Psychological Medicine, 2004, **34**, 1137–1142.
Printed in the United Kingdom

Book reviews

Psychological Medicine, **34** (2004).
DOI: 10.1017/S0033291704213204

Handbook of Chronic Fatigue Syndrome. Edited by L. A. Jason, P. A. Fennell and R. R. Taylor. (Pp. 794; £58.50; ISBN 0-471-41512-X.) John Wiley & Sons: Chichester, UK. 2003.

In 1869 George Beard described fatigue as 'the Central Africa of medicine, an unexplored territory into which few men enter'. The *Handbook of Chronic Fatigue Syndrome* provides a number of differing theoretical accounts of chronic fatigue syndrome (CFS) along with a variety of assessment and treatment strategies. The *Handbook* illustrates that CFS is no longer 'an unexplored territory' and there is no shortage of 'explorers'. Anyone reading it from cover to cover will discover that there is still no clear consensus regarding the definition, aetiology, diagnosis, prevalence, assessment and treatment of CFS.

CFS remains controversial and the *Handbook* adds some very contrasting perspectives to the on-going debate. Some contributions are stimulating, scholarly and scientific while others are contentious or apocryphal.

Why do we have so many disparate views and so little consensus regarding CFS?

In the management of chronic illness, and CFS in particular, conventional medicine stands accused of various crimes ranging from 'benign neglect' to 'iatrogenesis'. Perhaps there would be no controversy if CFS fulfilled the current medical definition of disease. Western medicine has its origins in the rationalist scientific method. The whole emphasis of the scientific method is on proof. Disease became defined as a biological event with pathology, a specific entity, concrete and identifiable. CFS does not currently fulfil these criteria because CFS does not have a unique symptom profile or specific diagnostic laboratory marker.

Fatigue, like pain, is a subjective sensation – it is private data that cannot be objectively measured. The severity of fatigue can only be gained by listening to the personal report of the sufferer. Any symptom that causes suffering should be taken seriously with or without objective corroborative data.

CFS is, according to its definition, medically unexplained. Medically unexplained symptoms (MUS) consistently account for 20–40% of all consultations. MUS, and CFS in particular, continue to pose a challenge to the orthodoxy of medicine and psychiatry. Perhaps it is biomedicine's own belief system, its 'institutional dualism' – the separation of the mind and the body that is ultimately responsible for the controversy surrounding CFS. Doctors may, in the absence of an identifiable disease – ('not in the body' – 'nothing the matter'), explicitly or implicitly, label the patient's problem as psychological or psychiatric – ('all in the mind'), although CFS is inconsistently associated with mental-health problems.

People have always sought credible explanations for their symptoms and understandably they tend to reject a psychological explanation for a set of symptoms that they experience in a very real and physical way. Medicine's failure to provide an explanation can appear to reject the reality of the patient's physical symptoms and the patient may feel disbelieved and alienated. The explanatory void left by medicine can create uncertainty and distress for the patient, damage to the doctor–patient relationship and the void is filled by the anarchic growth of alternative explanatory models.

Perhaps it is medicine that needs to change by moving towards a new, more inclusive clinical method that does not exclude this substantial proportion of patients.

Doctors often see their primary role as excluding disease. Technological advance has placed increased importance on biochemical and physical abnormalities, objective data, rather than the patient's symptoms, their emotional well-being, their beliefs, or their social and cultural background.

Cognitive behavioural therapy (CBT) is well reviewed in the *Handbook*. Research shows that CBT is an effective treatment for CFS. Despite

the evidence to support the clinical effectiveness of CBT, in a wide range of clinical conditions, there are number of obstacles to its widespread implementation. One obstacle is the significant societal stigma attached to mental or psychological health and CBT is seen as a psychological therapy. It is hardly surprising that a lot of people with CFS are extremely sceptical about the relevance of CBT in the treatment of their illness. The stigma is a legacy of the dualistic medical model. The psychological component of the biopsychosocial approach does not imply that CFS is entirely or primarily psychological. It is important that medicine and science remain neutral on this issue because if psychological factors are involved in the development and maintenance of CFS, as they have been shown to be in a wide range of clinical conditions (ischaemic heart disease, diabetes, chronic pain), then gaining a greater understanding of them could help in both the prevention and treatment of CFS.

