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Book reviews

Psychiatric Care of the Medical Patient, 2nd edn. Edited by A. Stoudemire, B. S. Fogel and D. B. Greenberg. (Pp.1237.) Oxford University Press: New York. 2000.

What does a liaison psychiatrist actually do? This question, posed frequently by colleagues, including other psychiatrists (with tongues only partially lodged in cheek), is comprehensively answered by Stoudmire *et al*.'s authoritative text. Wisely steering clear of quibbles about nomenclature (liaison? consultation-liaison? medical psychiatry?), the editors of this updated and expanded second edition (third, if you count their earlier *Principles of Medical Psychiatry*) have also stuck with a title that aptly describes the book's contents.

The increased prevalence of psychiatric disorders in medical patients compared to the general population is well recognized, as is the fact that psychiatric morbidity in this group is often poorly managed. What is more contentious is how these issues should be addressed. As the editors acknowledge in their introduction, the specialized role of the liaison psychiatrist while being of value in the management of individual patients, is clearly limited when it comes to addressing the majority of psychological morbidity on a medical ward. During a period in British psychiatry in which the management of 'severe' mental illness (i.e. psychosis) has become the exclusive priority of mental health services, the care of patients with both medical and psychiatric disorders is increasingly the province of the interested physician and nurse specialist. What makes this work particularly successful is that it will be of use to non-specialist clinicians as well as liaison psychiatrists.

The book has 11 sections that can be broadly split into three areas. First, general principles of assessment and management are covered. The chapters dealing with the various modalities of psychotherapy (including hypnotherapy) are uneven in quality, reflecting the extent to which such treatments have been evaluated in clinical practice. Oddly, these chapters precede those on assessment. The management of acute and chronic pain syndromes is dealt with in sufficient detail to stand alone as a text. The same may be said for the four chapters on psychopharmacology in the medically ill. There follows extensive coverage of the psychiatric aspects of practically every medical and surgical speciality (including anaesthesia). Neuropsychiatry is rightly the focus of several chapters, with those on delirium, seizures and headache being particularly strong and well written. A further section is given over to the management of 'special syndromes', a catch-all term for those problems not easily positioned elsewhere. Included here along with personality disorders and sexual dysfunction in the medically ill, are somatization disorder, factitious disorder and the most topical of the medically unexplained syndromes, chronic fatigue and multiple chemical sensitivity. Finally, there is a welcome section on the psychiatric assessment and management of medically ill children, including the management of bereavement, and the book ends with three chapters relating to medico-legal issues. Although this is written from a North American perspective and focuses on US law it deals primarily with the issue of competence, which bears similarities to the UK concepts of capacity and consent to treatment, and as such has broad relevance.

The text is up to date with references as recent as 1999 and throughout the book generous use is made of case studies for illustration. With over 120 contributors there is bound to be an element of 'hesitation, repetition and deviation', but Stoudemire *et al*. have succeeded, overall, in their wielding of the editorial whip, maintaining a judicious mix of basic science and evidence-based approaches to treatment.

In such a large work, it is inevitable that one will stumble across points of disagreement or omission. I would question the helpfulness of viewing malingering as a continuum with somatoform disorders. The acute management of suicidal patients, for many liaison

psychiatrists the 'bread and butter' of their work, is disappointingly brief, with little more comment than on the importance of close observation. Also, it is surprising that in the chapter on oncology there is no mention of breast cancer, despite the fact that this disease is almost wholly responsible for the development of psycho-oncology services. These negatives are, however, outweighed by many pluses – the chapters on ethical issues, and palliative care being worthy of especial mention.

In conclusion, this encyclopaedic text provides answers on (almost) any question you might have about the psychiatric aspects of physical illness. It is a weighty tome, and as such is unlikely to be used as a portable handbook, but with its accessibility to both specialists and generalists alike, it would form an exceptional addition to the library of any psychiatric, medical and yes, even surgical department.

STEVEN REID

Ethics and Values in Psychotherapy. By A. C. Tjeltveit. Routledge: London. 1999.

Ethics for Psychologists. By R. D. Francis. British Psychological Society Books: Leicester. 1999.

Tjeltveit an Associate Professor of Psychology in Pennsylvania, outlines the diverse dimensions of ethics implicated in the work of the psychotherapist and other mental health professionals. These dimensions include 'professional ethics', 'theoretical ethics', 'clinical ethics', 'virtue ethics', 'social ethics' and 'cultural ethics'.

