precise clinical description, 2) delineation of syndromes from near-neighbors, 3) delineation of syndromes that have a common outcome, 4) delineation of syndromes that have pathogenic validity, and 5) delineation of syndromes that lead to improved assessments or treatments. Some of the relational constructs already meet these criteria; others require further research. The chapter concludes with several examples of research paradigms, from animal studies to improved assessment—treatment and prevention strategies—that address the validity of relationship constructs.

This book is a relevant summary of the broad range of research focused on relational processes and relationship disorders. Its link to the planning efforts, beginning now for DSM-V, is timely and appropriate; the book nicely underscores the advantages and challenges of having a relational taxonomy in DSM-V. However, the book is more important than just its reference to the next DSM. It is a must read for all mental health professionals and students of human behavior who believe that relationships are an important component of human development, personality, and general well being. The authors of *Relational Processes and DSM-V* demonstrate their courage. Many investigators would be dissuaded from studying the complexities of relationships as being too difficult. Certainly, funding priorities and previous DSM planning efforts support such advice. Nevertheless, these researchers have persisted. They have used rigorous biopsychosocial paradigms that have conclusively demonstrated the relevance and utility of relational processes for clinicians. If a new relationship axis or additional relationship categories do not appear in DSM-V, given the continued efforts of these investigators, they will certainly do so in DSM-VI.

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The Future of Psychoanalysis, *by Richard D. Chessick. Albany, N.Y., State University of New York Press, 2006, 265 pp., $70.00.*

In the introduction of his book, Richard D. Chessick tells us that psychoanalysis is in peril of becoming "whatever the psychoanalyst is doing" and losing its anchor in Freud's work. His book is a plea to return to the writings of Freud, the keystone of the training of the previous generation of psychoanalysts. To Chessick, recent emphasis on phenomenology, self-psychology, object relations theory, and the analyst-patient relationship help the psychoanalyst listen and complement Freud's approach. However, it is Freud's topographical and structural theories that remain central, and it is Freud's emphasis on transference, drives, childhood experience, core unconscious fantasies, repetition compulsion, compromise formation, defenses, and the like that are the profession's bedrock. Chessick argues that to establish a future for psychoanalysis, psychoanalysts must return to its past while making use of the newer ideas. Kohut, Klein, and Mitchell may complement Freud but do not supersede him.

If psychoanalysis is to have a future, Chessick believes that it must avoid the Scylla of relativism where many points of view regarding analytic technique exist and the Charybdis of absolutism where only one, the classical view, is acceptable. He warns that extreme intersubjectivity where both the analyst's and the patient's views bear equal weight can border on nihilism but that the so-called classical psychoanalysis of mid-twentieth century America can rightfully be viewed as absolutism because only the analyst's view is correct. He goes on to see, through the lens of a Ph.D. philosopher and experienced clinician, that "there is a dangerous fallacy in the extreme intersubjective as well as those hermeneutic viewpoints that assume the centrality of continual co-creation of the data of psychoanalysis" (p. 19). Freud believed in the analyst's capacity to maintain objectivity toward both the patient and his own countertransference. It is upon this assumption that Chessick places his belief that accumulation of reliable data by many well-trained analysts can yield reliable theories that can position psychoanalysis as a science with a future.

Chessick translates a passage from Plato's *Symposium* where the physician Eryximachus describes two kinds of love. He then compares his own translation from the Greek with three others that differ sharply from it and from one another. This leads Chessick to the issues involved in the "translation" of dreams from the manifest to the latent where interpretations can also vary widely, depending on the theoretical stance of the analyst. This point also holds regarding the translation of Freud from German to English where similar variation takes place.

Another chapter centers on phenomenology and the continental philosophers who have contributed most to it. Chessick once assigned Heidegger as reading for a group of psychiatric residents and met with much resistance. Although important to Chessick, Heidegger, Husserl, Merleau-Ponty, Sartre, Boss, and Gadamer may not be the average expectable American psychiatrist's favorites either. Chessick tries to make their work seem relevant to ours, but really does not succeed. A chapter called "The Secret Life of the Analyst" deals with integrity "burnout," in which analysts no longer believe in their method of treatment. There is a chapter on Dante, who Chessick feels addressed common problems that psychoanalysts have to deal with today, such as depression, rage, hope, and love.

Chessick considers transference to be Freud's greatest discovery, and many would agree. The chapter on transference is an excellent overview of the literature that would benefit those nonanalyst psychiatrists who are seriously interested in dynamic psychotherapy. Chessick clearly explains why transference is not just a replication of past object relations and clarifies the role of the compulsion to repeat.

