some attention to the possibility of incorporating motivational interviewing skills into their toolkit. Motivational interviewing would appear to be a useful adjunct for engaging people who are having difficulty in following established interventions and could be used to effect a better adherence to other talking therapies and medications.

The overall tone of this book is modest, self-critical and illuminative. It should be of major value to trainees who are looking for effective and humane interventions that fit into the mix of interventions delivered in day-to-day mental health services. I highly recommend this book to all clinicians.

This book charges current psychiatric practice with overdiagnosis of major depressive disorder, by including ‘normal’ reactions to losses. The authors note that big pharmaceutical companies have much to gain from casting the diagnostic net wide, and that sales losses. The authors note that big pharmaceutical companies have much to gain from casting the diagnostic net wide, and that sales are going up. They identify one, or the chief, culprit as the move in the Diagnostic and Statistical Manual of Mental Disorders (DSM) to descriptions of symptoms and syndromes regardless of context. The upshot, they argue, is that mood and behaviour may satisfy the DSM criteria for major depressive disorder even though they are not normal responses to a significant loss (including, but not only, bereavement).

Clearly a lot – everything – hangs on how the authors differentiate ‘normal’ sorrow from ‘genuine mood pathology’. Their proposal is that normal sorrow has three features, in brief: (a) it has an appropriate object, i.e. loss; (b) its intensity is proportionate to the extent of loss; and (c) it fades as normal adjustment recovery mechanisms come into play. Pathology is then indicated by failure of one or more of these conditions. According to the authors, this way of differentiating normal sorrow from depressive disorder follows from Wakefield’s influential evolutionary
theoretical conceptualisation of mental disorder. I doubt this, but in any case the main implication is that diagnosis of genuine depressive pathology would have to establish whether the individual with symptoms was reacting to a loss in a proportionate way and for about the right length of time. This, as Robert L. Spitzer notes in his foreword, would present serious challenges to the reliability of diagnosis.

However, there are other problems with the authors’ approach. The DSM’s conceptualisation of mental disorder assigns primary importance to distress, disability or risk thereof; these in turn are connected, of course, to perceived need to treat (or to wait watching). In this context of (unmanageable) distress, downturn in functioning or risk, it is questionable whether the normality of mood – in the sense of understandable in relation to context – plays a critical role. We may well be able to understand, somewhat or well enough, why a single parent with little social support and a history of significant losses should become depressed, with distress and disability. Why should they, nevertheless, not be offered treatment? So far as I can see, clinicians have little use for the distinction between normal and abnormal depression except in the sense that normal may be used to mean: self-limiting, unlikely to carry risk, and no need to treat. Contextualising is less the issue: harm, risk and need to treat are.

The issue identified by the authors – increase of pathologising and prescribing – is serious and current; and they make clear one key possible diagnosis, that the limits of pathology are being illegitimately stretched. The authors are expert in this position and their book is essential reading for anyone concerned with these problems. This remains so even if there are differentials, for example that methods of detection have improved, and/or that there is no lower limit on the extent of distress and disability that we will take to the clinic in hope of help, especially if encouraged, for instance by direct-to-consumer advertising.

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This book is both a comprehensive introduction to empirical bioethics and an exploration of familiar problems in psychiatric ethics. However, despite the common goal shared by all contributors, there is a wide variety of views on how the ethical and the empirical should be combined.

This thoughtful and varied collection should appeal to practitioners primarily interested in psychiatric ethics, as well as those who are interested in the theory and practice of empirical ethics. Having just been tasked with developing a course on empirical bioethics, it comes as a great relief to find a book to which I can refer students; one that captures so well the conceptual tools to begin to critically examine the chapters that follow.

This book sets out to give a detailed account of the subtypes of obsessive-compulsive disorder and to consider whether there exists a spectrum of such disorders. The subtypes presented in Part I include those that will be familiar to most, such as fears of contamination, checking and unacceptable obsessive thoughts, and others like scrupulosity that may be less known. Each chapter...
‘Books’, says Wessely, ‘are not very important for us’ (‘And now the book reviews’, British Journal of Psychiatry 2000; 177, 388–89). For once he is wrong. This is the fourth edition of what has become a standard American text, well nearly so – the chapters by Tarrier and by Fairburn, Cooper and Shafran keep the UK on the map. Barlow begins by extolling the virtues of evidence-based practice but for once he is only partly right. He discusses psychological therapies (cognitive–behavioural therapy plus variants) for the common mental disorders – anxiety, mood and substance use disorders, psychosis, eating, sex and borderline personality disorders, couple distress – but a chapter on generalised anxiety disorder is missing. Most chapters do review the available evidence and define the evidence base but the strength of this very good book is the depth of clinical advice. The authors have considerable clinical experience and publish therapy plans and transcripts of ‘who says what to whom’ to prove it.

