Book Forum

PSYCHOTHERAPY

Object Relations Brief Therapy: The Therapeutic Relationship in Short-Term Work, *by Michael Stadter. Northvale, N.J., Jason Aronson, 1996, 351 pp., $50.00.*

Wallerstein R: Personality Styles and Brief Psychotherapy. Northvale, NJ, Jason Aronson, 1984

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Most psychotherapists are eclectic. They read or attend conferences, present a brand-name approach, and put together a quilt of practices. Some then find a pattern that works well with many patients and report their integration in a book. Frequently, these books simply present a new brand-name approach to an old issue. This book, however, belongs to a different category; it is an excellent example of how to introduce a general theory to the field.

Why, then, call it "object relations brief therapy"? There are good reasons to do so. The field is huge; no one book can attempt to cover it. This particular approach focuses on short-term work and, within that frame, focuses on making maladaptive relationships successful. The author's attention to efficiency helps even skilled therapists review how to sharpen their focus in time-limited situations. Therefore, the title of the book is an apt description of the book's content.

One of the splendid features of this work is the author's emphasis on in-depth rather than superficial problems. The concepts of self and of roles in relationships are handled with appropriate complexity. The topic of self is discussed with regard to the multiple states of self and other conceptualizations that each person may manifest. Stadter also clearly defines the difference between rationing sessions and well-formulated work. Managed care, which represents the former, often "makes the holding environment of the therapy unstable and often causes the patients to feel unsafe." The latter can lead to change that endures well past the point of a planned termination.

Stadter's historical review is masterful: although it occupies the first third of the book, it is not an unreadable tour de force of all references but an apt sampling of what he calls "generations." The first generation includes Freud, Alexander, and French; the second, Malan, Davanloo, Sifneos, and Mann; the third, Horowitz, Strupp, and Binder, plus a pragmatic grouping of Balint, Winnicott, Bloom, Budman, and Gurman. Stadter's approach to personality disorders is aptly attenuated to his purpose, yet it is both clear and clinically sophisticated.

The vignettes are excellent teaching examples, and the book is recommended for use in training mental health professionals for brief psychotherapy. It is comparable to *Personality Styles and Brief Psychotherapy* (1), which has more on personality disorders and systematic formulation. *Object Relations Brief Therapy* is more recent, covers a wide gamut of cases, and has more historical review and focus on current issues of managed care.

REFERENCE

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A Clinical Introduction to Lacanian Psychoanalysis: Theory and Technique, *by Bruce Fink. Cambridge, Mass., Harvard University Press, 1997, 287 pp., $35.00.*

An outstanding facet of this book is the jacket illustration, part of a design by Annamarie McMahon. It consists essentially of a reproduction of the painting fatuously entitled *The Tempest,* executed around 1505 by the Venetian painter Giorgione. This painting has a long history of controversy; there are innumerable disagreements about what it means, and X-ray studies have shown that there were figures in it subsequently painted over by the artist for reasons we do not know. So, just as it is with Lacan's work, we are confronted with an ambiguous, controversial, and multilayered presentation.

Bruce Fink, professor of psychology at Duquesne University, is labeled on the dust jacket as a "practicing psychoanalyst." In his acknowledgments section, Fink tells us that Jacques-Alain Miller is "widely recognized as the foremost interpreter of Lacan's work today—and taught me the lion's share of what I know about Lacanian psychoanalysis." Unfortunately, Jacques-Alain Miller, Lacan's son-in-law, is an extremely controversial figure and, like Lacan, has become involved in a great many arguments about the interpretation and teaching of Lacan's system, in spite of the fact that he was the designated heir of Lacan's mantle. So what we are presented with in the book under review is Lacan as interpreted by Jacques-Alain Miller, whose teachings in turn have been interpreted by Bruce Fink—i.e., a multilayered representation of Lacan's system. Fink acknowledges that writing such a book "is a bold and perhaps foolhardy endeavor, and in attempting it I have no doubt exposed myself to criticism from all fronts" (p. 219). This is certainly true, but the purpose of this review is not simply to criticize Fink but to introduce the prospective reader to Fink's difficult book.

Actually, the book contains three books. The first 78 pages form an attempt to introduce some of Lacan's basic concepts. This is followed by three long chapters presenting Lacan's theoretical formulations of psychoses, neuroses, and perversions, as well as a valiant attempt on Fink's part to illustrate some of these concepts with clinical material. The final portion of the book, about 65 pages, consists of notes and recommended readings and should be read by anyone interested in Lacan because some of Fink's best elucidations are unfortunately buried in this section, which readers might tend to skip over.

