

Book Reviews

The Conscious Mind. By D. Chalmers. (Pp. 414; \$14.95.) Oxford University Press: Oxford. 1996.

This important book presents a well-argued and sophisticated exposition of a property dualist theory of consciousness written by a philosopher with a background in mathematics and computer science. Materialists believe that the events we experience in consciousness are simply events in our brains. A substance dualist holds that events in consciousness are a different series of events from their correlated brain events – something extra – and that the link between them is causal rather than one of identity. A property dualist tries to have the best of both worlds and suggests that events in consciousness that we experience and the brain events described by neuroscientists really are both brain events but represent different properties, or aspects, of them.

Chalmers appropriately starts off with a catalogue of conscious experiences. I say ‘appropriately’ because he does not attempt to *define* consciousness – a procedure that Crick (1994) has warned us against – but describes it and its contents. He then delineates two senses of ‘consciousness’ – the phenomenal (our experiences) and the psychological (‘access to some information which can be used to control behaviour’). He says the latter presents no deep problems for cognitive science but the former does. He argues against the attempt to ‘explain’ consciousness merely by discovering its neural basis: ‘Neurobiological approaches... can also tell us something about the brain processes that are correlated with consciousness. But none of these accounts explains the correlation: we are not told why brain processes should give rise to experience at all. From the point of view of neuroscience, the correlation is simply a brute fact... the problem of consciousness goes beyond any problem about the explanation of structure and function, so a new sort of explanation is needed’ (p. 115). And again ‘Once we have explained all the physical structure in the vicinity

of the brain, and we have explained how all the various brain functions are performed, there is a sort of explanandum: consciousness itself. Why should all this structure and function give rise to experience? The story about the physical process does not say’ (p. 107). Freddie Ayer said much the same in 1950. He pointed out that, if there are two sets of events *a* and *b* and you want to find the relation between *a* and *b*, it is not sufficient merely to accumulate data about *a*, or about *b*. You have to come up with a theory that relates *a* and *b*. Ayer concludes ‘If what we are seeking is a bridge across a seemingly impassable river it will not help us merely to elevate one of its banks.’ As Gray (1992) has suggested, the problem of consciousness will only be solved by a theory that specifies, in scientific terms, what the relation is between the events that we experience in consciousness, that form the field of study of introspectionist psychology, and the events in the conscious-related neurons, as studied by neurophysiologists. If Ayer and Gray are right, it will not be solved by any theory that simply describes in ever more fascinating detail events in the neurons themselves, or how these events affect the behaviour of the organism. Any viable theory of consciousness simply cannot ignore the (phenomenal) events in a person’s consciousness.

After his description of the contents of consciousness he accepts the validity of introspection: ‘When I introspect, I find [as did David Hume] sensations, experiences of pain and emotions, and all sorts of other accouterments’ (p. 189). He also recognizes that (some of) the events in consciousness (e.g. those in the visual field) have a detailed internal structure and geometry: ‘An individual’s conscious experience is not in general a homogenous blob: it has a detailed internal structure’ (p. 223). As examples of this he gives, in the case of vision, stripes, squares, triangles and cubes as well as the geometry of depths.

However, instead of following up on this important and promising insight, he proceeds to place much stress on the need to develop

psychophysical laws that will specify how phenomenal properties depend on physical events in the brain. These psychophysical laws, he says, must not interfere with physical laws because physics is a causally closed system and there is no room for any 'ghost in the machine'. But he admits that at present we have very little idea of what these psychophysical laws might be like.

He then embarks on a series of philosophical 'thought-experiments' dealing with such themes as the possibility of zombies (people physically exactly like us but lacking conscious experiences), the inverted spectrum, absent qualia, inverted qualia, dancing qualia, etc. as well as Mary the superneuroscientist who has achromatic vision. Although Mary knows all there is to know about the physiology of colour vision, she does not know, it is claimed, what colours really are as she has never experienced any, except black and white.

The problem with this book is that Chalmers fails to understand the nature of two scientific disciplines – introspectionist psychology and psychophysics. The way to find out about consciousness is not to get immersed in philosophical thought experiments but to study the structure and function of e.g. our sensory fields as introspectionist psychologists do.

I feel this problem arises because Chalmers has not got a clear idea of how perception works as a whole. When he talks about 'experience', in the context of the *very basis* of consciousness, it is not clear if we are supposed to experience external objects (as phenomenal Direct Realist philosophers mistakenly believe) or our own sensations (as the rival scientific Representative Theory correctly holds to be the case). Until this point is settled we are not likely to get far with any theory of consciousness.

