ESSAY REVIEW

Ladd, P.D. & Churchill, A.M. (2012). Person-Centred Diagnosis and Treatment in Mental Health: A Model for Empowering Clients. London: Jessica Kingsley Publishers. ISBN 978-1-8490-5886-5

Margot Lindsay RGN BA MPhil MCLIP PhD

Correspondence address
Dr. Margot Lindsay, Research Department of Mental Health Sciences, Charles Bell House, 2nd Floor, 67-73 Riding House Street, London, W1W 7EJ. E-mail: rejumev@ucl.ac.uk

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Introduction

This comprehensive manual provides a methodology for mental health practitioners to understand and empower patients to lead a full life and to develop insight into the disabling thinking which has reduced their quality of life so far. In so doing, it is an essential reference book for all those involved in mental health diagnosis and treatment, including psychologists, psychiatrists, mental health counsellors, clinical social workers, school counsellors and therapists. This empowerment of patients can be part of a process that has significant consequences for their health and futures. Rather than a list of symptoms associated with mental disorders the authors provide a visual schematic pattern of experience that is unique to each mental health disorder. This process can broaden perspectives and clarify professional roles. Throughout the manual, patient input into diagnosis and treatment is recognized and an attempt is made to formally empower the perspective of patients with selected mental health disorders and other mental health patterns. This approach provides mental health practitioners with meaningful person-centred experiences of patients in diagnosis and treatment.

The patient as expert on their condition

The uniqueness of the approach described in the volume is that it addresses a much wider range of mental health disorders than would otherwise be possible in a narrow medical model. Mental health patterns include: loneliness, bullying, abuse, loss, self-hatred and "burnout" or compassion fatigue and all are carefully addressed. This modern, problem-solving and inclusive approach to mental health diagnosis and treatment planning is part of the trend throughout life of individual engagement with large systems and power structures. This model may hold more meaning for the patient than a medical model of diagnosis, especially when the diagnosis is used to create new possibilities for growth and change. Understanding patients' problems in this way is potentially more than a label of dysfunction. They can also be working instruments where mental health practitioners and clients seek solutions together. Collaboration with patients becomes empowering through information sharing. The model addresses the whole person, not just their symptoms. It requires a therapeutic alliance with the client in understanding their condition.

Rather than focusing on removing symptoms the authors of the book focus on suffering, adding meaning to life which could be achieved with the support of a collaborative mental health practitioner. The authors do, however, acknowledge that there are occasions when pharmacological treatment is necessary in combination with other therapeutic approaches. A person-centred outlook speaks of the importance of patient involvement in all stages of mental health. A patient empowerment model works more effectively when a dynamic schematic pattern of each disorder is presented to patients, so that the patterns then make sense to them. Proposed treatment options are based on the entire experience of the patient and are not limited to treating specific symptoms. From a person-centred perspective, the primary purpose is to create developmental growth and change in future encounters with anxiety. This teamwork, including both patients and mental health practitioners, brings meaning to mental health practice. In order to find meaning in the experience of the person, it is important to treat the whole person, not just one facet.

How the book is organised

This manual deals with 9 disorders over 7 chapters on mental health patterns. This is ideal reference text for mental health practitioners who can very quickly have

access to invaluable tools to understand the disabling conditions of their patients. The case studies of each condition are followed by descriptions and suggested treatment approaches. The book is supported by a comprehensive bibliography to predominantly monographs, including specific references for every condition which has been considered.

The introduction explains how the medical model is augmented with a patient empowerment model that values a more person-centred outlook and the combination of these 2 models offers an alternative approach when diagnosing and treating patients. The voice of the patient is central so that the frequent reference to "empowering clients" is very appealing. An important attribute of this text is the consistently high standard of supportive guidance for assessing people's needs. These are described as Collaborative Diagnosis and Treatment Plans. Very helpful relevant questions for patients and mental health practitioners for an understanding of what each condition means to the patient. Personal diagnostic and treatment plans can be completed in collaboration between patients and mental health professionals.

The “medical model” implies that specific biological diseases of the brain cause mental health problems. However, many doctors now think that psychological and environmental difficulties may be at least as important. Doctors acknowledge that it is important to see the person behind the diagnosis and what interests that person as an individual. Since assessing anyone’s mental health problems depends almost totally on the person’s account of his/her experiences, this account is seen to be very important. The person’s experiences are unique to them and known completely only by the person themselves.