I direct a service that provides cognitive–behavioural therapy for people with anxiety and depressive disorders. We treat 1000 new patients a year, face-to-face or via the internet, and so should be blase’ about the first half of the book that deals with these disorders. I’m not. I am about to photocopy chapters to give to my staff who work with the relevant patient groups. It is that good. The opening chapter on panic/agoraphobia is a masterpiece and the chapter that describes a unified protocol for the treatment of emotional disorders is exploring what we all know to be true – the anxiety and depressive disorders are frequently comorbid and we need therapy models for such individuals. There are three chapters on the psychological treatment of depression, which is appropriate given that the burden is large and current initiatives do not seem to be reducing it.

The second half of the book deals with psychotherapy for the functional psychoses, borderline personality disorder and substance use disorders. All chapters are useful but for me the chapters on borderline disorder and alcohol use disorders suddenly made explicit how one might actually treat a patient with these disorders in a way that endless research reports have not done. For eating disorders the author attempts a trans-diagnostic approach with a unified programme for anorexia, bulimia and eating disorders not otherwise specified, which seems eminently sensible to this ignorant reviewer.

In short, it is a great resource for psychotherapists. All staff should have a copy.

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The preface suggests that this book is aimed at students, researchers and practitioners. Given the significant slant towards psychology, it is more likely to appeal to practitioners in this area, although doctors in training may find some of the vignettes useful. I was not convinced that all the disorders could be included within the obsessive–compulsive spectrum, but the authors gave balanced arguments throughout and acknowledge the lack of clinical evidence available to them.

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Clinical Handbook of Psychological Disorders: a Step-By-Step Treatment Manual (4th edn)

Polarities of Experience: Relatedness and Self-Definition in Personality Development, Psychopathology and the Therapeutic Process

It is a daunting task to be set to review a book that marks the culmination of over 50 years of study, research and writing in the field of personality development and psychopathology. Professor Blatt has written extensively in this field and has moved with the times, incorporating the latest thinking and research from...
across the globe into his work. Recently, this includes the increasingly large contribution of research studies exploring attachment theory and its implications for childhood and adult development.

For those wishing to keep up to date with research highly relevant to clinical practice, the book is a one-stop-shop that allows the reader to become conversant with attachment theory research, discussed in the initial chapters. For those who are willing and able to invest more time and thought into the implications of Professor Blatt’s book, they are unlikely to be disappointed. Peter Fonagy asserts in his foreword that Blatt’s work represents ‘the first comprehensive integrated model of personality development and could provide the foundation for the developmental psychopathology of the future.’ No doubt some would contest this statement, but none the less this publication certainly represents a milestone in the integration of clinical experience, theorising and research from the psychodynamic school.

Blatt’s thesis is essentially that although it has been recognised for decades that personality development appears to hold a tension between relatedness and self-definition (the desire/drive/need to be close to others physically, emotionally and cognitively and the desire/drive/need to be separate and ‘individuate’), what has not been fully recognised is the absolute interdependence of these processes.

Blatt takes as his springboard concepts such as the ‘dialectical spiral or helix’ to describe the way in which the infant’s capacity to relate to itself and others gradually develops from its experiences of physical and psychological attunement and autonomy. From there he interweaves research on primates, which has similarly found their social organisation and behaviour to inhabit ‘agonic’ and ‘hedonic’ modes, narrative research identifying themes of ‘intimacy’ and ‘power’, and psychodynamic theory that has identified a tension between ‘competition and success’ and ‘brotherly love and humility’. On this basis, Blatt proposes a ‘dynamic structural developmental approach’ that views psychopathology as arising from an imbalance in these facets of development.

The book stands alongside such classics as Erich Fromm’s The Fear of Freedom (1942) in its contemporary relevance and originality of thought. However, it is unique in its scholarly richness and comprehensive integration of the research across psychology, psychiatry, psychodynamic theory, social anthropology and neuroscience, to name a few of the academic fields from which Blatt draws. One aspect of psychological thought notably absent from the book was any reference to systems theory or a nod in the direction of understanding how individuals in society seem to present in a ‘pathological’ way not simply due to their development in their proximal social systems (families) but also over time due to how, once pathologised, their behaviour is influenced by society’s response to their new identity. The elusive concept of ‘power’ was conspicuous by its absence, yet we know the role that poverty and social disadvantage play in incidence of those identified with mental illness.

Of particular interest to me was the challenge Professor Blatt’s work represents to current diagnostic systems. He sets out a convincing rejection of the current psychiatric nosology in favour of a classification system that can hold itself up to scientific scrutiny and is based on valid concepts. For a clinician who has spent many years attempting to help individuals diagnosed with ‘schizophrenia’ (which can sometimes mean ‘drug-induced psychosis’ or be an indicator of neurological damage as a result of a head injury, or refer to hearing voices following severe and ongoing trauma, or hide Asperger’s syndrome and so on, but for which there is no evidence of a biological brain ‘disease’ as

is so often misunderstood by those we work with) this is a breath of fresh, logical air. I can see Professor Blatt and the now retired Professor Mary Boyle (author of Schizophrenia: A Scientific Delusion? Routledge: 2002) exchanging thoughts on this topic. However, whether Professor Blatt’s meisterwerk, despite its vast expertise, will be able to move the mountain of the DSM–IV–TR or the ICD–10, I have grave doubts given the market forces which pull in the other direction.
Act and the concerns of their effect on civil liberties resulting in the shelving of these proposals.