There are two ways to teach Lacan. I have been trying to introduce Lacan to psychiatrists and psychotherapists by presenting selections and snippets from his teachings that would have immediate application to everyday clinical problems (1–3). Fink, on the other hand, attempts to introduce Lacan's

entire system, at least in outline. In order to do this, he has to make many unsupported generalizations, and the reader must be tolerant because many of Lacan's pronouncements are of a "take it or leave it" quality. It is fairly well-known that although Lacan claimed to be returning to the early work of Freud, his system actually differs from Freud's in many fundamental ways; a book review is too short a forum to discuss this at length.

Lacan deliberately wrote in an obscure and at times absolutely unintelligible manner, one made infinitely more complicated, I have painfully learned, by much play on words in sophisticated French that defies translation even by professors of French. Fink attempts to be as clear as possible, and one must give him credit for making a tremendous effort to explain Lacan's ambiguous, deliberately obscure, and narcissistically esoteric prose, but at certain points he simply is unable to do so. For example, he almost immediately gets into the issue of "the analyst's desire," which Fink tells us "is a kind of pure desiring that does not alight on any particular object, that does not show the analysand (the person engaged in analyzing himself or herself) what the analyst wants from him or her—though the analysand almost inevitably tries to read a specific desire into even the slightest intervention or interpretation" (p. 6). I must admit that I never gleaned from Fink's book an understanding of what is meant by "pure desiring," which sounds like a kind of Platonic concept devoid of any content. I do not blame Fink for this; I think it is an example of Lacan's obscurity and ambiguity. Fink writes, "The French man or woman in the street understands nothing of Lacan's grammar, much less of his multilayered polyvalent pronouncements" (p. xii), and he argues that French therapists have to learn about Lacan's work in a sort of apprenticeship to other Lacanians. This is how Fink maintains he learned about Lacan, and there is nothing to quarrel with in that contention.

If "pure desire" simply means that the analyst should usually feel free to express a desire for patients to continue their analysis, I would have no trouble with the concept, but I disagree with Fink that "the therapist must always express a desire for patients to continue, even if he or she feels that these patients have completed their work" (p. 5). I do not agree with his criticism of an analyst who told a patient that he could do nothing further for her; on the contrary, I admire this analyst's honesty. It is sometimes necessary, when the material seems to indicate it, to firmly suggest to a patient that perhaps at some level the analyst is considering termination, and I do not think this indicates to the patient that the analyst wishes the patient would stop coming, as long as there is no unusual countertransference problem. In my view, it is an indication that the analyst appropriately places the patient's needs ahead of his or her own, including the analyst's need to keep all analytic hours filled for financial purposes.

The other major area where I disagree with Fink is on the issue of the so-called short session. As Fink correctly notes, Lacan's varying of the length of the sessions scandalized the psychoanalytic establishment, and Fink tries to defend such behavior, although he admits that in most schools of psychology and psychoanalysis "such behavior on the analyst's part would be considered a serious breach of professional ethics—abusive, unconscionable, and downright nasty" (p. 19). He even goes on to suggest that a patient who received several extremely short sessions in a row was "in a sense, asking for it" (p. 19), which reminds me of the old argument that a woman who was raped brought this on herself by "asking for it" in some fashion. Fink says, "Not openly, necessarily; not even verbally, perhaps. But he may very well have known, at some level, what he was doing; he simply could not help it" (p. 19). This is usually known as blaming the victim, and I think that any analyst who practices what Fink labels as "scansion" is simply acting out some form of countertransference or worse. The argument that "scansion" makes it impossible for the patient to fill up the session with trivia does not hold, since it is quite feasible to interpret this to the patient and try to understand the meaning of it without punishing the patient—and charging a full fee for a 5-minute session is punishment no matter how it is rationalized. It is also something that Lacan himself used, according to Roudinesco (4), whose outstanding biography of Lacan would make a good starting point toward an understanding of Lacanian psychoanalysis before reading Fink's book. Roudinesco tells us that Lacan got his hair cut and received pedicures during sessions with his patients (p. 391). Fink does not discuss this.

Fink correctly notes that "psychotherapy has been largely discredited in the United States, and is frequently no more than a last resort . . . . To the American mind, the psychotherapist is often assumed to be someone who could not hack medical school, who flunked college math or science, and whose experience of human nature may be no more profound than that of talk-show hosts. Americans have no more faith in psychology or psychoanalysis than they do in astrology and palmistry (indeed, they may have less)" (p. 29). Fink does not mention that obscure writing and elitist seminars such as those offered by Lacan only add to the opprobrium in which psychotherapy is falling in the United States, along with the fact that, as he notes, "health insurance companies often consider any therapy with a prefix 'psycho' in it to be worthless; and the media depict nothing but therapists who take advantage of their patients and are more deranged than their patients in the first place" (p. 27). This is tragically correct and requires vigorous action on the part of professional organizations like APA and the American Academy of Psychoanalysis, but it is very difficult to counteract the power of the huge multinational insurance and pharmaceutical corporations, which are among those who influence the media and the political process in the United States. Fink claims that the worship of psychopharmacology is not so great in France and that there is a more tolerant understanding of human problems in that country.