He also fails to be consistent about the difference between 'consciousness' (my *experiencing* X) and the 'content of consciousness' (X itself – *what* I experience). Having said that 'consciousness [i.e. X] has a detailed internal geometrical structure' he later says '...consciousness [now my experience of X] is not directly observable in experimental contexts; we cannot simply run experiments measuring the experiences that are associated with various physical processes, thereby confirming or

disconfirming various psychophysical hypotheses' (p. 215). If consciousness is not directly observable how does he know it has a detailed internal geometrical structure? Also experiments of the kind he says are impossible are carried out in psychophysics every day especially those conducted using various neuroimaging techniques (where X is measured, not, of course, our experience of X). However, what we need are the properties of X and we do not have to worry about what our experience of X amounts to.

In order to study consciousness scientifically we do not have to get bogged down in unanswerable metaphysical questions about 'qualia' (this is a dreadful buzz word that infests the pages of current philosophical treatises on consciousness: 'sensation' is much better), i.e. *what it is like* to experience something, or what is the essential nature of a colour. We simply have to observe e.g. the visual field and its contents, note their properties (especially their spatio-temporal properties) and relate these properties to what is going on in the brain at the same time. The appropriate relationships here are geometrical and topological as I have argued elsewhere (Smythies, 1994).

Chalmers claims that '...the cornerstone of a theory of consciousness will be a set of *psychophysical* laws governing the relationship between consciousness and physical systems' (p. 215). However, these laws do not form a *cornerstone*; they form part of the *superstructure* of a theory of consciousness. The real cornerstone is an accurate and comprehensive account of the natural phenomena of consciousness – our sensory and image fields and their contents – obtained by the scientific methods of introspectionist psychology.

Chalmers suggests that an account of the physical basis of consciousness can help in understanding the structure of consciousness: '...the patterns of similarity and difference between experiences, the geometric structure of the visual field and so on' (p. 107); and again '...the study of topographic maps in the visual cortex helps shed light on the structure of the phenomenal visual field...'. However, as Lord Brain recognized, this cannot be done. The intrinsic geometrical structure of the visual field is not isomorphic with the intrinsic geometrical structure of what is going on in the visual brain.

Hence the two cannot be identical. In order to discover the actual geometry of the visual field it is necessary to study the visual field itself as psychologists such as French have done. Of course a study of what is going on in the visual cortex will give us fascinating *correlates* of what is going on in the visual field – but that is all. It will not tell us anything about the geometry of the visual field. The fact that it cannot may be illustrated as follows. If we state that the events in my visual field are identical with events in my visual brain, then, since ‘identity’ is a symmetrical relationship (if *a* is identical with *b* then *b* is identical with *a*), and since I can gain valid data by introspection, then the structural data I collect by introspection of the content of my visual field (e.g. that a certain after-image is squarish in shape) will *ipso facto* give me information about the structure (neuroanatomy) of my visual brain – which is clearly not the case.

There is no deep metaphysical mystery here – it is merely a part of the logic of all representative mechanisms (such as television). The electromagnetic waves carrying the TV signal have a certain intrinsic structure. The events deep in my TV set have a different yet correlated structure (they carry the same information). The events on my TV screen have yet a different but still correlated structure, which yields a picture of the events in the TV studio. This is what the whole set-up was designed to do. The same information is carried at all levels but in different structural forms. Likewise the information content in my visual brain (expressed as a vector code) and in my visual field (expressed as a topographic code) is (more or less) the same. It is the geometrical structure that is different. Little more than this simple fact is involved in the relationship between consciousness and brain events.

Chalmers does not mention Niels Bohr’s sophisticated form of property dualism in which conscious events are held to be complementary, not identical, to brain events, just as the particle and wave accounts of an electron are complementary. Moreover, the only form of substance dualism that he discusses is the Cartesian variety. In a more modern version of substance dualism the ‘basic laws’ that Chalmers is after, I suggest, may be expressed as follows:

1 Phenomenal events are not identical to brain events. The relationship between them is causal. In the case of vision they represent successive stages of a TV-like representative mechanism.