All of the mental health conditions examined are considered in great detail from the point-of-view of lived experiences, greatly enhanced by case stories. This review identifies 4 out of 16 chapters to demonstrate the same high standard of psychological and social insights which are found throughout the text. The 4 themes are: borderline personality disorder, bulimia nervosa, depressive disorder and general anxiety disorder.

Borderline personality disorder (BPD)

The examination of borderline personality disorder (BPD) identifies: impulsive/suicidal behaviour an unstable self-image, imagined threats and dependent relationships. Considering the lack of understanding of social situations that BPD entails, impulsive behaviour and even suicidal thoughts and behaviour become more understandable. It may be that people experiencing this disorder feel in crisis most of the time. They may also feel that they do not ‘belong’ and are unacceptable as human beings.

Discussing the impulsive acts exhibited by a patient during mood shifts, or a pattern of impulsive behaviour, may help to understand BPD. There may be meaning in certain situations that causes the person to have impulsive behaviour. It may be necessary to describe what experiences trigger a patient's suicidal behaviour, or whether these suicidal acts are based more on chance than on an established pattern. The patient’s image of himself can keep shifting from an affectionate love to a person no one could love. A person going through BPD can shift their self-image to accommodate the experience they are going through. Pointing out the meaning behind these shifts in self-image could be valuable in understanding self-image. The patient may be acting in this way to establish control over fear of abandonment issues, or to match the perception he thinks others have of him.

To identify imagined threats, it is important to understand the belief system of a person going through a pattern of BPD. Imagined threats are related to beliefs about life in general and it may be productive to connect these beliefs to how the patient experiences the world. The patient perceives the world as a threatening place and so even the most benign comment or reaction from others can be threatening and cause him to act defensively. He overreacts to what is happening in everyday experiences and cognitively distorts these experiences. Showing the disparity between the threat-laden beliefs of the patient and the context in which these beliefs are applied, demonstrates the destructive implications of imagined threats.

Measuring the extent of the need that a patient believes is mandatory in relationships with others may add an understanding of the intensity connected to these relationships. For example, is there a need to be with people for reasons of loneliness or anxiety, or is this need more severe such as “If I am not with somebody, then I will die” or “If I am not with someone, I am worthless”? Assessing how much patients believe others are responsible for meeting their needs may indicate the intensity of the BPD pattern. Measuring patients’ level of dependency may help in directing the appropriate treatment for that need. Dwight’s need for relationships caused him to become jealous and his jealousy reinforced his intense need to form dependent relationships.

Discussion of borderline personality disorder

It may be that the reactive mood swings found in the BPD experience are based on a lack of both empathy and double empathy. There seems to be difficulty with fully understanding another's words, feelings and experiences and being able to respond appropriately. For people experiencing BPD, they may feel consumed with their own need to survive. The inappropriate behaviour observed in the BPD pattern can be related to fear of abandonment issues and imagined threats-at the expense of engaging in the actual dynamics of what is going on in any given situation at any given time.

For most people who overcome BPD patterns, experiencing a caring, non-judgmental and understanding mental health professional who is willing to work with them over the long term may be the starting point for their healing. It may be that experiencing this disorder is an attempt to form an identity that feels comfortable and real. Through trauma, abuse and other disruptions originating in

childhood, people experiencing BPD may have been robbed of their identity and may be desperately looking for an identity that is acceptable to others. Therapy may be a safe place to begin that journey, with the goal of extending new roots of identity into other areas of a patient's life.

In the field of mental health, treating some of the symptoms of BPD solely with medication seems an incomplete remedy based on the interpersonal nature of this phenomenon. Many of the symptoms appear socially based, where developing interpersonal skills seems as important as chemical balance issues in the brain. It may be that mental health professionals have an opportunity to empower people experiencing this disorder by bonding with them in a structured and assertive way, while helping them find identity that keeps them from wandering on the 'border of life'.

Mental health practitioners may need to structure situations where interpersonal skills are learned, but also a sense of belonging is established, so that going through this experience does not keep people on the border, but helps them establish a sense of being part of a group. Social connectedness and belonging to a group may be primal needs of human beings.