The Editors of the *Handbook* are to be congratulated for bringing together such a diverse range of contributions that helps to highlight the predisposing, precipitating and maintaining factors in this complex illness. CFS is a heterogeneous condition with a multifactorial aetiology. The *Handbook* will provide a useful resource for those working with CFS patients. I particularly enjoyed the section on 'Phenomenonology: illness course and patient perceptions', the chapter on 'Neuroendocrine dysfunction' and the chapter on 'Pain and fatigue', given the overlap between CFS and fibromyalgia there is much to learn from those working in chronic pain management. Surprisingly, it was some of the medical contributions that I found most contentious because of their doctrine of specific aetiology. One medical contributor did volunteer that 'some of my views and findings may be inconsistent with many in this field'. I will leave it to you to discover which.

Although the *Handbook* is multidisciplinary, in as much as it provides a wide range of academic and clinical viewpoints on CFS, it is essentially a collection of unidisciplinary theoretical frameworks and treatment strategies.

Increasing specialism and unidisciplinarity could represent a genuine obstacle to progress. We are all products, and frequently prisoners, of the system that creates us. William James refers to our inculcation into a belief system as the 'older truths':

> The point I now urge you to observe particularly is the part played by the older truths … their influence is absolutely controlling. Loyalty to them is the first principle; for by far the most usual way of handling phenomena so novel that they would make for a serious rearrangement of our preconceptions is to ignore them altogether, or to abuse those who bear witness for them.

There is now a substantial body of research that contributes to our understanding of the interactive dialogue between the physiological, nutritional, cognitive, emotional, social, behavioural, endocrine, immune and autonomic systems. There is evidence that these various systems are not autonomous but are engaged in a complex interactive dynamic. Disruption in any one part of the system can result in significant disruption across the whole network. We need to move away from the disease model, the unitary linear model of causality, and develop some joined-up thinking about CFS.

The present state of affairs is unsatisfactory. Patients with CFS who are seeking treatment and health professionals wishing to provide the most appropriate care for their patients face a profusion of confusing and sometimes contradictory information about CFS.

There is so much research evidence with little dissemination and uptake.

We need a new clinical method that transcends dualism and transforms the current 'reductionist' model into a genuinely integrative model of medical care. The real challenge is to develop a multidisciplinary consensus, a conceptual framework that provides an integrated model of understanding CFS. A biopsychosocial approach that incorporates the dynamic interaction of physiological variables, social context, and psychological factors, because the reality is that these are not isolated systems but intimately interdependent.

An agreed conceptual framework for CFS could then inform the development of a much-needed, integrated, evidence-based model of care that could be disseminated into the primary- and secondary-care setting. The efficacy of treatment could then be evaluated, and modified, by a combination of good-quality quantitative and qualitative research.

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https://doi.org/10.1017/S0033291704223200 Published online by Cambridge University Press

Psychological Medicine, **34** (2004).
DOI: 10.1017/S0033291704223200

Suicide in Children and Adolescents. Edited by R. A. King and A. Apter. (Pp. 320; £47.95/ $65.00; ISBN 0-521-62226-3.) Cambridge University Press: Cambridge. 2003.

This book is the latest offering from the Cambridge Child and Adolescent Psychiatry Series. Suicide and suicide attempts remain among one of the leading causes of death and morbidity amongst the young. As death rates from other causes decline with advances in medical research the persistently high rates of suicide become ever more apparent. However, our understanding about how these deaths might be prevented or anticipated and the role that biology and culture play in their aetiology is very rudimentary. A number of authors in this book point out that a small number of adolescent suicide completers and a fair number of attempters do not have any diagnostic psychopathology and the vast heterogeneity within this group of individuals makes identification of 'at risk' individuals particularly difficult. This book moves beyond the traditional approach of viewing suicide as a diagnostic feature of depression, personality disorder or other diagnostic category *per se*, and discusses suicide and suicidal behaviours as a continuum of behaviours which cut across diagnostic boundaries. Many authors throughout the book discuss the emerging literature which views impulsivity and risk-taking behaviour as important underlying personality attributes contributing to suicidal behaviours irrespective of diagnostic category.