In discussing analytic technique, Fink recommends "providing interpretations that are enigmatic and polyvalent" (p. 46). These are the sort of Lacanian statements that one either accepts or rejects, probably on the basis of one's own personality, and there is no point to criticizing or arguing with him in a book review. There are some really interesting aspects of the Lacanian system that should cause every psychoanalyst to stop and think, however. One of my favorites is Lacan's very vague, esoteric, and continuously changing concept of "object *a*." Fink says, " 'Object *a*' can take on many different guises. It may be a certain kind of look someone gives you, the timber of someone's voice, the whiteness, feel, or smell of someone's skin, the color of someone's eyes, the attitude someone manifests when he or she speaks . . . . Whatever an individual's characteristic cause may be, it is highly specific and nothing is easily put in its place. Desire is fixated on this cause, and this cause alone" (p. 52). He also reminds us of the importance of how our parents' desire becomes a mainspring of our own; however, he then begins to focus on Lacan's adaptation of Freud's emphasis on childhood sexuality (the so-called primal scene, for example) as the cause of all neuroses. Fink points out that Lacan, like the early Freud, emphasizes the role of the father in the formation of the neuroses, the psychoses, and the perversions, and so Lacan, in my opinion, neglects the pregenital and preverbal era. Psychoanalytic thought has shifted

away from this early Freudian attitude, at least in the United States, where the preoedipal period and the role of the mother are increasingly seen as fundamental in providing the soil on which neuroses grow. In this sense, Lacan does return to the early Freudian theory as he claims to do.

Lacan's approach to diagnosis also leans somewhat on Freud's early work, and it is interesting to note that the concept of a borderline personality disorder "does not constitute a genuine diagnostic category in Lacanian psychoanalysis" (p. 77). This is an example of where Lacanian psychoanalysis loses touch with reality, for, at least in the United States, borderline personality disorder is one of the most common and difficult problems that we have to face. It is interesting to learn that Lacan's 1960 reformulation of the mirror stage (p. 88), which Fink says is currently available only in French, sounds very much as if it were taken from the work of Kohut.

What Fink does not discuss is what I consider one of the most fundamental points of disagreement between Lacanian psychoanalysts and American psychoanalysts who commonly employ Freud's structural theory. The question of whether, as Lacan says, the ego is a false concept, a misconception, and an attempt to hide a self that has no essence and is nothing but chaos brings us to a philosophical debate involving postmodernism (5). At the same time, it expresses Lacan's unresolved negative transference toward his analyst Lowenstein, who was one of the founders of American ego psychology. It is unfortunate that this does not receive more attention from Fink for a U.S. audience.

The central chapters of the book, on psychoses, neuroses, and perversions, are theoretical and very difficult. The reader will have to be quite dedicated to the task of understanding Lacan to plow through his abstract concepts, but on the whole these chapters seem to me a fair attempt to make sense out of Lacan's obfuscatory seminars. I do not agree with Fink's claim that an interpretation can lead to a psychotic break. I do not believe that a psychotic break is ever precipitated by an analyst's interpretation; to me this is a form of *post hoc, ergo propter hoc* reasoning. If a person is going to have a psychotic break, he or she is going to have a psychotic break, but afterwards all sorts of things are customarily blamed for it on the basis of this type of reasoning. Fink promises us more discussion of Lacan's ideas about psychoses in a sequel to the present book.

Fink recognizes that nobody can write a book about Lacan without stirring up a great deal of controversy and complaint. On the whole, I think he has made a reasonable attempt to give at least a glimpse of Lacan's approach for U.S. mental health professionals. If those mental health professionals are interested in finding out about Lacan, I suggest that Fink's book might be one place to begin—after reading Roudinesco's biography (4). My own favorite introductory text to Lacan is by Lemaire (6). There are many others. Certainly, Fink's is the best book I have seen so far that makes an attempt to find some kind of clinical application of Lacan's approach that might be intelligible to U.S. readers.

Because I sincerely believe there are aspects of Lacan's teaching that are worthwhile for those interested in practicing psychoanalytic psychotherapy, I welcome the appearance of his book, and I believe Fink deserves congratulations for the effort he has made, even though it exposes him to criticism from all sides.

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Psychopathology and Psychotherapy: From DSM-IV Diagnosis to Treatment, 2nd ed., *edited by Len Sperry and Jon Carlson. Washington, D.C., Accelerated Development (Taylor & Francis Group), 1996, 546 pp., $44.95.*

Few would dispute that DSM-IV has been a major success in reestablishing the reliability (if not the validity) of psychiatric diagnosis in the United States. With their empirical, phenomenological orientation and categorical taxonomy, the DSMs, from the third edition onward, represent the resurgence and near triumph of neo-Kraepelinian psychiatry. In the sphere of psychiatric diagnosis, the atheoretical DSM approach now seems to predominate, having supplanted psychodynamic and other approaches to the conceptualization of the human psyche and its disorders.