2 Some phenomenal (mental) events (e.g. visual and somatic sensations and images) are spatio-temporal events (contra Descartes) extended in and located in a space of their own (‘phenomenal space’) topologically ‘outside’ physical space (as has been suggested by the philosophers C. D. Broad and H. H. Price).

3 Physics is currently incomplete because it locates all events in the Universe in a single 4-D space-time manifold (ignoring for the moment Kaluza–Klein theory). To include the spatio-temporally organized events in consciousness within an expanded physics we may need to increase the geometry of space-time to more than four dimensions. Along these lines the physicist Andrei Linde has suggested that consciousness may have its own degrees of freedom as a basic constituent of the Universe on a par with matter and physical space-time. This strategy is similar to that used by Kaluza who united electromagnetism and gravity in a space of five real dimensions.

4 There is no ghost in the machine – just a more extensive machine.

In conclusion, this is an excellent book full of interesting arguments about important topics relevant to psychological medicine, although Chalmers’ criticisms of rival theories are more telling than his own theory. All property dualist theories, however sophisticated, are vulnerable to the criticism that the author wants to have his cake and eat it too (Bohr’s theory is a possible exception). It is simpler to believe that events in consciousness either are brain events or they are not. But today, if we want to explore the latter option, we need to consider more modern forms of substance dualism besides the traditional Cartesian variety.

JOHN SMYTHIES

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Death and Personal Survival: The Evidence for Life after Death. By R. Almeder, (Pp. 285; \$17.95.) Rowman and Littlefield: Lanham, Maryland. 1992.

Most academicians today consider that modern science has shown that the idea that some form of personal existence after the death of the physical body is an exploded myth. This view is not based on a careful study of the parapsychological evidence but arises as a consequence of the belief that science has shown that a consciousness cannot exist without its brain. However, this belief is unwarranted. Modern neuroscience and clinical neuropsychiatry have certainly demonstrated that there is a close and essential link between events in consciousness and events in our brains (just think of what happens in Alzheimer's disease). But it has not shown that this link is one of 'identity': it might just as well be causal, as William James argued many years ago. In other words it has been demonstrated that brain events are *necessary* for consciousness as we know it but not that brain events are both *necessary and sufficient*. We simply have to keep an open mind if we are not going to replace science with dogma.

Robert Almeder – a professional philosopher with an interest in parapsychology – has actually looked at the relevant evidence and has subjected this to a careful scientific as well as philosophical scrutiny. The topics he covers in this book are reincarnation (in particular the comprehensive research of Ian Stevenson in India), apparitions of the dead, possession, out-of-the-body experiences and alleged mediumistic communications from the dead. His method is to present particular research carried out by parapsychologists on these topics, to review the various theories that have been advanced to explain the phenomena and to explore various philosophical aspects.

His conclusion is that this large mass of data cannot simply be ignored. Many reports can of course be dismissed as due to overheated imagination, hoax or fraud. But there remains a residue of carefully investigated cases to which these explanations do not apply as judged by a series of reputable scientists and philosophers

(including William James, Ian Stevenson, C. J. Ducasse, C. D. Broad, H. H. Price, F. W. H. Myers, G. N. M. Tyrrell, Raymond Moody, John Beloff and others). Their judgement in these cases, shared by Almeder, is that survival of bodily death by some portion of a human personality is the most parsimonious explanation of the data. Moreover, the alternative explanations all involve super-ESP and this does not fit in with a materialist theory either.

In conclusion, this is an excellent and scholarly book that should be of interest to psychiatrists, in particular on account of the many fascinating cases described.

JOHN SMYTHIES

Seminars in Liaison Psychiatry. Edited by E. Guthrie and F. Creed. (Pp. 300; £15.00.) Gaskell Press: London. 1996.

Working in a medical setting can be disorientating for psychiatrists. Not only are some of the referrals on medical units very different from those in mental-health settings, but I also suspect that for some of us the sight of white coats and stethoscopes can still trigger flashbacks of careers where survival was partly dependent on emotional denial and 5-minute histories. The need to translate skills acquired from mental health services into this new environment, as well as to learn the new skills required for liaison psychiatry, presents a considerable challenge. Ideally training and supervision in liaison psychiatry should be adequate throughout the country, but despite the Royal College of Physicians and Royal College of Psychiatrists recent report (1995), the increasing crises in community mental health services mean that liaison psychiatry is likely to remain the poor relation in mental health services, propped up by general psychiatrists putting in the occasional session at the local District General Hospital rather than conforming to college recommendations.

