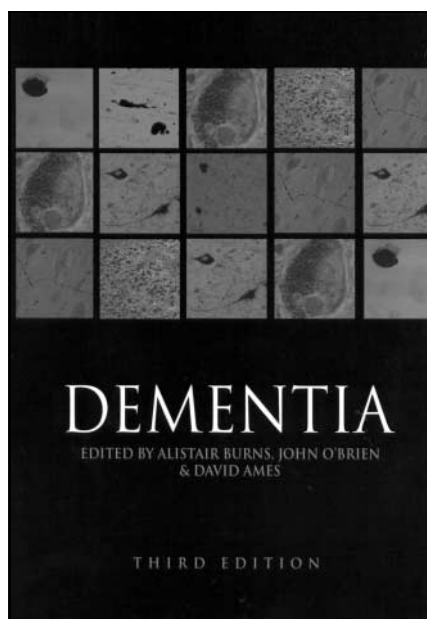


Book reviews

EDITED BY SIDNEY CROWN, FEMI OYEBODE and ROSALIND RAMSAY

Dementia (3rd edn)

Edited by A. Burns, J. O'Brien & D. Ames.
London: Hodder Arnold. 2005. 829pp.
£145.00 (hb). ISBN 0340812036



Like previous editions, the third edition of *Dementia* provides wide-ranging coverage of all aspects of the dementias, and is destined to become another classic text. The first part covers diagnosis, assessment, investigations and management of dementia in general, and includes structural and functional brain imaging, neuropsychological and neuropsychiatric aspects of dementia, management and service delivery. Parts two to seven cover Alzheimer's disease, vascular dementia, dementia with Lewy bodies and Parkinson's disease, focal dementias and other less common dementias, in addition to a new section on mild cognitive impairment and the potential therapeutic opportunities in this area. Written by leading researchers in their fields, each chapter present a comprehensive overview of the area in addition to recent advances in the areas of basic science and applied research.

The book follows the same format as the second edition but several new topics have been introduced. A chapter on epidemiology reminds us that the demographic shift to older populations continues, with concomitant increase in absolute numbers of older people with dementia throughout the world, but especially in developing countries. Several fascinating chapters on services available in developing countries are a stark reminder that many do not currently have the resources to deal with this explosion in need, and that traditional (female) carers in many societies are increasingly becoming less willing or are financially unable to look after their elderly relatives. Another chapter presents a very moving personal account by the husband of a woman with early-onset Alzheimer's disease, which sums up not only the 'terrible pain and fierce anger' but also the tremendous amount of love and humanity shown by committed carers. Unfortunately, many older people with dementia do not have this level of support. They still face abuse in generic care settings and in their own homes, and the ageism that exists in many societies serves as a major obstacle to improving the care that people with dementia receive. With the increasing numbers of people with dementia, and fewer younger people available to provide care, these issues will demand more attention in the future.

In this edition of *Dementia* there has been a swing towards the psychosocial aspects of dementia, and service development. There is a particularly good description of how speech and language therapists can help us to improve our communication with people with dementia. These skills will become increasingly necessary in the next few decades as more people with dementia are cared for in non-specialist settings. The matter of how care is provided for people with dementia in mainstream settings is an area that is currently receiving more attention from policy-makers and researchers. Hopefully, there will be sufficient material to warrant a chapter in the next edition as

this kind of research evidence will be essential to decision-makers attempting to provide good-quality care for the increasing numbers of people with dementia.

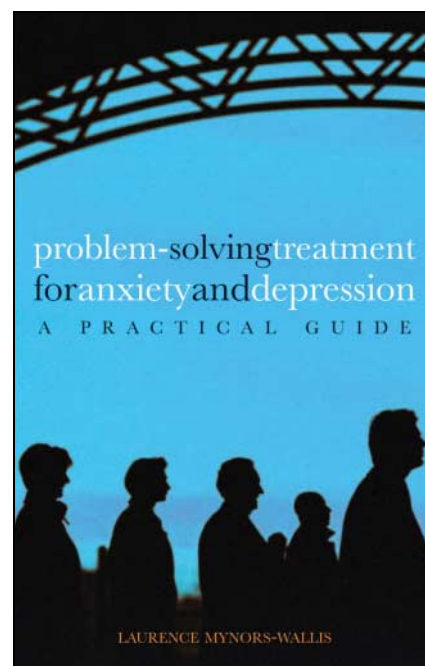
Like its predecessors, this edition of *Dementia* is an admirable piece of work that is a comprehensive and cutting-edge reference book, while being easy to read and accessible to readers from different professional backgrounds. No department that is providing healthcare to the elderly should be without a copy.

Sarah Cullum Old Age Psychiatry, Thornbury Hospital, Eastland Road, Bristol BS35 1DN, UK.
Email: sarahcullum@blueyonder.co.uk
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Problem-Solving Treatment for Anxiety and Depression: A Practical Guide

By Laurence Mynors-Wallis.
Oxford and New York: Oxford University Press. 2005. 206pp. £24.95 (pb).
ISBN 0198528426

Why aren't more people being trained in problem-solving therapy? All of the recent policy-related material about improving access to psychological therapies (I am thinking here not only of the influential report by Lord Layard, *Mental Health:*



Britain's Biggest Social Problem, but also the NICE guidelines for depression) focuses inevitably on how we must have more cognitive-behavioural therapy and that will be the answer to all of our problems. Here is a pragmatic, effective, easy-to-learn therapy that actually makes sense to patients and professionals and has been specifically demonstrated to be effective in primary care settings. Yet it hardly ever gets a mention. Perhaps it is quite simply because it is not dressed up in a language that is almost impenetrable to the uninitiated, it does not require years of training and it is not held to be the particular remit of a small group of mental health professionals.