Several contributors discuss the common risk-taking behaviours seen in many suicide attempters, namely weapon carrying, unprotected sex, alcohol and drug misuse, aggressiveness, drunk driving, etc. Given the increasing prevalence of some of these behaviours in certain societies, the future implications are worrying. A chapter on suicide prevention discusses tactics and strategies which appear to produce short-term positive results, such as screening programmes, education, as well as programmes aimed at enhancing self-esteem and coping skills. However, as the author points out, the long-term effectiveness of these programmes in reducing actual suicides is still not known.

Several chapters discuss the biological underpinnings of suicidal behaviour from the point of view of family and twin studies, and cite evidence which proposes the existence of an inherited diathesis underlying suicidality, which may be impulsivity or aggression and which is separate from the transmission of psychiatric disorder. Findings from molecular genetic studies are also presented, albeit twice in different chapters. Regrettably, there is no attempt to integrate the various biological and environmental risk factors discussed and how these may interact to increase susceptibility to suicidal behaviours.

There are several clinically orientated chapters, which I would recommend anyone assessing potentially suicidal children to read. A discussion of the developmental issues in children relating to concepts of death, finality and suicidality highlights the need for appropriately, developmentally trained staff to be assessing such children and adolescents. The book ends with the rather depressing reminder that many adolescent suicide attempters receive little or no treatment. Perhaps as an attempt to address this poor state of affairs several excellent chapters deal with treatment issues and provide concrete practical ideas for group work and CBT approaches.

Despite some lack of integration, each chapter provides an authoritative account of the current literature, which is generally well appraised and I would definitely recommend this book to anyone who has any contact with suicidal youth, particularly for the chapters addressing assessment and treatment.

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Psychological Medicine, **34** (2004).
DOI: 10.1017/S0033291704233207

Catatonia: A Clinician's Guide to Diagnosis and Treatment. By M. Fink and M. A. Taylor. (Pp. 256; Price $50.00, ISBN 0-521-82226-2 hb.) Cambridge University Press: Cambridge, UK. 2003.

Catatonia is the Rosetta Stone of psychosis. It is the only external sign of psychosis. It is easily observed in the active phase of catatonia

(psychosis). Its pathophysiology and its neurochemistry are well described. Its treatment response is well described (with lorazepam and electroconvulsive therapy).

Fink and Taylor have written an excellent book on catatonia. The book is a very interesting and clinically relevant review of the authors' extensive experience in the research and treatment of this neuropsychiatric illness. The authors declare that they hold strong opinions regarding the diagnosis and treatment of catatonia. Not all readers will embrace every viewpoint expressed in this book. However, neuropsychiatrists, neuroscientists and any mental healthcare professional who works with patients with psychosis or coexistent medical illnesses will benefit from reading this book.

In particular, there are clinical scenarios dedicated to catatonia in neurology, in-patient psychiatry, child psychiatry, consultation-liaison and forensic settings. The chapters are organized by history, psychopathology, differential diagnosis, frequency, detection, treatment and aetiology.

However, there are those clinicians and researchers who mistakenly declare 'We don't see catatonia anymore'. Fink and Taylor point out that catatonia is measurable and common. They provide the means to detect catatonia for those clinicians and researchers who have stopped looking for it. Like the 'Emperor's New Clothes' mental health professionals and other clinicians are likely to see patients with catatonia but may not recognize it.

Catatonia has been identified, studied, mapped, treated and can translate the other forms of psychosis. Catatonia has a neuropathology that has been identified (Northoff, 2002). It cannot be and has not been localized to one discrete area of the brain. It is a loop, a neural circuit.