Within this context the need for a practical guide on liaison psychiatry is essential. As part of the Royal College of Psychiatrists seminars series, *Liaison Psychiatry* is both clinically and MRCPsych orientated. The clinical emphasis of the book is provided in particular by the many detailed case histories (so detailed I would be

happier to know that patients' consent had been obtained for them to be published!) and thorough chapters on 'Basic Skills' and 'Treatment'. Boxes and tables allow easy use of this book for revision purposes. The editors in the preface state that organic psychiatric syndromes have been well covered elsewhere and that this is not intended to be a comprehensive textbook of liaison psychiatry, so this is not a traditional liaison psychiatry textbook with a systematic review of psychiatric disorders related to organ systems. Instead the book focuses on two areas that are often omitted or dealt with poorly in liaison psychiatry – namely, somatization and psychological reaction to physical illness. Other chapters include an overview of liaison psychiatry, classification of psychiatric disorders related to physical disorders, research in liaison psychiatry and psychiatric disorders leading to physical complications (including deliberate self-harm and substance misuse). There are also two specialist chapters, on paediatric and old age liaison psychiatry. These chapters are all comprehensive although realistically its depth means that it is the type of book one reads while working in a liaison psychiatry setting for several months rather than a book one picks up just before exams. I felt that the chapters on classification, and somatization and somatoform disorders, could have been shorter and occasionally the writing became dualistic rather than systematic, but these are minor quibbles.

Two chapters deserve particular comment. First the 'Basic skills' chapter is excellent in dealing with how to be a psychiatrist in a medical setting. Reading this chapter is certainly worth a few weeks experience on the medical wards. The pitfalls encountered by the 'inexperienced' liaison psychiatrist's case history seemed all too familiar. The second chapter I found extremely useful was 'psychological reactions to physical illness'. Reactions to illness (such as stigma, search for meaning, loss of control, uncertainty about the future, etc.) are not confined to those who suffer physical illness, and mental health professionals would do well to consider these issues in psychiatric settings as much as in medical settings. This chapter remains essential reading for any doctor and should be fundamental to any clinical medical student training.

The editors state that this book is not intended to be a substitute for supervised clinical practice. It is, however, the next best thing, and as a result, I for one will be visiting medical wards with a few less flashbacks, and a bit more sense of purpose.

DAVID PROSSER

REFERENCE

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Treatment of Anxiety Disorders: Clinician's Guide and Patient Manuals. By G. Andrews, R. Crino, C. Hunt, L. Lampe and A. Page. (Pp. 423; £23.95 pb, £65.00 hb.) Cambridge University Press: Cambridge. 1994.

Cognitive Therapy for Depression and Anxiety. By I. M. Blackburn and K. Davidson. (Pp. 228; £17.99.) Blackwell Science: Oxford. 1996.

While we cannot learn to drive by reading a book, texts can tell us a great deal about what vehicle to select and what model might suit us most. A textbook can also make good clinical practice explicit. These books share the common goal of trying to describe the art rather than the science of psychotherapy. Both do this well but, at the same time, the authors all acknowledge that books alone will not ensure that their readers develop the skills required to treat depression or anxiety disorders.

Blackburn and Davidson's book is now in its second edition. It is an excellent clinical guide to the use of cognitive therapy for both depression and anxiety disorders. I was particularly impressed by the layout of this book. Key words are listed in the margins throughout the text so that it is easy to find information about specific topics or techniques. The style of writing is very accessible and all standard cognitive and behavioural techniques are covered very well. In addition, this is a textbook to be enjoyed by clinicians. Blackburn and Davidson draw on their considerable clinical expertise and illustrate specific topics by including extracts of patient/therapist dialogue and interactions. Again, this is useful to novice and experienced therapists alike.

The only slight weakness of this book, is that

perhaps not enough space is given to a discussion of conceptualization. This area is important, particularly for clinicians who are new to cognitive therapy. In the end, the use of conceptualization differentiates cognitive therapists from people who use cognitive and behavioural techniques. However, the section on assessment of clients for cognitive therapy is otherwise very comprehensive and helpful.

Blackburn and Davidson's text is a valuable addition to the bookshelf of anyone who would like to practise cognitive therapy. It should certainly be available to mental health professionals from a variety of disciplines, particularly psychology and psychiatry. In addition, undergraduate students in medicine and psychology, and indeed more experienced post-graduate clinicians who wish to learn something about cognitive therapy, would be strongly recommended to read a copy of this text.