The translation of DSM diagnoses into models of treatment has been much less successful. The remedicalization of psychiatry, the deemphasis of psychological factors, and an increasing emphasis on psychopharmacological approaches await the fervently sought linkage between psychopathological diagnoses and the "silver bullet" of psychotropic medications.

In contrast to psychiatric diagnosis, theories of treatment continue to reflect and rely on clinical theories of human nature and adaptation. In this sphere, the theories of Freud, his followers, and neo-Freudian innovators, supplemented by more modern cognitive, interpersonal, and systems approaches, continue to hold sway.

Psychopathology and Psychotherapy links DSM-IV diagnoses to the theoretical and psychotherapeutic thinking of Alfred Adler's "individual psychology." In contrast to the abstract metapsychological theorizing of his early mentor, Sigmund Freud, the Adlerian approach—with its core notion of the "life style" as central to understanding human function and dysfunction—is pragmatic and largely couched in the language of ordinary experience. Since few clinicians ordinarily encounter Adler's approach in their training and education, the current volume provides a primer of Adlerian concepts. Additionally, the reader is introduced to the importance of "clinical formulation" in the understanding of the individual patient. Later developments in Adlerian theory are much more akin to today's social learning, interpersonal, and cognitive psychotherapies. In contrast to the DSM-IV approach, Adlerian diagnoses and treatment are psychological in nature and integrate etiologic, psychodynamic, cognitive, and systems approaches.

After introducing Adlerian concepts and contrasting them to DSM, the remaining chapters review the various DSM-IV diagnostic criteria, recast the DSM-IV diagnosis in Adlerian

clinical concepts, outline treatment strategies, and illustrate with reasonable case examples.

Psychotherapy and Psychopathology would appear to be most useful as a textbook for graduate students in clinical and counseling psychology, for psychiatric residents in courses in psychopathology, and for the clinical supervision of novice counselors and psychotherapists. The obvious virtue of the book is its explicit, jargon-free linkages among diagnosis, clinical formulation, and concrete strategies of treatment. My third-year psychiatric residents in psychotherapy supervision struggle to move from the inpatient unit with the focus on DSM-IV diagnosis, stabilization, and case disposition to the more sustained, detailed, and nuanced understanding of the psychotherapy outpatient and the requirement to interact in a planful and understanding way to the patient's benefit. In an accessible handbook format, this book specifically describes the reasons that people are the way they are, the manner in which they maintain their unhappy and unfortunate maladaptations, and what is corrective from a psychotherapeutic point of view. In contrast to the dry DSM-IV categories, the reader finds people and their varied complexes, complexities, and life dilemmas vividly described and readily recognizable.

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TRAUMA

The Gulf War and Mental Health: A Comprehensive Guide, *edited by James A. Martin, Linette R. Sparacino, and Gregory Belenky. Westport, Conn., Praeger (Greenwood Publishing Group), 1996, 190 pp., $55.00.*

This book is an outstanding contribution to the psychiatric literature that summarizes many important issues related to the diagnosis and treatment of combat-related psychiatric disorders in the Gulf War. The editors all have special expertise in military medicine and military psychiatry. Dr. Martin served as a mental health officer in the Second Armored Cavalry Regiment during the Gulf War and coauthored five of the 16 chapters in this book. Ms. Sparacino is an accomplished medical editor with special expertise in the field of military psychiatry. Dr. Belenky is a well-known authority in the field of military psychiatry and combat-related psychiatric conditions who is still on active duty as Director of the Division of Neuropsychiatry at the Walter Reed Army Institute of Research. He also served in the Gulf War as a mental health officer in the Second Armored Cavalry Regiment.

The book begins with a fascinating historical review of psychiatric disorders that frequently occur in combat. Dr. Robert T. Joy is one of the world's experts in military medical history and currently chairs the department of military history at the Uniformed Services University of the Health Sciences in Maryland. His foreword gives a wonderful overview of the evolution of psychiatric combat disorders. An equally fine contribution is that of Dr. Faris Kirkland, a military historian with extensive combat experience in Vietnam. He summarizes the military situation in the Gulf War for the general reader in a succinct yet understandable fashion. Both of these contributions set the stage for the book and are essential reading before examining any specific chapters.

The book is organized in a logical fashion into three parts: Mental Health Services and the Theatre of Operations, Coping With the Experience of Combat, and Assessing the Gulf War Experience. The initial chapters in the first section focus on global mental health issues in the theater of operations and in Europe, whereas the later chapters focus on corps and divisional combat psychiatry issues. There is also a chapter that discusses the Navy's contribution to combat psychiatry for marine forces who are involved in combat. The editors were able to attract as authors individuals who were involved in the design and implementation of the various systems that are discussed in individual chapters.

