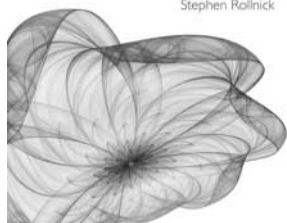


## Book reviews

Edited by Allan Beveridge, Femi Oyeboode  
and Rosalind Ramsay

**Motivational  
Interviewing**  
IN THE TREATMENT  
OF PSYCHOLOGICAL  
PROBLEMS

Edited by  
Hal Arkowitz  
Henny A. Westra  
William R. Miller  
Stephen Rollnick



**Motivational Interviewing  
in the Treatment of  
Psychological Problems**

Edited by Hal Arkowitz,  
Henny A. Westra, William R. Miller  
& Stephen Rollnick.  
Guilford, 2007.  
US\$38.00 (hb). 354pp.  
ISBN: 9781593855857

The rapid expansion of and growing interest in motivational interviewing across different aspects of mental health problems has been dramatic. This book of expert contributions co-edited by William Miller, the originator of motivational interviewing, is a very welcome text. It looks at the use of motivational interviewing in anxiety disorders, post-traumatic stress disorders, depression, suicide, eating disorders, gambling disorders, medication adherence, and other aspects of psychosis. The chapters are structured in a very readable fashion, providing a basic introduction and rationale to how and why motivational interviewing might be used in combination with existing approaches. A range of clinical examples are used to discuss and highlight specific points and these clinical cases provide a good discussion of the key messages in the chapters. The research evidence for efficacy is presented, with a clear, critical and well-informed approach and recognition of the limits of the existing evidence.

Motivational interviewing is a complex and subtle intervention, a mixture of art and science. The terminology used is that of developing empathy and the core is very much inspired by Rogerian non-directive approaches. However, motivational interviewing is slightly different in that it recognises ambivalence and resistance to change and aims to develop a reflective listening approach that actively promotes change within the individual.

Working with ambivalence and resistance to change is at the heart of many day-to-day clinical problems. Developing skills that enable doctors to structure their responses to such clinical challenges is welcome and in theory should readily integrate with the broader range of interventions.

The chapter on eating disorders is a very fine example of the application of motivational interviewing. The authors report that it has been a hit with both staff and patients and that it has been readily incorporated into the broader management strategy of anorexia. They present some data on randomised controlled trials and comment that motivational interviewing has a place across most aspects of eating disorders but the evidence is currently the strongest for anorexia.

I suppose the question that arises is how specific the treatment is that can be applied across a wide range of disorders and integrated with other forms of interventions. Is this simply improving the communication skills and the capacity for

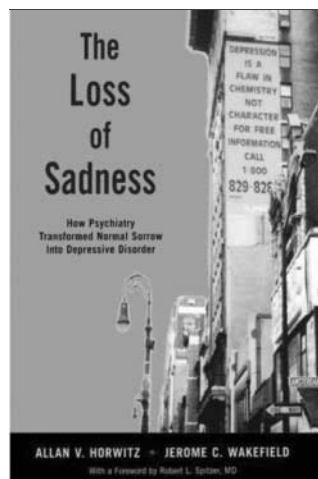
understanding, empathy and connectedness that should be at the heart of any talking therapy? The skills used are those of decent therapists and likely to have been used without articulation in many settings before the concept of motivational interviewing was formulated.

However, despite such commentary, this book outlines some clear and convincing evidence that the present-day eclectic therapist would do well to pay some attention to the possibility of incorporating motivational interviewing skills into their tool kit. Motivational interviewing would appear to be a useful adjunct for engaging people who are having difficulty in following established interventions and could be used to effect a better adherence to other talking therapies and medications.

The overall tone of this book is modest, self-critical and illuminative. It should be of major value to trainees who are looking for effective and humane interventions that fit into the mix of interventions delivered in day-to-day mental health services. I highly recommend this book to all clinicians.

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**The Loss of Sadness:  
How Psychiatry  
Transformed Normal  
Sorrow into Depressive  
Disorder**

By Allan V. Horowitz  
& Jerome C. Wakefield.  
Oxford University Press, 2007  
312pp. £17.99 (hb).  
ISBN: 9780195313048

This book charges current psychiatric practice with overdiagnosis of major depressive disorder, by including 'normal' reactions to losses. The authors note that big pharmaceutical companies have much to gain from casting the diagnostic net wide, and that sales are going up. They identify one, or the chief, culprit as the move in the Diagnostic and Statistical Manual of Mental Disorders (DSM) to descriptions of symptoms and syndromes regardless of context. The upshot, they argue, is that mood and behaviour may satisfy the DSM criteria for major depressive disorder even though they are normal responses to a significant loss (including, but not only, bereavement).

Clearly a lot – everything – hangs on how the authors differentiate 'normal' sorrow from 'genuine mood pathology'. Their proposal is that normal sorrow has three features, in brief: (a) it has an appropriate object, i.e. loss; (b) its intensity is proportionate to the extent of loss; and (c) it fades as normal adjustment recovery mechanisms come into play. Pathology is then indicated by failure of one or more of these conditions. According to the authors, this way of differentiating normal sorrow from depressive disorder follows from Wakefield's influential evolutionary

theoretical conceptualisation of mental disorder. I doubt this, but in any case the main implication is that diagnosis of genuine depressive pathology would have to establish whether the individual with symptoms was reacting to a loss in a proportionate way and for about the right length of time. This, as Robert L. Spitzer notes in his foreword, would present serious challenges to the reliability of diagnosis.