Gavin Andrews and colleagues have produced a text that focuses specifically on anxiety disorders. The particular strength of this book is that it serves a dual purpose. As well as providing a more conventional clinician's guide to anxiety disorders with chapters on aetiology and treatment approaches, it also includes patient manuals that can be offered to clinic attenders. This approach is increasingly practised in the United States where experts in particular clinical areas produce a therapist manual and then waive the copyright on manuals of handouts that can be used by the patients. This is obviously very helpful to clinicians as it offers the option of systematically pursuing a particular line of treatment.

In a textbook that tries to cover the treatment of all anxiety disorders, there are bound to be some sections that are stronger than others. Information on post-traumatic stress disorder and adjustment disorder is rather limited, and no patient manuals are provided. Indeed, the last few chapters do feel as if they are added as an after-thought. Having said that, other sections, such as those on panic disorder and agoraphobia, are very informative. The book was first published in 1994, and some areas of the text would benefit from updating. For example, certain aspects of the work on social phobia have now moved on quite considerably and new information is available on obsessive compulsive disorders.

The book is built largely around the patient manuals. I was concerned that the reading material for clients is quite sophisticated. Recent guidelines produced in Britain suggest that we should aim our written materials at a reading age of 7–11 years. Most of the manuals in this textbook, would certainly be aimed at a more educated patient population. However, the richness of the patient material should not be underestimated. The clinicians' guides are comprehensive, offering overviews of drug treatments and psychological therapies. The interventions described mainly focus on cognitive models and in this respect this textbook would obviously compete with many other similar books produced by authors in the United States and Great Britain. This book would be valuable to clinicians as it does try to identify and discuss issues relating to therapeutic style. Perhaps more space could have been given to barriers to progress in therapy, but in general there is a sound attempt to cover process issues which clinicians trying these approaches will appreciate.

In summary, Andrews *et al.* have produced a sound and useful textbook that combines a conventional approach to the discussion of aetiology and treatment with a more adventurous approach in terms of the publication of patient treatment manuals. Clinicians working in the field of anxiety disorders will certainly want to consider buying their own copy of this text. I would also anticipate that most libraries should have copies available for both medical and psychology postgraduates and undergraduates.

JAN SCOTT

Multiaxial Classification of Child and Adolescent Psychiatric Disorders. By the World Health Organization (Pp. 302; £40.00.) Cambridge University Press: Cambridge. 1997.

This book will be indispensable to child and adolescent psychiatrists and an essential item in libraries serving psychiatrists and psychologists and those concerned with mental health. At first glance the reader may be mistaken in thinking that this is simply a hardback version of the ICD-10 *Classification of Mental and Behavioural*

Disorders, published by the WHO in 1992, but it differs from the clinical version of the ICD-10 in a number of important respects. These are all laid out very clearly by Sir Michael Rutter in the introduction. First, the ICD-10 has been cast into a multi-axial framework. This is broadly comparable to that contained in *A Guide to a Multi-axial Classification Scheme for Psychiatric Disorders in Childhood and Adolescence*, prepared by Rutter, Shaffer and Sturge in 1975 for ICD-9 but lays out six axes rather than five: the sixth axis being a global assessment of psychosocial disability that follows the format and subdivisions of the comparable DSM-IV axis but without reference to specific symptoms. The fifth axis concerned with associated abnormal psychosocial situations has been largely reworked in comparison with the ICD-9 version which proved unreliable in field trials. These two axes, therefore, constitute major additions to the existing ICD-10 clinical volume and are of particular relevance to those working in the field of child and adolescent mental health. The definitions relating to these axes are thorough, and in the case of the fifth axis, are not available elsewhere in any form.

The first three axes contained in the book are essentially a re-ordering of the ICD-10 classification to make it more appropriate for those practising in the field of child and adolescent mental health and to establish the appropriate axial framework, namely; axis 1, clinical psychiatric syndromes; axis 2, specific disorders of psychological development; and axis 3, intellectual level. Axis 2, therefore, comprises the categories listed under F80–F89, disorders of psychological development in ICD-10 and axis 3 comprises those listed under F70–F79, mental retardation. With regard to axis 1, F84, pervasive developmental disorders are listed first, followed by F90–F98, behaviour and emotional disorder with onset usually occurring in childhood and adolescence. This is because these are the most frequently used and specific categories for child and adolescent psychiatry, although there is increasing recognition that many children have mood and neurotic disorders, in particular, that may fit adult diagnostic criteria and it is emphasized that these should be used if they are appropriate. For categories of disorder that very rarely or never occur in childhood, such as Alzheimer's

disease, only the code and heading are included and for those that are relatively uncommon, such as 'Delirium, other than induced by alcohol and other psychoactive substances', a relatively brief definition is included.