The Rosetta Stone, demonstrated that in order to translate Egyptian hieroglyphics complete sentences and context were required. Translation of individual hieroglyphics did not lead to an understanding of the language. In psychosis, catatonia provides us with the complete sentences and context to translate psychosis. Authors Fink and Taylor provide us with valuable clinical experience and information for an improved understanding and a more effective treatment of this form of psychosis.

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Reference

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Psychological Medicine, **34** (2004).
DOI: 10.1017/S0033291704243203

Autism: Explaining the Enigma, 2nd edn. By U. Frith. (Pp. 249; £50.00 hb, £15.99 pb.) Blackwell: Oxford. 2003.

This is the second edition of an extremely successful and widely-read publication on autism, the first edition of which is now some 12 years old. It is, as has been clearly stated in the Preface, an exploration of autism that is presented from the personal perspectives and interests of the author. However, this does not detract in any way from the publication since Uta Frith has long been regarded as one of the leading experts in current autism research and psychological theory in this country.

Many readers will be entirely familiar with the original edition of '*Autism*'. This second edition updates and extends the first edition in a variety of ways. There has been substantial rearranging of existing content such that some of the original chapters are now presented across two or even three more detailed chapters, or are located in a different sequence to the original as the updated 'story' of autism is presented. The book opens with a chapter exploring 'What is autism', as did edition one. The main change in this second edition is the inclusion of newer diagnostic criteria and some discussion on the ease and age at which it is possible to identify autistic features. Chapter 2 'Enchantment of autism' and Chapter 3 'Lessons from history' are basically re-workings of the original 'Lessons from the wild boy' and 'Beyond enchantment' chapters. The differences include further examples of historical figures who may have had autism or Asperger's syndrome, and the authors reasons for addressing this, as well as discussion of the autistic-like traits presented by more recent history's Romanian orphans and the subsequent 'recovery' of such features once the children were settled with their new adoptive families. Chapter 4 is entitled 'Is there an autism epidemic?' While this is a new title, much of the

content again has its basis in the original edition covering many aspects that were included in the original 'Background facts'. The new edition adds to this by exploring prevalence studies of recent years, and the genetics *versus* environment debate, with comment included on what the author defines as the recent 'vaccination scare'. Chapters 5, 6 and 7 replace the original Chapters 8, 9 and 10, covering and expanding on theory of mind, autistic aloneness and the difficulty of talking to others respectively. While these do include several new studies and comments the advance of scientific research during a 12 year period can be painfully slow, and as such the novel material does not lead to vastly extended information. Similarly, Chapters 8 and 9 update the weak central coherence theory and issues surrounding talents of people with autism, or 'islets of ability'. However, these five chapters feed directly into a well-presented Chapter 11 'Seeing the brain through a scanner', which provides a fairly comprehensive overview of current neurological research and theory that links neatly to the developed and expanded psychological theory. Preceding this is a short chapter on sensations, which also covers rigidity and routines. It is pleasing to see the inclusion of a chapter exploring sensory issues and attention in autism, however the chapter is perhaps disappointingly brief and one is left feeling the topic has been somewhat skirted over. The final chapter 'A different brain – a different mind' attempts to address how theory and practical experiences can overlap, and offers some interpretation of what it may be like to have an autism spectrum condition along with comments on how to understand and support such individuals. The author explores her own personal interpretation of current and past theories, and touches nicely on some of the common misinterpretations and misconceptions of the condition.

To summarize, this second edition presents an easy-to-read and logical journey through autism, from what it is and how it is and has been perceived, through current psychological theory to neurological explanation and practical implications. It is an extremely worthwhile book for anyone who wants a research-led understanding of the psychology of autism, particularly students interested in the topic or parents and professionals who may wish to understand the theories feeding future interventions and current understanding of this complex spectrum of conditions.