In practice as a clinical psychiatrist and educator, I have found the distinction between 'professional ethics' and 'virtue ethics' particularly important. Simple observation of one's own and one's colleagues' practice will confirm the regular encounter with patients/clients whose behaviour, attitudes and ethics appear to be in contrast to the clinician's idea of virtue. Failure to recognize this and articulate its importance in the clinical encounter may lead to negative counter-transference or reinforce negative counter-transference arising for other reasons. Such a situation may arise, particularly, in the management of patients with borderline or antisocial personality disorder or substance misuse, especially when inexperienced staff is involved. Highlighting the distinction between personal commitment to virtue and professional commitment to act in the patient's best interest may provide the foundation for an examination of the clinician's counter-transference and the attainment of a better therapeutic outcome.

Tjeltveit's conviction is that psychotherapists, of all orientations, have paid inadequate attention to ethics in practice. Therapeutic neutrality in classical psychoanalysis and scientific neutrality in behaviourism lie at the root of this. He gives a number of clinical examples that challenge this neutrality. Increasing emphasis on third party payment and brief therapy coupled with scepticism towards scientific authority in a rapidly changing society underpin the challenge. In the final chapter he offers his own values: an 'ethically rich' psychotherapy, with practitioners who are aware of and able to consider ethical 'alternatives' in their practice, through 'knowledge' of the diverse ethical theories. Such knowledge will underpin ethical 'articulacy' and 'acuity' and a commitment and ability to maintain 'dialogue' on these issues. He advocates 'balance' as a virtue for psychotherapists. These values reflect the emphasis of the book on ethics in the one-to-one therapist-patient/client encounter.

Professional ethics is the focus of Francis' book. He has been Chairman of the Australian Psychological Society Committee on Ethical and Professional Standards and at the time of publication was a Member of the State of Victoria Department of Justice Research Ethics Committee. His style is dry, even dull, but his discussion of Legal Issues, Covenants and Cognate Codes and Ethical Infrastructures, in part one of his book, is both sound and well informed. Francis' experience, which includes business consulting, leads him to pay attention to organizational and institutional factors as well as dyadic therapist-patient/client interactions. Hence, for example, his reference to 'whistleblowing' as an important issue.

Francis is strongest on specific advice on practical issues. The third part of the book consists of a 'Compendium of Ethical Issues'. These are arranged in alphabetical order, starting from 'Accounting' and 'Advertisements (Services)' and concluding with 'Unqualified Practitioners' and 'Warn (duty to) (see also

reporting)'. Other entries include 'Disagreements with colleagues', 'Memories (Recovered)' and 'Psychologist as employee'. The shortest entry is on 'Data trade', which reads 'Commercial or personal trafficking of personal information is unethical'. The longest entry is on 'Clients' which is in excess of four pages. This whole section is less than 50 pages.

With rapidly evolving knowledge, communication technology and social attitudes 'social' ethics and 'cultural' ethics will continue to have an increasingly important role in psychotherapy, mental health services and health services in general. Complaints and litigation, patient advocacy/user groups, explicit concern about the needs of minority and vulnerable groups and public debates on rationing of scarce resources are examples of this. An area to watch is that of the Internet. The example of the Falkirk surgeon who found himself criticized after agreeing to amputate the leg of a patient, who requested it for psychological reasons, gives a taste of things to come. What is interesting in this case is that the surgeon had insisted that the patient be assessed by a psychologist and a psychiatrist and only acted after considering their reports. The problem arose when the surgeon's willingness to perform such an operation was made public on the Internet and referrals began to arise from all over the world. This caused concern and quick and vociferous adverse public comment by a number of local opinion leaders and authorities, not all of which appeared to be fully informed of the care the surgeon had taken.

Both Tjeltveit and Francis review theoretical/philosophical ethics. Neither author succeeds in basing their recommendations firmly in a theoretical framework. It is unlikely that a single ethical theory will ever achieve sufficient breadth, flexibility and general acceptability to address all practical concerns arising out of the richness of clinical practice. Ethical theory, however, remains important in challenging unwarranted assumptions and supporting a more sophisticated analysis of issues. The wise clinician, therefore, will keep an eye on this as well as professional and clinical ethics.

G. IKKOS

Handbook of Psychiatry in Palliative Medicine. By H. M. Chochinov and W. Breitbart. Oxford University Press: Oxford. 2000.

Psychiatrists have worked in palliative care settings ever since the modern hospice movement started in the 1960s, yet this is one of the first textbooks of psychiatry in this setting edited by two of the most influential and prolific researchers in this field. Palliative care psychiatry is a small discipline, but the diversity of psychiatric disorders represented is huge – from the hard neuropsychiatry of delirium to the softer, but no less important areas of adjustment to illness and bereavement – with everything else in between. Psychiatrists have played a similarly diverse variety of roles – from assessment and management of individual patients and their relatives, to advising on the legal and ethical issues raised when patients refuse treatment or demand euthanasia.