The second section of the book, on coping with the experience of combat, moves from organizational issues to the individual responses of soldiers and sailors to combat. Chapters include information on the role of critical incident stress debriefings and battle reconstructions to deal with combat-related stress reactions. There is a chapter on how survivors of a SCUD missile attack responded and were treated. Another chapter discusses a specific incident related to stress debriefings following death from unexploded ordinance and how sailors reacted to an accident on a naval ship that resulted in the death of a number of their co-workers. Finally, there is a chapter that discusses the important role of occupational therapy.

Two chapters in the final section include lessons learned from the Persian Gulf War: the importance of unit cohesion and the need for the organization and training of mental health professionals to provide appropriate support and treatment of military personnel in future combat situations. The last chapter, by Drs. Belenky and Martin, discusses their perspective on how mental health teams will be organized for future operations: small, multidisciplinary, and mobile operational units to provide direct support to individual soldiers in small units.

The Gulf War and Mental Health is not for the general psychiatrist but for those many psychiatrists who work in Veterans Administration settings, who may be on active duty in the military, or who treat trauma survivors in civilian settings. Over the years, military psychiatrists have made major contributions to our understanding of posttraumatic stress disorder and acute stress reaction. This book details more recent findings. I found it to be one of the best publications to date on the role of military psychiatry in the Gulf War. Those with a special interest in military psychiatry should definitely purchase this text and review it carefully. Others wishing to have an overview of military psychiatry and its contributions to community psychiatry would also benefit from reading it. Dr. Martin, Ms. Sparacino, and Dr. Belenky should be commended for a wonderful contribution to the military psychiatry literature.

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Trauma and Self, *edited by Charles B. Strozier and Michael Flynn. Lanham, Md., Rowman & Littlefield, 1996, 303 pp., $58.50; $22.95 (paper).*

This book is a collection of essays inspired by the work of Dr. Robert Jay Lifton. Emphasizing the fundamental importance of Robert Lifton's work in the area of trauma and self, the editors state in their introduction, "Any investigation of violence, trauma and survival that moves below the surface will soon encounter Lifton." These essays address a wide variety of topics from very different perspectives, and most of them are compellingly well-written and thought-provoking.

The papers are not necessarily a tribute to Lifton but, rather, provide a sample of his influence on a variety of disciplines concerned with trauma and self.

The editors have divided the book into three sections. The first one, Trauma, is composed of four papers. The lead paper, by Judith Lewis Herman, discusses the effects of violence and trauma on memory; the principal question targeted is, What happens to the memory of crime? This is followed by a paper by Betty Jean Lifton on the adoption experience. The other two essays in this section explore a psychoanalytic context for trauma.

The second section has six papers focusing on trauma and violence within a social and historical perspective. The essay by Margaret Thaler Singer, "Thought Reform Today," which includes a very interesting discussion of thought reform (brainwashing) in cults, is particularly intriguing.

As described by the editors, the last section, Self and Transformation, includes essays dealing with "further understanding of the self in the present era." The topics of these papers range from an illuminating discussion of the relationship between Robert Lifton and Erik Ericson to an essay on the Japanese psyche. Of these, Gerald Holton's excellent essay on whether there is a substantial postmodern turn in science is remarkably incisive.

This book offers a comprehensive collection of well-written essays, grouped in a coherent manner, that explore the interaction of trauma and self. The topics covered are surprisingly wide-ranging, but the juxtaposition of such diverse perspectives within a single volume provides an important advantage: the scope is commensurate with and thereby illustrates the range of influence of Robert Lifton's work. This book is not, and does not pretend to be, a textbook; however, this impressive collection of essays will be of interest to anyone with curiosity in the issues of violence, survival, and the self.

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Role of Sexual Abuse in the Etiology of Borderline Personality Disorder, *edited by Mary C. Zanarini, Ed.D. Washington, D.C., American Psychiatric Press, 1997, 236 pp., $40.00.*

This is a superbly written and edited book that quickly and clearly answers the question implied by the title and then goes into rich detail on recent research examining issues and questions about the etiology of borderline personality disorder. The first chapter, written by the editor, gives a succinct but pithy review of the conceptualization of borderline personality disorder. Zanarini summarizes what she refers to as the first and second generations of studies of the pathogenesis of borderline personality disorder. She then describes "the start of a third generation of studies of the etiology" of borderline personality disorder, which are collected together in this book. She briefly describes the studies and their findings, which I found piqued my interest in reading the respective chapters for more detail. She points out that the studies share a number of conceptual and methodologic features setting them apart from previous research in this field. These studies assess a range of pathological childhood experiences rather than looking almost exclusively at sexual abuse; examine the facets of sexual abuse rather than simplistically assuming that all sexual abuse has the same effect on the development of borderline personality disorder; and apply multivariate analyses to determine significant findings from the wide variety of factors measured and recorded in the studies.