Several times, Chessick mentions "the contemporary subservience of the U.S. psychiatric profession to the wealthy and powerful international pharmaceutical industry" (p. 152) as well as the powerful influence of managed care. These two factors, along with psychoanalytic writers who privilege the patient's relationship with the analyst over the interpretation of unconscious conflict, are at the heart of Chessick's fears for the future of psychoanalysis. The three are related because all three weaken psychoanalysis by suggesting that "quick fixes" can replace psychoanalysis. Surely, achievement of insight through interpretation of deeply rooted unconscious conflicts is far from a rapid process. Medication, brief psychotherapy, and highly supportive techniques, in which no interpretation of the therapeutic relationship occurs, are often helpful, yet psychoanalysis is far from obsolete. In the opinion of this reviewer, it should always be considered when the above have not helped and the patient is suitable and practitioners or clinics offering it are available.

Chessick's background in philosophy allows him to compare the splintering of psychoanalysis in the decades since Freud with the disintegration of Plato's academy after his death. The mind-brain problem also receives careful attention with a review of contemporary views. His sense that psychoanalysis may succumb to the financial demands of managed care yields to a wishful, elaborate fantasy that it will revive and thrive all over the world in the third millennium because of a renewed interest in human processes. This follows a stimulating digression about creativity. Such is typical of the wide ranging scholarly yet clear writing that makes this a book for the psychiatrist's library, shelved hopefully somewhere near the well worn writings of Freud.

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Behavioral Treatment for Substance Abuse in People with Serious and Persistent Mental Illness: A Handbook for Mental Health Professionals, *by Alan S. Bellack, Ph.D., A.B.P.P., Melanie Bennett, Ph.D., and Jean Gearon, Ph.D. New York, Brunner-Routledge, 2006, 288 pp., $49.95.*

Studies of both community and clinical populations have repeatedly shown that many individuals with severe mental illness have co-occurring substance use disorders. Since the early 1990s, numerous authors have advocated the use of "integrated treatment" for patients with these two disorders. The term integrated treatment, however, has been defined in many different ways. If one were to survey substance abuse treatment program directors about their treatment approach with patients with co-occurring psychiatric illness, they would virtually all state that they deliver integrated treatment. However, they would be delivering quite different treatments. That is because there is no single, gold-standard definition of integrated treatment.

Allan Bellack, Ph.D., along with his colleagues Melanie Bennett, Ph.D., and Jean Gearon, Ph.D., have developed a model of integrated treatment entitled Behavioral Treatment for Substance Abuse in Schizophrenia (BTSAS), which they have broadened and re-titled to include individuals with bipolar disorder and other serious mental illnesses. Their handbook is a beautifully written, clearly delineated, user-friendly description of their treatment model.

BTSAS is a small-group (i.e., 4 to 6 participants) treatment approach that focuses specifically on substance use. Its six major components include 1) motivational interviewing to increase motivation to address substance use issues; 2) structured goal-setting regarding substance use; 3) a urinalysis contingency program, in which patients are reinforced for reductions in substance use; 4) social skills and drug refusal training; 5) education about both reasons for and consequences of substance use, with a goal of enhancing motivation to reduce or stop use; and 6) behaviorally-oriented relapse prevention training. A chapter is devoted to each specific topic in this book.

This book includes all of the core elements that one would hope for in a treatment manual: why, what, how, and what if. An excellent theoretical background section discusses the extent of the problem of substance use disorder-psychiatric illness comorbidity and reviews the ways that others have tried to address it. The theoretical underpinnings of BTSAS are discussed, along with the solid empirical evidence supporting its efficacy. The greatest strength of the manual is in the "how" and "what if" sections. The reader (perhaps a prospective therapist) is taught step-by-step how to prepare to conduct BTSAS and how to set up and run a BTSAS program. Groups are reviewed session-by-session. Skill sheets (e.g., making small talk, coping with depression and stress) are provided, along with outlines for conducting each session. Ample clinical examples are given, in which the therapist is instructed quite concretely about what to say throughout the group session. Common clinical problems are discussed, along with potential ways to deal with them. Indeed, an entire chapter is devoted to this topic; the therapist is advised on dealing with issues such as poor attendance, continued drug use, and crises such as loss of housing.

Dr. Bellack and his colleagues are clearly highly experienced with this population. They blend academic expertise with real-world experience in a way that enables the reader to benefit enormously from this manual, whether conducting BTSAS *per se* or working with this patient population in another treatment setting. This book is an excellent guide for both beginning and experienced clinicians working with seriously mentally ill patients. While many clinicians may have previously had difficulty knowing exactly how to address substance use in this patient population, this book will help them enormously to address this vexing and clinically important problem.

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