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.

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

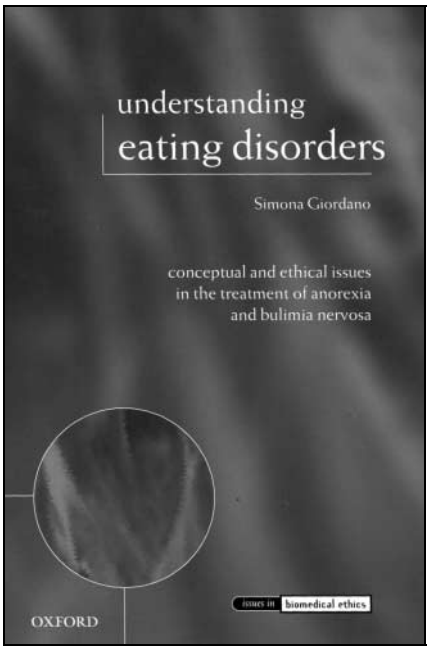
By Simona Giordano. Oxford: Oxford University Press. 2005. 297pp. £45.00 (hb). ISBN 0199269742

'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

> discriminatory attitude towards those who receive a psychiatric diagnosis' (p. 207)
>
> 'There is no ethical justification for the different treatment that the law reserves for people who have received a psychiatric diagnosis' (p. 6)
>
> 'Eating anomalies are not the symptom of an underlying mental disorder, as it is often argued' (p. 8)
>
> '. . . the provisions that in England and Wales regulate the care of eating disorders are based on assumptions that are either controversial or mistaken' (p. 208)

According to the author, the diagnosis of an underlying mental illness is no justification for coercive treatment. This also applies to the patients with anorexia nervosa. Yet when it comes to the crunch she inclines towards the need to save the patient's life, adopting weak paternalism because she can accept that the patient's behaviour is not truly autonomous. She describes eating-disordered behaviour as far too irrational: 'it is impossible for one to sacrifice her health and even her life for the sake of "thinness" '. The ethics of care and treatment of the person with an eating disorder therefore relies on a better understanding of the disorder.

With this aim in mind the author has conducted a compelling analysis of the psychological mechanisms whereby the anorexic patient's autonomy is likely to become impaired. They consist of a disturbance of body-image, a faulty awareness of signals of hunger and satiety, and cognitive distortions ('I'm different, 300 calories a day is plenty for me'). These faulty mechanisms compromise the process of deliberation and thus rule out eating-disordered behaviour from being autonomous. This may provide an ethical justification for non-consensual intervention.

This book achieves a high level of scholarship in its reviews of the literature on philosophy, ethics and the law relevant to eating disorders. It suffers a serious lapse, however, when it comes to the interpretation of empirical studies on the compulsory treatment of patients with anorexia nervosa. The small number of these studies makes it all the more important to report the findings accurately.

It is not true that there have been no studies of treatment outcome comparing compulsorily and voluntarily treated patients (Griffiths *et al*, 1997; Ramsay *et al*, 1999). It is a serious misinterpretation to state that the short-term weight gains in compulsory patients will be followed by higher long-term mortality, or that suicide is more likely (Ramsay *et al*, 1999). It is erroneous to state categorically that compulsory treatment compromises the relationship with the therapist (Serfaty & McCluskey, 1998).

In conclusion, the practising clinician may gain only limited practical help from this book when it comes to the non-consensual treatment of anorexic patients, with one exception. This exception concerns the author's clear guidelines on how to assess the individual patient's autonomy (or mental competence/capacity) when accepting or refusing medical treatments. But the most important reasons for studying this book carefully are for its tightly argued philosophical and ethical discourses.

Griffiths, R. A., Beumont, P. J. V., Russell, J., *et al* (1997) The use of guardianship legislation for anorexia nervosa: a report of 15 cases. *Australian and New Zealand Journal of Psychiatry*, **31**, 525–531.

Ramsay, R., Ward, A., Treasure, J., *et al* (1999) Compulsory treatment in anorexia nervosa: short-term benefits and long-term mortality. *British Journal of Psychiatry*, **175**, 147–153.

Serfaty, M. & McCluskey S. (1998) Compulsory treatment of anorexia nervosa and the moribund patient. *European Eating Disorders Review*, **6**, 27–37.

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Clinical Manual of Impulse Control Disorders

Edited by E. Hollander & D. J. Stein. Arlington, VA: American Psychiatric Association. 2005. 368pp. US$42.95 (pb). ISBN 1585621366

When Al Gore 'invented' the internet, he can have had little understanding of the Pandora's box he was opening. Unparalleled access to sex, gambling, and shopping, according to the editors of this clinical manual, have led to a dramatic rise in all kinds of impulsive behaviour, which is why the publication of this book is timely. However, despite the claim that the impulse control disorders have only recently burst onto the scene, they do have a history and are present in DSM–IV. Intermittent explosive disorder, kleptomania, pyromania and trichotillomania form an odd assortment of diagnoses thrown together as they did not fit in elsewhere. Although linked by problems with impulsivity it is acknowledged that this is a defining characteristic of many psychiatric illnesses, and the correlation (oft-repeated here) between reduced serotonin function and measures of impulsivity seems a tenuous basis upon which to construct a new diagnostic category. Yet with DSM–V in the early stages of development, now is the time to stake a claim for the legitimacy of this rubric, and to bolster the case a number of other disorders have been added: sexual compulsions, binge eating, self-injury, compulsive shopping and, yes, internet addiction.

Each chapter reviews one disorder, providing historical background, theories of pathogenesis, and means of assessment. As a clinical manual, however, the book disappoints when it comes to approaches to management. This may of course be a reflection of the lack of evidence for interventions being of benefit; notably, the preface contains a disclaimer stating that no US Food and Drug Administration-approved medication exists for impulse control disorders. Unsurprisingly, selective serotonin reuptake inhibitors and cognitive–behavioural therapy head the list of suggested treatments.

For me this book founders particularly in its failure to address the larger question, a question hinted at by an astonishing statement: 'Conscience is not a DSM–IV concept because it is difficult to operationalize how humans form moral judgements'