The role of medication, the side-effects and benefits are explained, again though with an assumption that most individuals adhere to treatment regime. Neat and tidy, if the person can be relied upon to keep a treatment diary – many cannot.

There are useful chapters on the place of the carer and the need for balance in responsibility to ensure a carer’s own wellbeing. It is wonderful to read that blame for the illness of a loved one should not be shouldered – easier said than done.

The ability of an individual to access the correct benefits and allowances makes all the difference between living an independent and dignified life and one that is not so ‘privileged’, therefore the comprehensive chapter on these issues is invaluable and places this book ahead of many others for practical help.

To sum up, a lot of information is contained in this concise book, which makes it a valuable reference, particularly for people confronted with a shocking diagnosis of schizophrenia for the first time.

Would you accept: (a) a handshake, (b) a lift, (c) a drink from a patient? Perhaps in a multiple-choice ethics examination you might avoid giving the impression that you were embarking on the famous ‘slippery slope’. In real life, you might be somewhat puzzled at these situations having become apparently ‘problematised’. Yet this is apparently the case for psychiatrists in the USA, following the extensive focus on boundary violations, with sexual misconduct being the most serious. In the view of the authors, the concept of the slippery slope has given rise to extensive constraints and fear of legal action or professional complaints, deriving more from overzealous risk management than the good of the patient.

Gutheil & Brodsky derive their thinking and material from hours of discussion over many years at the Program in Psychiatry and the Law at Harvard Medical School. Their expertise is evident. The chapter on self-disclosure is particularly helpful in inducing reflection and considering wider options than in Britain, where they tend to range only from ‘disclose nothing personal under any circumstances’ to non-discussion and personal idiosyncrasy.

Psychiatrists, used to asking the questions, may be taken aback by a more ‘equal’ approach and being asked ‘Tell me, doctor, are you gay?’ or ‘Do you find me sexually attractive?’, though ‘Do you have children?’ is not uncommon. Sometimes, honesty and straightforwardness is best, sometimes asserting that the question is ‘not part of therapy’, sometimes reversing the question by replying, for instance, ‘What would it mean to you if I did find you sexually attractive, or if I did not?’. The ethical standard recommended is that the response should be for the benefit of the patient.

Encounters in the community may be tricky. Therapists are advised that attending a patient’s funeral is usually all right, as it may be appreciated by the bereaved family. On the other hand, attending a wedding has potential pitfalls – one might be asked to dance with one’s patient or be perceived as trying to drum up custom on the basis of success.

Gutheil & Brodsky are clearly most used to transference-based analytic work in private office practice and their references to community and hospital psychiatry or other forms of therapy are brief and artificial, though an attempt is made. In the UK we have been slow to realise the extent of professional abuse of patients and give serious consideration to boundary issues, yet it is evident that remedies will depend so much on context that books such as this one almost require translation.

Synaesthesia is a fascinating phenomenon (or group of phenomena) in which stimulation of one sensory modality apparently leads to sensory experience in another modality (e.g. sounds producing visual experience of colour, as in the example that gives this book its name), but it has often been seen as a diverting curiosity rather than a subject deserving serious scientific study. In recent years this situation has changed and synaesthesia has attracted the attention of prominent psychologists and neuroscientists. Jamie Ward, a senior research psychologist at the University of Sussex, has emerged as one of the leading experts in the field, and has now written this short but compelling book, the first full-length ‘popular science’ treatment of the topic.
Ward begins with an entertaining survey of historical reports, before reviewing more recent work aimed at the elucidation of the mechanisms underlying synaesthetic experiences and the implications of this research for our understanding of sensory processes and perceptual awareness. The closing chapter is more speculative, as he ponders far-reaching questions around evolutionary psychology, language development and the structure of memory. These ideas are firmly rooted in what has gone before and do not feel contrived or excessive. Along the way, an extraordinary amount of work from experimental psychology and other disciplines (e.g. anthropology and linguistics) is used to bolster and illuminate the key arguments. Ward has mastered the art of popular science writing: the style is engaging and accessible throughout, and there is a coherent narrative flow as the ideas are developed. Those who have become wary of popular treatments of neuroscience will be gratified by the clarity of the author’s thinking, which avoids or cuts through the simplistic reductionism and other conceptual confusions that often mar books on the brain. My only criticism is that the discussions of neuroanatomy might have benefited from being supplemented with simple schematic illustrations, but this is a minor point. The extensive notes and references (happily these are included at the end, rather than sprinkled all over the text) enable readers to explore further should they wish.

This is not a book about mental illness (as Ward stresses, there is no reason to view synaesthesia as a deficit or a diagnosis), but nevertheless it deserves a wide readership among psychiatrists. It is highly recommended to anyone with an interest in the science of conscious experience – a category that surely includes readers of this Journal.

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