The chapter authors present a veritable panoply of research examining the etiology of borderline personality disorder. These include factors such as childhood sexual abuse, other childhood factors, maternal attachment, development of dissociation and self-mutilation, self-destructiveness, familial environment, and physical trauma and neurological vulnerability. Additionally, two chapters discuss theories of etiology and their application to the treatment of patients with borderline personality disorder. I found all the chapters to be eminently readable and logically coherent while also providing me with new knowledge and a new perspective about the complexity of this disorder. I will be more subtle and detailed in my history taking and have a new respect for patients' struggles dealing and succeeding with the stressors of living.

Zanarini states that "the evidence suggesting a complex etiology for BPD is also strenuously ignored by the clinicians who believe that sexual abuse per se is both a necessary and a sufficient precondition for the development of BPD. Although appealing in its simplicity, this view is simply not consonant with the relevant research findings. No study, including our own, which reports on the childhood experiences of an extremely impaired group of inpatients, has found that all borderline patients report having been sexually abused, and not all sexually abused patients in these studies are borderline" (p. 39). These chapters repeatedly document this and examine the complexity of this disorder, rather than looking for simple answers. The clinical relevance of the studies and their findings will be of interest to all clinicians who assess, diagnose, and treat patients with borderline personality disorder. I felt that the studies dealing with those patients who frequently mutilate or hurt themselves and those who repeatedly attempt suicide provided me with a richer perspective on the meaning of these behaviors than I previously had.

The editor is to be congratulated for providing the kind of guidance to authors that results in a book rich in detail, readable, and applicable to researchers and clinicians alike. Each chapter provides a good balance between hard data and clinical application. There are abundant references for each chapter. I recommend this book highly for researchers and clinicians alike who work with patients who suffer from borderline personality disorder. I feel the research methodology sets a new standard and overall approach for the effective study of all personality disorders as we try to better understand these complex illnesses and behaviors. As Zanarini writes, these patients' "pain and their future well-being are what is important, not our need to defend closely held theoretical positions."

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DEPRESSION

Caring for Depression: A RAND Study, *by Kenneth B. Wells, Roland Sturm, Cathy D. Sherbourne, and Lisa S. Meredith. Cambridge, Mass., Harvard University Press, 1996, 243 pp., $39.95.*

This is a well-written report of research—the Medical Outcomes Study—designed to investigate how depressed patients fare under the care of different medical caregivers and within the context of fee-for-service reimbursement plans compared with prepaid ones. The book begins with a sprightly although traditional review of how the illness of depression is currently defined, its widespread incidence, its serious toll in suffering

and economic costs to society, and the methods of treatment now available. In reviewing the literature, the authors point out that, in spite of all the efforts at professional and public education about depression, only about 6% of people with major or minor depression consult a psychiatrist. The general medical sector is the only source of care for at least half of all depressed patients, yet primary care physicians fail to recognize depression in at least half of the patients affected.

The Medical Outcomes Study obviously took an enormous amount of planning and work, involving 20,000 patients and 500 caregivers over a 4-year period. The investigators are to be commended on their enterprising attempt to answer this basic question: How can more cost-effective, high-quality treatment programs be made available for depressed patients?

Their study demonstrated that substantially fewer depressed patients were seen by psychiatrists in prepaid health plans (10%) than in fee-for-service reimbursement plans (22%). Psychiatrists treated more of the seriously ill patients. In general medical practice, depressed patients were more likely to be diagnosed and appropriately treated under fee-for-service plans.

Fifty-nine percent of all depressed patients received no pharmacotherapy whatsoever; 12% used only an antidepressant, 19% used only minor tranquilizers, and 11% used both. Antidepressants appeared to be substantially underused in patients under the care of primary care physicians and nonmedical mental health specialists, but even psychiatrists did not prescribe antidepressants for half of their patients categorized as suffering from high-severity depression. Minor tranquilizers were commonly prescribed by primary care physicians and psychiatrists alike.

Psychotherapy and counseling styles were also assessed. On average, primary care physicians offered 10 minutes or less of counseling, consisting largely of giving advice and education. Psychiatrists and psychologists offered longer sessions, using psychodynamic and behavioral approaches to therapy.

The most effective form of treatment, as measured by symptomatic improvement and improved overall functioning, consisted of a combination of counseling and the appropriate use of antidepressant medication. Combining counseling with antidepressants plus the regular use of minor tranquilizers failed to achieve as high a level of recovery and actually proved to be more costly. Counseling alone seemed to achieve better results than antidepressant medications alone. The best outcomes and highest costs were seen in patients treated by psychiatrists, and the poorest outcomes and lowest costs were seen in those managed by the general medical practitioner. This is hardly a surprise. One would expect psychiatrists to get better results, just as cardiologists specializing in hypertension should get better results when dealing with patients with high blood pressure.

