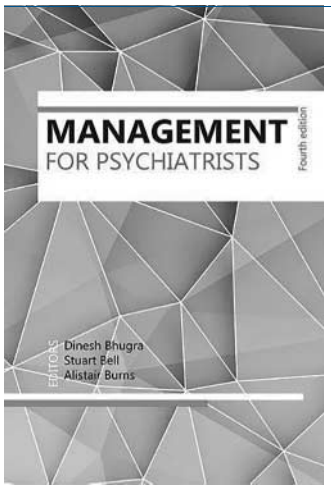

Management for Psychiatrists, 4th edition

Edited by Dinesh Bhugra, Stuart Bell & Alistair Burns, RCPsych Publications 2016. £45.00 (pb). 544 pp. ISBN 9781909726659

To many clinicians I suspect management is an anathema and has an air of mystique about it. This book provides a comprehensive guide to the complex world of management in psychiatric practice so as to debunk such ideas. It reflects changes where management and leadership skills for doctors have now taken on a degree of prominence. The book is comprised of 3 parts and 36 chapters.

Part 1 provides the theoretical overview: it describes mental health development within the wider National Health Service (NHS). It separately considers each country within the UK and encompasses political, funding and resource issues, mental health legislation and policy development.

Part 2 covers changes and conflicts. The chapters on change processes (especially the in vogue 'Plan Do Study Act' model), understanding systems, measurement of needs and quality improvement ('Quality and quality governance is everyday business and work') are vital for clinicians and impart solid theoretical knowledge that can be put into practice – so often change projects can appear to lack such theoretical underpinning and appear to be knee-jerk responses devised on the hoof. Revalidation, clinical audit (providing sage advice on a topic that can easily be poorly attended too), patient complaints and how to undertake mental health tribunals are also useful chapters.

Part 3 focuses on personal development. This part is pertinent for trainees and new consultants as it provides excellent guidance including an innovative chapter on compassionate care (caring for mental health service staff and the moral architecture of healthcare organisations and 'emotional labour' – new concepts I was unaware of). It covers the essential basics of chairing meetings, time management and presentation skills (who knew Aristotle still underpinned the art of speech-making used today!). An important chapter on stress and burnout will develop self-awareness about these issues that will inevitably touch many clinicians during a long career. The 'surviving as a junior consultant' chapter was erudite in its realistic advice.

The book is well edited in the sense of how well it flows considering so many contributors and how little, if any, repetition there is. A key theme elucidated is how management and leadership overlap but that by and large they are separate activities.

Some chapters may have benefited from having key learning points and resources summarised at the end. The chapter on getting the job you really want may have been more up to date had it discussed the now commonplace NHS jobs online application process (which sometimes specifically asks *not* to send an accompanying CV).

Given the ever-changing NHS landscape, management and leadership skills are intrinsic within a clinical career. This is a 'must have' book for all core and specialist psychiatric trainees and new consultants. For more experienced consultants, it will be an invaluable CPD resource. I fully concur with the editors who believe the relationship between personal skills and clinical management needs to become mainstream. Indeed, this book is so comprehensive it could potentially serve as the basis for an examination or accreditation as yet to be developed on this indispensable topic.

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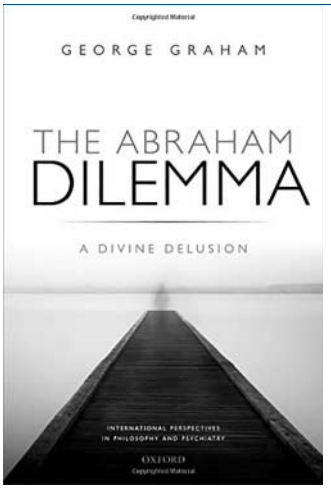

The Abraham Dilemma: A Divine Delusion

By George Graham, Oxford University Press 2015, £29.99 (hb), 192 pp. ISBN 9780198728658

The Abraham Dilemma is a philosophical exploration, proposing a theory of religious or spiritual delusion. It includes several modern case histories, some protagonists deluded and some not. The focus on Abraham is his offering his son, Isaac, as a sacrifice to God. The hostility of some mental health professionals to the very notion of spirituality or religion is decried, as is the claim that spiritual ideas, ipso facto, are delusional.

Graham's central argument is collecting the elements of religious delusion in the 'Five Factor Conception': personal over-engagement/over-investment/over-identification (i.e. lack of insight); harmful consequences of unwarranted sorts (serious harm comes from belief); resistance to criticism (overwhelming conviction); faulty belief formation and normative misjudgement ('even if this empirical belief is not false, the apparent subjective warrant for empirical beliefs is too strongly influenced and faultily biased' – belief based on delusional evidence); and impairment in reflective self-control (unable to examine critically attitudes and beliefs). The implication is that 'various mental disorders are often failures of proper moral habits of mind and behavior in people'.

Mental health professionals are specifically addressed. Unfortunately, the discussion on delusion is based on DSM-5, an epidemiological tool not suitable for delineating individual cases. In psychiatry, we identify delusion, a sign, and diagnose mental illness; delusion of itself does not constitute diagnosis. Our definition of delusion must include all delusions, not just religious – delusions are morally neutral; the term delusion should exclude beliefs in people who are not mentally ill. Form and content is an essential consideration for delusion and we need to make a clear distinction between delusion, a false belief, and hallucination, a false perception.

Was Abraham deluded? Graham writes: 'If truth is told and humility assumed, we are in no position definitively to diagnose

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Abraham'. Graham decides that Abraham was deluded because his belief would have resulted in unwarranted harm – the 'moral odiousness' that he should sacrifice Isaac. From a psychiatric standpoint, that is not sufficient reason to identify delusion, and there is no supporting evidence for mental illness. Descriptive phenomenology, the bedrock of psychiatric diagnosis, depends on finding the personal meaning of thought or behaviour for the individual, and that, for Abraham, we can never do.

The features of the 'Five Factor Conception' are a refreshing restatement of the features of delusion and are applicable for spiritual or religious delusion. From the perspective of psychiatry, which must also consider delusions other than religious and must make diagnosis leading to treatment strategy, we need to retain our existing definition or the detailed features of delusion listed by Munro (*Delusional Disorder: Paranoia and Related Illnesses*; CUP, 1999).

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