Laurence Mynors-Wallis, who has been working on problem-solving therapy since its early days in Oxford, has written a very accessible and immensely practical book which guides the reader through what problem-solving therapy is, the evidence for its effectiveness, the specific difficulties that might be faced in trying to do it and finally how to teach it. Problem-solving therapy has been demonstrated to be effective for major depression in primary care, and for people who self-harm. It is less effective for minor depression and dysthymia. But why has there never been a head-to-head study of problem-solving therapy *v.* cognitive-behavioural therapy?

In general, the case examples in the book are realistic and useful, but I could not help wondering whether the initial patients seemed to have problems that were too straightforward; if a problem is so easy to solve, you generally don't need to use a problem-solving approach. Also, I would have found it helpful to have a section on dealing with people who present with a difficulty in making a decision, as this is a common scenario in the setting of depression and the problem is usually brought to the professional for their advice on 'what to do'.

So, to answer my own question, why settle for something simple and cheap that works when you can get something so much more expensive and complicated? Maybe this is one of those intractable problems of healthcare delivery that even problem-solving therapy cannot solve.

Linda Gask Professor of Primary Care Psychiatry, University of Manchester, Walmer Street, Manchester M14 5NP, UK.
Email: linda.gask@manchester.ac.uk
doi: 10.1192/bjp.189.3.287a

Understanding Eating Disorders: Conceptual and Ethical Issues in the Treatment of Anorexia and Bulimia Nervosa

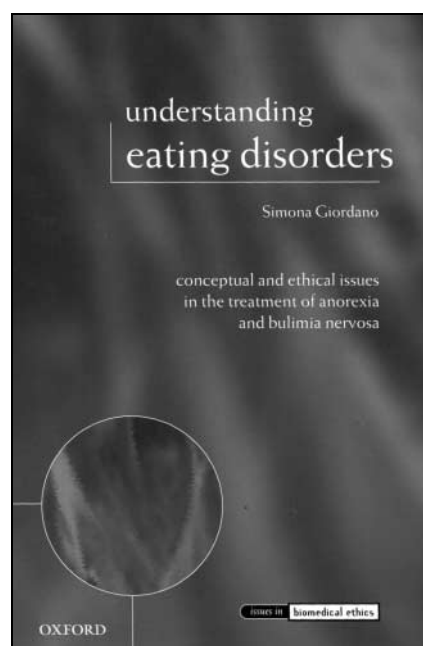
By Simona Giordano. Oxford: Oxford University Press. 2005. 297pp. £45.00 (hb). ISBN 0199269742

'When someone is taken into hospital dehydrated and malnourished, we have to make a choice. You may say "I don't have to do anything. Thank God I'm not a doctor, I'm a philosopher and my job is to think, not to act".'

This snatch of a conversation is related by the author in an ironic vein. Yet it illustrates the gulf between the ethicist and the clinician which is the main theme of this book.

Simona Giordano is a lecturer in bioethics at the School of Law in Manchester. She holds a Doctorate of Philosophy from the University La Sapienza in Rome. From the acknowledgement in her book, it appears that she worked with patients in the private psychiatric clinic Villa Rosa in Viterbo, Italy. Her book purports to be the first full philosophical study of ethical issues in the treatment of anorexia and bulimia nervosa.

The author presents the principle of 'weak paternalism' which requires some explanation. In the sphere of clinical decisions, paternalism is when the doctor intervenes against his patient's manifest wishes in order to protect her welfare.



The term weak paternalism is used in a technical sense meaning that the paternalistic intervention should occur only when the patient's autonomy is impaired. Strictly speaking it is not so much the paternalism that is weak, but the patient's autonomy that is so impaired that her welfare is at risk in the absence of a therapeutic intervention.

Autonomy is the person's right of self-rule and is generally supported and defended in liberal societies. The restriction of autonomy is justified only if it is likely that the individuals will do serious harm to themselves, or if they deny themselves important benefits (e.g. health). Weak paternalism is thus the justification for a non-consensual intervention when it can be shown that the person's autonomy is impaired.

Although autonomy seems to be a very similar concept to that of 'mental capacity' proposed by the UK Law Commission in 1995, the author shrinks from accepting that impaired autonomy is due to a mental illness. After all, mental illness does not necessarily impair a person's autonomy. A patient's lack of competence (capacity) in reaching treatment decisions should not be presumed but rather it should be assessed, and this assessment will need to be repeated at different times.

The author distinguishes two kinds of autonomy. The first, named *substantive autonomy*, is satisfied when the *content* of the person's action is deemed rational, that is, the majority of people would act similarly in similar circumstances. The second kind is the *formal or procedural* conception of autonomy. It is satisfied when the person's process of reasoning and deliberation is judged appropriate to her decision-making. The person requires an assessment of her understanding and her ability to 'balance the costs and benefits of proposed alternatives' (rather than the result of the choice). This capacity for decision-making is relative to the specific decision and to the time it has to be made. This second kind of autonomy is characteristic of the legal approach to decision-making capacity in the UK.

This is not a dull book. At times it may be taxing to follow the tight-knit arguments but the reader's attention is soon revived by a series of radical and controversial asides. For example:

'From the points of view of respect for people's autonomy, the very existence of a mental statute (the M.H. 1983 Act) is therefore the signal of a