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Psychological Medicine, **34** (2004).
DOI: 10.1017/S003329170425320X

Care and Treatment of the Mentally Ill in North Wales 1800–2000. By P. Michael. (Pp. 252; £14.99.) University of Wales Press: Cardiff. 2003.

The explosion of interest in the history of asylum-based psychiatry has thrown up some gems in recent years. Researchers have dug around archives, and often even in abandoned hospitals themselves, in search of patient records, administrative data and other materials with which to analyse and explain the troubled history of asylumdom. Armed with an increasingly sophisticated historiographical apparatus, the authors of many latter-day works have greatly enriched our understanding of the regional peculiarities of the 'museums of madness'. In the present work, Pamela Michael, a lecturer in Social Sciences at the University of Wales at Bangor, illuminates one interesting corner of the United Kingdom, by assessing the records of the Denbigh Asylum in Clwyd, North Wales.

The reason why the vast and brooding asylums were built throughout the United Kingdom from the early 1800s remains a hot topic. Andrew Scull has famously argued that the underlying structure shaping the emergence of the state-sponsored mental hospitals was provided by the growth of the industrialized capitalist economy. Prior to Victoria's long reign, agrarian economies allowed families and communities to look after their own. With the Industrial Revolution, by contrast, *ad hoc* community care became obsolete, and centralized welfarism, introduced under the cover of the Poor Laws, built, and soon filled, the asylums. In England, the asylum system was greeted with a more-or-less enthusiastic welcome, as it answered to (even 'created') a pressing social need. In North Wales, however, local reformers had to push to get their asylum built, for the communitarian mode of home-based custody remained intact long after its English equivalent

was scattered to the wind by the incursions of capitalist economy. Why so? Michael finds that in impoverished North Wales, the Industrial Revolution sent males into the mining industry, leaving women at home in their rural communities where they could continue to care for the insane.

Thus, Michael partly capitulates to Scull's argument that economic changes, rather than the infusion of humanitarian concern, drove the move to institutionalization. This sits a little oddly with her expressed intention to 'view the establishment of hospital care of the mentally ill as a great "humanist project"' (p. 2). Surely, having rejected anti-whiggishness, it would be best to mount a full-scale counter-narrative, rather than to borrow shards of a thesis with which one does not agree.

Moreover, if the author has 'an enduring fascination with the architecture of asylumdom' (p. vii), why not incorporate some of the splendid recent literature on the topic? All told, Michael's slightly uncritical eclecticism lends the book a lukewarm feel. The narrative slips in other ways also. For instance, in the early years of the twentieth century 'Dr Stanley Hughes came direct from Claybury, bringing with him many progressive ideas about the treatment of "incipient insanity", and the importance of after-care of the insane and these were fed into the plans for future developments' (p. 104). But there the well runs dry: no further mention of Hughes is made, and the reader is left to wonder precisely what were his 'many progressive ideas', and how they 'fed into the plans for future developments'. Throughout the book, Michael seems only partly to have succumbed to the temptation, common to researchers in this field, to fall in love with 'her' asylum. Granted, she does not try to diminish Denbigh's faults, but equally, the temptation was not so strong in the first place: the asylum seems to have enjoyed a largely scandal-free existence.

That said, Michael's work does throw light on the history of British psychiatry in unexpected ways. At Denbigh, the patients and staff were almost exclusively Welsh-speakers. When Welsh lunatics had been sent to English asylums for care and custody, their lot was an unenviable one. 'Nothing can exceed his misery: himself unable to communicate … harassed by wants which he cannot make known, and appealed to by sounds which he cannot comprehend, he becomes irritable and irritated' was one Victorian reformer's observation (p. 31). At Denbigh, by contrast, another contemporary noted the laudable 'absence of that sullenness coupled with suspicion which is so marked a feature among the Welsh patients in English Asylums' (p. 62). Most of the patients, and many of the staff, continued to speak Welsh well into the twentieth century.

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https://doi.org/10.1017/S0033291704223200 Published online by Cambridge University Press