However, there are other problems with the authors' approach. The DSM's conceptualisation of mental disorder assigns primary importance to distress, disability or risk thereof; these in turn are connected, of course, to perceived need to treat (or to wait watching). In this context of (unmanageable) distress, downturn in functioning or risk, it is questionable whether the normality of mood – in the sense of understandable in relation to context – plays a critical role. We may well be able to understand, somewhat or well enough, why a single parent with little social support and a history of significant losses should become depressed, with distress and disability. Why should they, nevertheless, not be offered treatment? So far as I can see, clinicians have little use for the distinction between normal and abnormal depression except in the sense that normal may be used to mean: self-limiting, unlikely to carry risk, and no need to treat. Contextualising is less the issue: harm, risk and need to treat are.

The issue identified by the authors – increase of pathologising and prescribing – is serious and current; and they make clear one key possible diagnosis, that the limits of pathology are being illegitimately stretched. The authors are expert in this position and their book is essential reading for anyone concerned with these problems. This remains so even if there are differentials, for example that methods of detection have improved, and/or that there is no lower limit on the extent of distress and disability that we will take to the clinic in hope of help, especially if encouraged, for instance by direct-to-consumer advertising.

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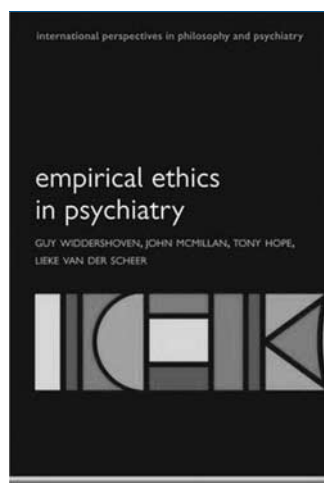
ethics is, the problem of the is/ought dichotomy and the naturalistic fallacy) and offers some reflections on possible methodologies, explanations and justifications for the emergence of empirical (bio)ethics as a discernable subfield of medical ethics. The second, longer section is devoted to specific examples of empirical ethics in practice that focus on ethical problems in psychiatry and mental health.

This book is both a comprehensive introduction to empirical bioethics and an exploration of familiar problems in psychiatric ethics. However, despite the common goal shared by all contributors, there is a wide variety of views on how the ethical and the empirical should be combined. Widdershoven and van der Scheer, for example, describe a pragmatic hermeneutic approach in which the practitioner, by virtue of his or her experience, is considered to have special moral knowledge that the empirical ethics researcher can access. In contrast, Verkerk, Polstra and de Jonge use case studies and Giddens' sociological theory of structuration to shed light on how healthcare structures influence our normative understandings of pressure and coercion. The editors have not shied away from including examples from both ends of the empirical ethics spectrum and many shades of grey in between. The excellent introduction and brilliantly clear first chapter by Hope and Macmillan gives even the novice reader the conceptual tools to begin to critically examine the chapters that follow.

This thoughtful and varied collection should appeal to practitioners primarily interested in psychiatric ethics, as well as those who are interested in the theory and practice of empirical ethics. Having just been tasked with developing a course on empirical bioethics, it comes as a great relief to find a book to which I can refer students; one that captures so well the possibilities, and problems, of the empirical ethics endeavour.

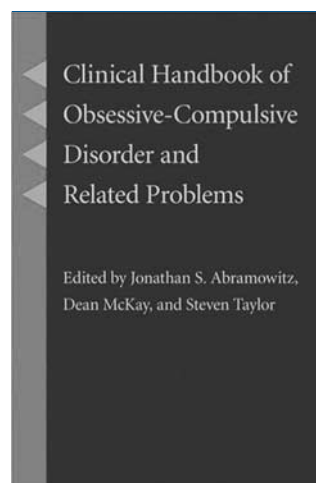
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### Empirical Ethics in Psychiatry

Edited by Guy Widdershoven, John McMillan, Tony Hope & Lieke van der Scheer. Oxford University Press. 2008. £29.95 (pb). 264pp. ISBN: 9780199297368



### Clinical Handbook of Obsessive-Compulsive Disorder and Related Problems

Edited by Jonathan S. Abramowitz, Dean McKay & Steven Taylor. The Johns Hopkins University Press. 2008. US\$60.00 (hb). 304pp. ISBN: 9780801886973

'Empirical bioethics' aims to combine philosophical analysis with empirical data to produce ethical analyses that are sensitive to and informed by practice, practitioners and patients. There is, however, disagreement about how this can be achieved. *Empirical Ethics* explores this tension in psychiatry. Section one describes a range of practical and theoretical approaches (what empirical

This book sets out to give a detailed account of the subtypes of obsessive-compulsive disorder and to consider whether there exists a spectrum of such disorders. The subtypes presented in Part I include those that will be familiar to most, such as fears of contamination, checking and unacceptable obsessive thoughts, and others like scrupulosity that may be less known. Each chapter