As has been the case in previous versions of the ICD classification, the emphasis is on description as the basis for classification, although there is some evidence that increasing knowledge, underpinned by research, has influenced the specification of certain categories, such as F94.1 Reactive Attachment Disorder of Childhood and F94.2, Disinhibited Attachment Disorder of Childhood. It is, indeed, very proper that classification systems, which are essentially hypotheses about the best way of ordering current information for the purposes of understanding aetiology and considering treatment and prognosis, should be modified in the light of systematic studies. Some will consider that more recent thinking about the nature of pervasive developmental disorders that emphasize their essentially developmental nature would logically point to the inclusion of those disorders within axis 2, specific disorders of psychological development. This is implicitly acknowledged by Rutter in the introduction, where he justifies their inclusion in axis 1 on the ground that this has been the 'usual usage in child and adolescent psychiatry' and is 'strongly preferred by clinicians working in field'.

Although there remains some continuing conflict between those who prefer to adopt dimensional approaches to child and adolescent mental health with an emphasis on 'problems' rather than 'disorders' this classification system, nevertheless, incorporates and is based on a large and increasing body of research evidence about child and adolescent mental health. As such, it constitutes a useful clinical reference book as well as a classification system. Much epidemiology, and, indeed many treatment studies have been based on disorder categories contained in the international or DSM classification systems, and provided that it continues to be remembered that these are essentially hypothetical categorizations, there will continue to be benefits from this approach. Incidentally, it should be noted that the reader is referred to the research criteria for ICD-10 for that purpose. Although the disorder classification approach to child mental health

has its value, problem-based and dimensional approaches also have value from the clinical and scientific point of view.

A. D. COX

Unwillingly to School. Edited by I. Berg and J. Nursten. (Pp. 312; £20.00.) Royal College of Psychiatrists/Gaskell: London. 1996.

'Isn't it normal not to want to go to school?' asked one of my undergraduate students. A typically 'loaded' question that preyed on my insecure knowledge of the topic. Is missing school bad for you? Is the desire to avoid school always associated with psychiatric disorder? Does the quality of contemporary schooling justify compulsory attendance? As Fogelman points out in *Unwillingly to School*, when truancy is discussed in the media the tabloids commonly bring forward a collection of sports stars, popular musicians, media personalities and business entrepreneurs who will talk with nostalgic pride about their own truancy from school. *Unwillingly to School* goes a long way to providing a resource to answer my querulous student, being a thoughtful review of school non-attendance ranging from the legal implications to the long-term sequelae, covering psychiatric diagnosis and multi-modal treatment along the way. The fourth edition follows some 15 years after the third edition by Kahn, Nursten and Carroll and is a tribute to the late Dr Jack Kahn. It contains both contemporary contributions and some chapters from the previous edition, which serve to highlight changes in nomenclature as well as psychiatric thinking over the years. Overall, the book is well written and a pleasure to read. Having said this, I have to admit to finding some aspects of the book a little odd. The title was presumably chosen to avoid the semantic confusion of school refusal/school phobia/school non-attendance/school withdrawal/truancy and does make a refreshing change from 'Handbook of...'. The organization of the chapters was puzzling, with the contributions from the third edition appearing in the middle of the volume when they may have usefully served as an introduction, not all the chapters on longitudinal research being grouped together, and the volume commencing neither with the clinical nor social implications of the problem, but with the legal aspects.