Among patients of general medical and nonmedical mental health practitioners, outcome did not seem to be influenced by type of payment plan, but among patients of psychiatrists, those under a fee-for-service plan improved more substantially, while those under a prepaid plan actually fell prey to new functional limitations.

The authors offer a model for improving the quality of care while containing costs. This model includes the following factors: 1) provider specialty, 2) counseling, 3) antidepressant medication, 4) minor tranquilizers, and 5) costs and health outcome. Essentially, they recommend that antidepressants be used more extensively and in adequate doses and that the regular use of minor tranquilizers should be substantially reduced. Counseling should be routinely provided. Efforts should be made to improve the primary care physician's skills and motivation to detect and treat depression effectively. Given the authors' observations that patients treated by psychiatrists under prepaid health plans manifested a rapid decline in antidepressant medication use over time, short patient-provider relationships, greater use of minor tranquilizers—and significantly poorer outcomes—how treatment is paid for appears to have some relevance.

The conflict between quality of treatment and cost containment refuses to go away. It seems to me that we are in danger of being penny wise and pound foolish, as the old saying goes. If, according to the authors' model, the cost per patient of treatment by primary care physicians is around $1,500 while that by psychiatrists or other mental health professionals working collaboratively with psychiatrists is between $3,000 and $4,000 (with meaningfully better results), isn't the extra expense well worth it?

Nonetheless, it is likely that the primary care physician will continue to be responsible for the majority of depressed patients. Having personally spent years exploring ways to educate primary care physicians in the management of depressed patients, I know it is not a simple matter. Part of the problem, I believe, lies in the fact that most people either think that being depressed is a sign of personal weakness or attach significant stigma to depression as a mental malady. Primary care physicians may be no exception; in order for them to be free to recognize, accept, and deal with depression in their patients, they must also be able to do so in themselves and their families as well. What is clearly needed is a new way to view depression, one that distinguishes between nonpathological depression and those elements of the depressive experience which truly constitute "the illness," one that encourages depressed patients to reach out for help and their physicians to be ready and eager to give it.

This book belongs within easy reach of anyone responsible for mental health care planning. My chief criticism is that it would have benefited from more skilled editing, so that the major points of the authors' important study would stand out more clearly, thus saving readers a fair degree of frustration in their effort to discover what these are and giving them more time to digest the findings and think creatively about their implications.

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Postpartum Depression: Causes and Consequences, *by Michael W. O'Hara. New York, Springer-Verlag, 1995, 217 pp., $69.00.*

Professor O'Hara is the first non-British President of the Marcé Society; he has led a research team dealing with "post natal depression" for a considerable number of years. The body of research he has produced is perhaps the most important coming from the United States since the pioneering efforts of the Gordons in the 1950s and the studies of Paffenbarger in the 1960s. Professor O'Hara's surveys rank with best British surveys in this area.

The present monograph—a work of some 80,000 words with 250 references to articles and books published in 1956–1993 (all in the English language)—is not really a review of the problem of postnatal depression, which would require a melding of personal research with other information coming from many other sources. It is a gathering together of Professor O'Hara's own work and is comparable to the publication of a thesis; it will be convenient for researchers who can study

it in this form rather than as a large number of papers published in different journals.

It is an impressive contribution, but I have some concerns, which begin on page 1, where the author tells us that emotional disturbances in the postpartum period are usually divided into three groups—postpartum blues, postpartum depression, and postpartum psychosis.

This is an oversimplification. Peripartum psychiatry is a complex discipline; it is important, both for research and clinical practice, to do justice to this complexity. There are dangers in conglomerating diverse disorders under a single heading, such as postpartum depression.

Two large groups of disorders are not covered in this monograph: 1) patients with major anxiety, obsessive-compulsive, or posttraumatic (stress) disorders, all of which usually meet criteria for depression but have a different focus with important etiologic and treatment implications, and 2) disorders of the mother-infant relationship, which form a vital component of about 25% of all patients presenting with postpartum depression.

These topics, which are much more important than the maternity blues and more common than puerperal psychosis, are not listed in the index and are hardly mentioned.

With these reservations, this book can be recommended to those working in the field.

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ADDICTION

The Selfish Brain: Learning From Addiction, *by Robert L. DuPont, M.D. Washington, D.C., American Psychiatric Press, 1997, 525 pp., $29.95.*

This work's major thesis is that 12-step programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous are ultimately indispensable ingredients in the treatment of addiction. That is bound to be controversial in psychiatry, at least in the context of the practice guidelines published by APA in November 1995 (1). That document refers to such self-help groups as adjunctive and probably helpful in many cases. Dr. DuPont briefly mentions traditional psychiatric interventions, but he as much as says they are useful to the extent that they get addicts into 12-step, abstinence-based fellowships, in which they need to be involved for life. An addict does not recover but is recovering.