Bulimia nervosa

The second mental health problem addressed in the manual is bulimia nervosa, which is thoroughly examined in the social psychological context. Ironically, social pressure to be thin and the constant comparing with others can increase a patient's desire for food. Food can become a highly meaningful symbol in the life of someone going through bulimia nervosa, where it can be an all-or-nothing mind-set in which abstaining from food creates increased pressure to eat food. In a sense, food may dominate other meaningful experiences in life. It becomes a battle over one's desire to lose weight while having an overwhelming craving to eat. However, the rules governing one's desire to eat can be rigid where one mistake may be viewed as a failure, weakening one's ability to stop craving food. Patients experiencing bulimia nervosa report very detailed descriptions of the food they consume, and how, where and when they consume it. Likewise, the purging or other weight loss techniques implemented after a binging episode are often very systematic. It is the combination between an over-emphasis on losing weight combined with an overwhelming craving to eat that can cause a loss of control, leading to behaviour that is perceived as compulsive and irrational.

Binging can be seen as the result of giving into one's desires and patients experiencing bulimia nervosa find meaning in self-criticism whereby they scrutinize themselves for their imperfect behaviour. It must be stated that the time between binging and the next step, purging, is short; however, that does not mean self-criticism stops when clients rid themselves of the binge food and calories through purging. Self-criticism seems to be a secondary symptom of the experience of bulimia nervosa. There is often an underlying theme in bulimia nervosa in which the act of binging is exacerbated by self-criticism. It seems hard to imagine patients engaging in purging behaviour without the influence of self-criticism as an underlying factor. Self-criticism seems to be most severe in the time between the binging and purging behaviour. Patients have reported that it is during this time that they criticize themselves the most.

The manual describes the final stage when going through a pattern of bulimia nervosa is similar to that experienced by patients who are suffering from anorexia nervosa. Dieting becomes an obsession where it can dominate meaning in one's life. It may become the principal meaningful event that all other meaningful events revolve around, as patients live from day to day. Beyond the prevalence of dieting in a pattern of bulimia nervosa and anorexia nervosa, dieting also seems connected to the social pressure and comparing stage in this pattern. In other words, dieting, social pressure and comparing behaviour seem intricately connected when patients are caught in a pattern of bulimia nervosa. Furthermore, binging and purging may be seen as an irrational solution to strongly held beliefs. Rules about the importance and meaning of dieting, social pressure and comparisons become other reinforcing characteristics.

It is important to identify the social, emotional and psychological pressures that reinforce bulimia. Some of the most predominant pressures are found in the culture of dieting, family dynamics and relationships, abuse and genetics. "I should be thin like my friends." A secondary theme was "If I am not thin, I am ugly and not as good as my friends." For other people, going through this experience may involve comparisons made with family members, people at work, feelings of emptiness, image of lovers and others not necessarily associated with one's peers. Making unreasonable comparisons can be the triggers that set the bulimia nervosa pattern in motion.

Often, the pathway to recovery from this disorder requires more than changes in behaviour. It may require a deeper understanding of why a patient desires to be thin and why such cravings create feelings of being out of control. It may be that making connections between desires and cravings with an understanding of pressures emanating from family problems, abuse issues, identity confusion, or self-esteem problems, will create important insight for patients experiencing bulimia nervosa.

It may be helpful to know if the binging serves any purpose other than or in addition to satisfying a craving, such as distraction from painful thoughts or punishment for what is perceived as shameful behaviour. It may be useful to identify the triggers. Treatment may include an understanding of the many methods that one uses in purging after binging on food. Education on the dangers of purging may be useful in curtailing this pattern; including pointing out that purging connected to bulimia does not make people lose weight. Instead there might be a slight weight gain. This makes bulimia different from anorexia nervosa. Beyond understanding how people purge, it may be important to help patients develop skills to stop purging, such as how to control thoughts and images, meditation techniques, methods for releasing pain in more positive ways and strategies to increase tolerance for discomfort. A

programme based on skills that slow down and counteract the patient's urge to purge may be helpful. Any preventative measure that equips the patient with proactive coping may short-circuit the cycle of binging and purging.

There is a small body of evidence that shows a weight maintenance diet based on dietary restraint theory can help patients control their pattern of bulimia. However, other treatments for bulimia indicate that dieting involving some form of reduced caloric intake does not work. It may be necessary to have a thorough understanding of nutrition in order to help people make healthy food choices as they go through this process. There is often a tendency when binging and purging to eat those foods that cause an increase in weight and are considered dead calories. For example, how many cases can be found where patients binge and purge on fruit and vegetables? The biology of nutrition and dieting in relation to metabolism and food composition may help patients understand the importance of a healthy diet. Referral to a nutritionist may be useful in the overall treatment of bulimia. The book reviews all of these factors and areas of study in the necessary detail.