The editors stated aim was to broaden discussion from emotionally based school refusal, which was the focus of the third edition, to the full range of problems that lead to school non-attendance. The reader is left in no doubt from the three chapters that review long-term follow-up studies of truants and the one chapter that reviews a Swedish follow-up study of school refusers, that truancy is the more malignant condition in terms of psychiatric and social outcome. It is, therefore, disappointing that the management of the individual truant is covered in less than two pages, while four or five chapters are devoted to the management of the emotionally based school refuser. Perhaps this reflects the current state of knowledge and practice, and supports the axiom that children and adolescents most in need of expert help for emotional and behavioural problems are the least accessible to intervention. It does beg the question, however, of whether specialist child and adolescent mental health resources are being directed to the area of greatest need. Further evidence for the limitations of current knowledge was the minimal reference to treatment evaluation, and the paucity of randomized control trials. Only pharmacological studies were given specific mention, the authors noting that the original study that reported significant benefit of imipramine over placebo for the treatment of 'school phobia' has not been replicated by subsequent research. The safety and efficacy of behaviour treatments were mentioned several times, but not substantiated with data. Evidence for the efficacy of family therapy, individual psychotherapy, *milieu* therapy in both in-patient and day-patient settings, and home schooling was absent.

The importance of a multidisciplinary collaborative approach between health, education and welfare professionals in the management of school non-attendance was given appropriate prominence, and reinforces my view that the effectiveness of community-based child and adolescent mental health teams in management school refusal is a good barometer of the interdisciplinary competence of the team. The review of psychiatric diagnosis in school non-attendance by Werry was particularly informative. The fact that some non-attenders have no identifiable emotional or behavioural disorder, but are withheld for social or ideo-

logical reasons, complicates the response to my querulous student.

In summary, *Unwillingly to School* is a useful embodiment of current knowledge about school non-attendance that says a lot about what health, education and welfare services can do for the problem, but also a lot about what is not, or cannot, be done.

PHILIP HAZELL

Hyperactivity Disorders of Childhood. Edited by S. Sandberg. (Pp. 517; US \$95.) Cambridge University Press: Cambridge. 1996.

This is the second in a series of monographs dealing with topics in child and adolescent psychiatry to be published by Cambridge University Press. The volume enters a competitive market, because more than 60 books have already been published on the subject of hyperactivity or attention deficit hyperactivity disorder (ADHD) in children and adults. An important question then is whether this volume has any features that distinguish it from other books on the subject. The answer is yes. First, this is one of the few texts that is orientated to a European perspective on the disorder, although there are contributions from several Canadian and one US author. Secondly, there is an extensive review of psychosocial contributions to the disorder that is written in a direct but non-pejorative manner. Thirdly, there is an attempt to examine cross-cultural presentations of the disorder, although this reviewer was not convinced that New Zealand and Hong Kong provided examples of cultures that were substantially different from the UK or USA. Fourthly, there is an extremely readable account of the role that inattention plays in the expression of hyperactivity/ADHD, which synthesizes very well the contributions of cognitive psychology to the field over the past 20 years or so.

This volume was not distinguished from the existing literature by its dealing of assessment, which, similar to the first monograph on childhood depression, was fairly brief. Perhaps, in this age where there has been a proliferation of published practice parameters, the editor felt that being too prescriptive may lead to a

stereotyped approach to assessment. Likewise, the section on treatment, while well-written, was brief in comparison to the extensive reviews of possible aetiological factors.

The series editors are striving for a uniformity of approach which includes historical background, prevalence, clinical description, developmental course, outcome, classification, co-morbidity, gene-environment interaction, family and peer influences, treatment and public health policy. For the most part of the authors of *Hyperactivity Disorders of Childhood* covered these topics admirably in a well-referenced and comprehensive manner. Public health policy was not covered in detail, and could have included topics such as the value of pre-school or early school screening for the condition, whether children with hyperkinetic disorder should be considered to have a disability warranting government allowances and special consideration in the education system, whether there is a need for the central monitoring of psychostimulant prescribing, and the medico-legal implications of the diagnosis.

The monograph was marred at times by lapses in proof-reading, as evidenced by spelling, typographical and grammatical errors. Problems were especially evident in Chapter 2.

The stated audience for this series of monographs is practitioners and researchers in child and adolescent mental health, although in the case of this volume the content would be highly relevant to paediatricians who arguably treat more cases of hyperkinetic disorder than do mental health specialists. Parents of children with the condition are becoming increasingly literate in the area, and also represent a potential audience. The chapter most likely to be subjected to critical scrutiny by such an audience is that titled 'Psychosocial contributions'. This reviewer considers the chapter to be written in such a way as to review the issue comprehensively without giving cause for offence.

In summary, *Hyperactivity Disorders of Childhood* is a well-written, comprehensive and comfortably sized volume that should address most needs of the intended audience as well as being informative to practitioners outside child and adolescent mental health.

PHILIP HAZELL