Dr. DuPont has impressive credentials. In addition to 25 years of clinical practice, he has served under three presidents as director of the National Institute on Drug Abuse. He has been certified in psychiatry, addiction medicine, and addiction psychiatry. He also has potentially controversial views. He wants us to do much more than we are doing to prevent young people from developing addiction and to force addicts into treatment. He advocates more mandatory drug testing, including in schools, and making the consequences of drug abuse stiffer. He is for "raising the bottom" for addicts.

There are four stages of addiction: fooling around, being hooked, hitting bottom, and recovering. Dr. DuPont acknowledges that there are many who can go no farther than the first stage, but he does not recommend it. Anyone can become addicted to the many reward-producing substances because of their profound effect on the pleasure centers of the brain. Everyone has those centers, but there are personal and environmental risk factors that heighten the danger of becoming addicted. Youngsters with character disorders are prime candidates for addiction and should never experiment with alcohol or other drugs. Families need to be vigilant and have a clear plan for dealing with the threat of nonmedical drug use by the children, including clear expectations of abstinence. Parents also need to establish the consequences, within the family, of failure to follow the rules.

Dr. DuPont sees the treatment of codependency as essential to effective intervention with the identified patient. Parents and spouses need Al-Anon as badly as the addict needs AA.

Addicts are self-centered and dishonest by definition. To the extent that their loved ones enable them to deceive themselves and others, they nourish the addiction. Anyone who is a codependent or has the potential to be one needs to know, says Dr. DuPont, that the addict's problem is not physical dependence but, rather, the appeal of the drug-caused high. The brain never forgets; that is why recovery is a lifelong process.

Dr. DuPont covers the subject of addiction from its history to predictions for the future. In a section of the preface entitled Hope for the Future, he predicts that the incidence of the disorder will increase, but he regards the recovery process as a "gift" to the recovering patient. I did not find this very convincing in terms of the prognosis for society. The Internet currently serves up prodrug propaganda, calls for repealing or weakening drug laws, and provides information about how to defeat drug testing and how to manufacture drugs (2).

Dr. DuPont has written this volume for everyone who is not already knowledgeable about the concepts and information that he so clearly illuminates. He obviously recognizes that it is too thorough and detailed for many readers, so, in the preface, he tells us how to get the most of the good from it by reading through it selectively.

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Research in Addiction: An Update, *edited by C. Stefanis and H. Hippius with D. Naber. Seattle, Hogrefe & Huber, 1995, 150 pp., $32.00.*

This book represents the proceedings of a symposium, sponsored by Ciba-Geigy Pharmaceuticals, held in Prien, Germany, in September 1993. Each chapter is a presentation by a particular speaker, followed by a discussion in which other participants comment on the presentation.

Like most symposiums, this collection does not aspire to represent a comprehensive review of the field in the manner of a textbook, giving equal weight to all of the various topics within that field. For example, the book contains virtually nothing on the subjects of cocaine, cannabis, or stimulant abuse or dependence. Similarly, the book provides only spotty coverage of many aspects of the epidemiology, phenomenology, and treatment of substance dependence syndromes. On the other hand, the neurobiological aspects of opiate tolerance and dependence are reviewed in great detail in two chapters, which together make up almost 25% of the book. Overall,

therefore, this is not a general text for the clinician interested in a comprehensive presentation on substance dependence, nor even a general reference for substance abuse specialists. Certain substance abuse researchers, on the other hand, may find some of the individual chapters of particular interest.

Among these chapters, I particularly recommend the two chapters on the neurobiology of opioid dependence, already mentioned, plus the chapter immediately following, in which Kalant offers a provocative hypothesis that drugs as diverse as ethanol, opioids, cocaine, cannabinoids, and benzodiazepines may share common mechanisms of reinforcement and tolerance. It is of interest that 4 years after the material in this chapter was presented, two new studies of cannabinoids (1, 2) have appeared that seem to support Kalant's predictions about common mechanisms of reinforcement. Other interesting chapters discuss the important questions of how to define "relapse" in outcome analyses and the interactive effects of psychosocial and pharmacological treatments for substance abuse. In highlighting these chapters, I do not mean to demean the others; it is simply that they tend to discuss relatively circumscribed topics, such as individual studies or particular public health problems in specific European countries. Among these, for example, are a discussion of intravenous temazepam abuse and intranasal snorting of flunitrazepam in the United Kingdom, results of a methadone substitution trial in Germany, and observations on opiate addiction in pregnancy and the newborn from an Italian clinic. Although these are perfectly reasonable presentations, they may be of little interest to the average American reader.

In short, therefore, although I have no particularly serious criticisms of the presentations grouped in this volume, I fear that its potential audience is limited. Typical readers of the *Journal,* I think, will be unlikely to want to purchase it for their shelves.

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