Discussion of bulimia nervosa

From the perspective of mental health professionals, bulimia nervosa is more than an intrapersonal problem that emanates within any given person. The book considers that bulimia can be considered a social problem, where the judgment and comparisons with others may increase the severity of the problem. In some respects, problems with control can be seen to be at the centre of the experience of bulimia. In other words, "Who is in control of one's behaviour?" In order to empower patients experiencing this disorder, it may be essential to help them regain the centre of control within themselves. Social pressure and comparing behaviour are elements of losing control over self. The ability of patients going through this pattern to successfully control social pressure and the ability to stop comparing one's self with others, may be 2 important interventions. Regardless of whether social pressure and comparing are based on negative body image, abuse issues, family systems problems, or genetic or biological tendencies, empowering patients to face these problems is a reasonable goal for both patient and professional.

A desire to lose weight and one's craving for food seems to be the paradox associated with this disorder. Herein is found the war that occurs between the thoughts and feelings of people going through a pattern of bulimia. The body-mind dilemma may be at the heart of understanding this pattern. The obsession to lose weight is only matched by the compulsion to binge uncontrollably, with both causing patients a loss of personal power. The development of strategies that address the connection between body and mind can empower patients to resist the pattern of bulimia, where a loss of control is the eventual outcome. It may be that the solution for bulimia nervosa requires a balance between addressing the causes of the disorder and developing skills to resist the behaviour pattern. Why one desires to lose weight may be as important as how one loses weight. Both of these elements may need to be addressed in a successful intervention to treat this disorder.

It is clear from the book that compulsive binging is strongly associated with a loss of power. When patients begin to binge, it may be the moment when power is given over to the disorder. To disrupt a pattern of bulimia and empower patients, the compulsive binging should be the focus of concern. Without binging, there are no elements of self-criticism or purging behaviours. It is the cycle of binging and purging that gives this disorder its name. Patients can be empowered by regulating their food intake in a manner that is meaningful to them. This may or may not include dieting, though many experts believe that dieting does not work. It may be that empowerment in a pattern of bulimia comes from food regulation as much as from food abstinence.

The self-criticism experienced by patients for their binging behaviour is a complex issue. Understanding and awareness regarding the different forms of self-criticism may decrease purging behaviour. Some might argue that binge eaters who purge through exercise may not have the level of self-criticism as those who purge by vomiting. However, in order to feel empowered in facing this disorder, it may be important to recognize that physically purging and the use of exercise are both desperate acts based on low self-esteem. Self-criticism may be more of a reaction to a lack of control in binging than an indication of how one feels regarding purging.

Actually, many people experiencing this pattern do not view purging as a problem, at least not at first, but as a solution to a problem. On this point, the book is clear. Finally, an obsession with food has the same elements as an obsession with anything else. It dominates one's thoughts and gives importance to one element in life over all others. Patient empowerment may require a balance in perspective. Being obsessed with food likely causes other areas of life such as relationships, personal projects and personal development to be neglected. It may be the imbalance in life projects that causes food to become so important. This can also be said for dieting. Being on a diet that regulates one's ability to be a healthy person seems different from being on a diet that feeds into one's obsessions. Obsession with food and dieting may indicate and inflame larger issues of cultural pressures, abuse, emotional emptiness, stress-filled transitions and past personal trauma. In this regard, food and dieting become attempts at relieving more extreme stresses or emotional upset by indirectly using food and dieting as unsuccessful solutions to these problems.

Depressive disorder

Worthless feelings seem a part of the devastation patients feel when going through depression and there is often a sense of incompetence or failure related to this experience. The book describes how finding out specifically what feeling worthless means to patients can give purpose to these feelings. In the narrative, feeling worthless meant that Frank was a failure at life and he was consumed with

guilt, while other patients may attribute different meaning to feelings of worthlessness. One patient narrated that her feelings of worthlessness meant she held little value as a person, which meant she was undesirable to others and doomed to be alone. It is one matter to have worthless feelings, but it is another to know *why* you are having these feelings and what these feelings mean to you. Pointing out that feelings of worthlessness may be based on numerous possibilities may create a conversation regarding worthlessness. For example, Frank seemed clear about why he felt worthless and by stating feelings into a more productive outlook where finding pleasure in life becomes meaningful. When patients understand the pattern of depression and the paradox of isolating and over-focusing on negative thoughts and symptoms, they seem less likely to internalize and inadvertently exacerbate their symptoms. Person-centered therapy can help patients be more kind and patient with themselves, rather than being critical about their lack of pleasure.