As in many other areas in psychiatry there is an apparent tension between understanding psychic phenomena and pathologizing them. A common example is the distress and pain a patient suffers when the last course of chemotherapy fails – is this a 'normal reaction' or is it depression? Similarly, should pleas for physician assisted suicide be taken at face value as the request of competent adults or should they be explored as a sign of psychopathology? Even the apparently straightforward diagnosis of delirium is affected by this question: the book discusses how in some hospices the experiences of patients who – while delirious – have visions of dead relatives may be 'normalized' as transitions from living to dying. In real life, these sorts of tensions may be overcome by pragmatism and common sense, but they exist none the less.

In palliative care, hope springs eternal. After speaking at a symposium on 'heartsink' patients in palliative care, I was thanked by a senior physician who added that it had been helpful to be reminded that not everyone can be helped; perhaps psychiatrists knew this better than palliative care physicians. His remark was prompted by the fact that I had – repeatedly – suggested that the patients who were discussed had intractable personality disorders and much of the behaviour which had led to their being labelled 'heartsink' had to be understood in this light. There were to be no magic cures –

these patients needed care and containment, but would continue to challenge their attending medical teams. The irony of his remark – implying that despite being surrounded by death and grief – palliative care can always help, stuck in my mind. To be able always to help is a motto of palliative care, no doubt fuelled by the early successes of the discipline in physical symptom management in general, and pain management in particular.

The tension between normalizing and pathologizing, and the expectation of unbridled hope in those delivering palliative care, can create unrealistic demands of the hospice psychiatrist. As ever, good medicine needs to be founded on good research, and research into psychiatric disorders seen in palliative care is in its infancy. This excellent book reflects the unevenness of this territory – with scholarly accounts of the research in depression and delirium, and more discursive accounts of other clinical problems based on common sense and clinical experience which have to substitute for research when there is none. Ethical and spiritual issues were thoughtfully tackled, and there was a helpful chapter on the management of physical symptoms. The sections on psychotherapy were illuminating as they described useful techniques and gave many moving accounts of psychotherapeutic work with dying patients.

The book disappoints in one central aspect – it fails to challenge the hope of palliative care. Depression and anxiety in this setting are difficult to manage, and may not get better. Many patients are quite unable to come to any comfortable resolution to their distress before death. Patients with persistent symptoms who fail to gain palliation are a reality that those working in this setting cannot afford to ignore. The motives behind the optimism so frequently expressed in hospices are obvious, but failing to rein it in may ultimately paralyse staff, and be a disservice to patients whose suffering must be taken seriously. In an era increasingly intolerant of pain, suffering, and the failures of medical care, it is essential that the noble ideals of the hospice movement are not oversold.

MATTHEW HOTOPF

Bion, Rickman, Foulkes and the Northfield Experiments, Advancing on a Different Front. By T. Harrison. (Pp. 319; £17.95.) Jessica Kingsley Publishers: London. 2000.

Taken over as a psychiatric military hospital in April 1942, Hollymoor Hospital, Birmingham, treated a large number of servicemen suffering from so-called 'war neuroses' until it was vacated by the army 6 years later. It has become well known for the so-called 'Northfield Experiments', the first run by Wilfrid Bion and John Rickman, and the second by Michael Foulkes, Harold Bridger, Tom Main and others.

Tom Harrison himself worked at Northfield as a consultant psychiatrist and this study is the outcome of 15 years of dedicated research. The history of this institution is clearly a great passion and has led him to painstaking archival research, together with numerous interviews of patients and staff. The best chapters deal with the organization and running of the therapeutic community, revealing the considerable contribution of Bridger, the original work of Laurence Bradbury as an art therapist and the tensions and rivalries that existed among the psychiatrists. However, it may be that Bion and Rickman are given too much credit for theoretical innovations. This is curious as Harrison's wide-ranging study provides evidence that others played important roles notably Delahaye in the War Office Selection Boards, Rees as Director of Army Psychiatry, and in the field of group therapy the roles of Joshua Bierer, Maxwell Jones and Foulkes are clearly documented. This is possibly a reflection of the pressure exerted by psychoanalysts to establish a position of prominence in the field of analytical therapy.

Northfield played an important part in the development of group therapy and rehabilitation techniques. Its success plausibly saved the UK exchequer considerable sums in war pensions as servicemen were returned to duty rather than being discharged with a disability pension. This is a readable and thorough account of the institution, its personalities and therapeutic interventions.

EDGAR JONES