Discussion of depressive disorder

Being overly sensitive and experiencing feelings of worthlessness become difficult but meaningful aspects and events in the lives of people experiencing depression that alter their beliefs about themselves and their existence in the world. The patient empowerment perspective applied to depression in this chapter differentiates itself from the medical model that is more concerned with symptom reduction. The patient empowerment approach helps patients identify meaning in the pattern of depression. Mental health professionals have an opportunity to help patients struggling with bouts of depression to go beyond symptom reduction and find meaning in their experience. With guidance focusing on growth and change, individuals can redefine the difficult experiences in their lives through the development of new interests, facing obsessions and redefining worthless feelings. Many patients report that the experience of overcoming depression, although painful, strengthened them and allowed them to reaffirm their values and commitment to living a meaningful life. The empowerment found in changing feelings of entrapment and the confidence found in overcoming a defeatist attitude, seem more focused on growth and change than symptom reduction. Such an approach may require a meaningful understanding of the patient's experience, which goes beyond the goals of controlling and stabilizing symptoms.

Overcoming depression and perceiving it as a meaningful experience may strengthen one's resolve to find new pleasures and interests. Mental health professionals may be in a position to empower people experiencing depression to differentiate between necessary and unnecessary suffering. If suffering experienced in a pattern of depression can add meaning to the life of patients, then it may be the responsibility of the mental health professional to understand what suffering needs to be eliminated and what suffering becomes an important part of the growth and healing process and how this suffering can be endured in a functional way.

Empowering clients to seek out pleasure and regain it may be as important as stabilizing one's symptoms of depression and it may be the therapeutic alliance between patient and practitioner that empowers patients to move beyond their symptoms. Given the vast numbers of people who experience depression, it may be more appropriate to view mental health providers as guides or partners who form therapeutic alliances with patients experiencing additional stressors. The process of developing an alliance between patient and mental health professional may be an important first step in mitigating the isolation that fuels depression, while contributing the benefits of a significant social experience.

General Anxiety Disorder (GAD)

Before relieving the symptoms of excessive worry; patients seem concerned with developing an understanding of their personal uncertainty, especially in how uncertainty influences their lives. Helping them to understand their personal uncertainty seems more amenable to growth and change than symptom reduction. Furthermore, helping patients learn skills that will stop them over focusing on problems can be a preventative measure that helps avoid the pattern of excessive worry. Another consideration for mental health professionals pertains to patients experiencing a sense of underlying crisis. Growth and change that refocus patients away from continuous underlying crisis to a more stable sense of normalcy is in line with many mental health practices. Finally, describing to patients the overall pattern of GAD and how the accumulation of uncertainty can be as problematic as the experience of anxiety again requires empowering patients to face this reality. Emphasizing growth and change, especially for a disorder like GAD, empowers patients to focus less on symptoms and to search for meaningful solutions for changing this pattern in their lives. This is a pattern that traps patients in a constant cycle of uncertainty, over-focusing, excessive worry, symptoms reduction and underlying crisis that accumulates over time. It is the freedom from searching for the elusive certainty that gives patients the focus and energy to function well and to pursue purpose and meaning in their lives.

Treating the whole experience

The book describes the variety of approaches and tools that mental health professionals give people to deal with ingrained, troublesome patterns of behaviour and which help them manage symptoms of mental illness. The best therapists will work with individuals to design a treatment plan that will be most effective for them as individuals. This sometimes involves a single method, or it may involve elements of several different methods, often referred to as an "eclectic approach" to therapy. Psychodynamic therapies, which emphasise developmental factors, are recognised in the treatment of chronic emotional difficulties including personality disorders and

some physical symptoms. Increasingly, hybrid or integrative therapies have been designed for specific applications, for example, DBT (dialectical behaviour therapy) for self-harm. These newer therapies are especially likely to have accrued an evidence-base during their development. A patient empowerment model for treatment follows a growth and change perspective more than symptom reduction or a symptom maintenance model. Treatment is then based on the entire experience of the patient and is not limited to treating specific symptoms. Treating the whole experience includes symptom reduction as well as growth and change issues regarding neuroscience, beliefs, thoughts, feelings, behaviours and the social environment. This allows for a different emphasis in treatment beyond symptom reduction.

Personal approach

The book is clear that our mental wellbeing depends on our individual life experience, including our sense of self, perceptions, thoughts and actions. At the core of everyone is the unique story of the experience of living and of life itself. An essential part of this story concerns our interactions with other people. Although we are all different, we are all human and we depend on one another. When someone has mental health problems, they often have extreme or upsetting life experiences that are preventing them functioning in their current situation. Very often, the person becomes isolated even from friends and family. The book focusses on people as individuals, rather than on their symptoms, or on statistical populations or diseases. We all have our own ‘personal toolkit’ from previous life experiences. Present and past relationships, spiritual and cultural issues could be important, but are highly individual and best worked on by discussion with the person seeking professional help. These personal perspectives and interpretations are powerful for understanding subjective experience, gaining insights into people’s motivations and actions and cutting through the clutter of taken-for-granted assumptions and conventional wisdom.

The alternative approach

The anti-psychiatry movement of the 1960’s was an attack on psychiatrists' use of psychiatric diagnosis, drug and ECT treatment and involuntary hospitalisation. From a psychoanalytic, existentialist or a humanist perspective, people criticised what they regarded as an authoritarian, hospital-dominated, drug-prescribing regimen. Doctors can become too focused on symptom reduction. Drugs can be prescribed for dubious reasons, such as the control of behaviour, not in the interest of the sufferer, but for the benefit of others, to make the sufferer easier to manage. Reaching for prescriptions and pills can be seen as the easier way out. Respect for the sufferer has to be at the centre of concern, meeting the person’s needs in individualised ways, free from coercive professionalism, indiscriminate medication and rigid organisational systems. The professional's 'I know what is best for you' is an unacceptable abuse of power.

To balance this it is necessary to mention that some physical conditions first manifest themselves by changes in feelings and behaviour such as thyroid dysfunction, multiple sclerosis or a brain tumour. Drug treatments are the primary means of bringing acute psychotic symptoms under control and the maintenance of medication remains a key factor in preventing relapse. Drug treatments on their own are clearly not enough; rehabilitation and dealing with the socio-emotional factors which contributed to the illness, or which the illness has created, will call upon a wide range of skills and disciplines. Many people are rightly suspicious of drug use, especially when they are given little explanation of what the drugs are for, how they work, what effects and side-effects they may have, how long they may be needed with what risks and what, if any, alternative treatments might be available to enable a sufferer to make an informed decision. A patient may continue on inappropriate medication when, with correct assessment, a psychological or social intervention would have been preferentially indicated.

Writing style

Some aspects of the book need to be read critically. There are frequent references in the text to phenomenological narrative. However, tests have shown that the greater the use of polysyllabic words, the thicker the ‘fog’ that settles between author and reader. Phenomenology is an exploration of 'the essence of lived experience'. This philosophical approach concentrates on the detailed description of conscious experiences. Supporters of this approach do not deny objective reality, but emphasize the importance of each person's unique subjective experience of events on the way he or she reacts to the events. The value of such an approach is one of the most impressive claims of these authors, but a definition would have enhanced explication for readers not disciplined enough to consult dictionaries. The frequent use of “Diagnosing for…” could speak to the wider readership targeted by using word such as “understanding, identifying, establishing….”

Some psychotherapeutic methods which focus on the development of self-awareness to enhance wellbeing include many of the 33 mental health practices which are cited in the volume. These include: Mentalization-based, Attachment, Schema, Acceptance and Commitment (ACT), Existential, Behaviour, Meditation, Eye Movement Desensitisation and Reprocessing (EMDR), Rational Emotive Behaviour (REBT), Neurolinguistic programming (NLP), Existential and Narrative therapy. The Appendix offers clear explanations of these therapies, but the target readership of mental health practitioners could find them arcane.

The core strategies of Cognitive Behavioural Therapy (CBT) are that it aims to "manage" the production of symptoms of mental disorders. CBT excludes feelings,

emotions, unconscious forces – the depths that are so painful and the heights that are so joyful, the things that make life alive. Life is also about deep unconscious forces. CBT lacks a loving or expansive vision of human potential. It is highly structured with little room for the creativity of the moment. If mentally healthy people are self-directing, behavioural modification methods can be seen as manipulative.

Conclusion

The unique person-centered approach described in the book is a very welcome contribution to reference manuals for people working in mental health services. Every condition is very thoroughly examined with remarkable insight into living with and seeking solutions to psychological disorders in collaboration with mental health practitioners. The strength of the insights is that it addresses behavioural aspects of mental illness in a non-judgemental and sensitive way. The discussions of each disorder provide excellent and thoughtful explanations of living with mental imbalances. If students preparing for work in the caring professions use this manual they would greatly increase their work satisfaction from enriched relationships and successful rehabilitation of their patients. The book contains no quick fixes, but rather concentrates on the growth and development of individuals collaborating with mental health providers in person-centered relationships.