The Social and Political Contexts of Psychiatry

Psychological Concepts and Biological Psychiatry: A Philosophical Analysis: Advances in Philosophical Analysis, vol. 28, *by Peter Zachar. Philadelphia, John Benjamins Publishing Co., 2000, 326 pp., $39.95 (paper).*

Marcus Tullius Cicero (106 to 43 B.C.) defined six mistakes of man:

- The illusion that personal gain is made up of crushing others.
- The tendency to worry about things that cannot be changed or corrected.
- Insisting that a thing is impossible because we have not been able to accomplish it ourselves.
- Refusing to set aside trivial preferences.
- Neglecting the development of refinement of the mind and not acquiring the habits of reading and study.
- Attempting to compel others to believe and to live as we do.

These warnings were valid in Cicero's time and are valid now. I see them especially in the imposition of the will of managed care programs on health care providers and consumers. I also see their validity in the academic training programs for mental health professionals, whose leaders impose their particular perceptions of science rather than what the author of this book calls "folk psychology" on medical students and psychiatric residents. These programs have an influence on how mental health care is delivered, not only by mental health professionals but especially—and more alarmingly—by primary care physicians, who treat more than half of all patients with psychiatric disorders.

A survey conducted by the Rand Corporation in 1993 found that only half of the general practitioners participating in the study who treated depression spent three minutes or more discussing the patient's personal problems. This sobering statistic is very scary for all psychiatrists because most general practitioners are so biased toward the scientific, "broken brain" model that, without so much as a standard mental status examination or inquiries into family histories, they prescribe antidepressants and potentially addictive anxiolytics.

I have been doing book reviews since 1971, first for the *New England Journal of Medicine,* then for the *Journal of the American Academy of Child Psychiatry,* and now for the *American Journal of Psychiatry.* Nancy Andreasen, the Editor-in-Chief of the *Journal* and its Book Forum editor, is my former classmate, a friend, and one of the most brilliant minds I have ever encountered. I had a very difficult time reviewing this book and had to put it aside several times because the author, Peter Zachar, attacks her by name, as he does the St. Louis group headed by the late George Winokur, who was one of my professors.

This book is remarkable for its catholicity of intellectual breadth and the courage of the author in taking on the powerful intellectual forces that dominate the academic scene today. He tells these emperors that they may not be wearing the clothes of wisdom.

Zachar very skillfully builds his case brick by brick by exposing the specious "facts" on which "biomedical and eliminative materialists" build the foundation of their assault on folk psychology. Defining in laborious detail the evidence on which each of those facts is based, like Marc Anthony giving his famous speech praising the "honorable" men who assassinated Julius Caesar, Zachar makes it sound as if he were convinced that the quacks of folk psychology deserve to be hoisted by their own petards.

In fact, so well researched is Zachar's understanding of the materialists that the reader is best warned to be well versed in semiotics, physics, and philosophy and to have the patience of Job. The fainthearted and those with a less than intimate working knowledge of the Oxford English Dictionary might drop of mental exhaustion by page 294. In this regard, Peter Zachar is very much like Vladimir Nabokov: he is so encyclopedic in his knowledge and so elitist in his rarefied vocabulary that he never bothers to explain a lot of complex ideas or pause to use simple words rather than polysyllabic, arcane, or esoteric neologisms—the way a wiseacre would say "floccinaucinihilipilification" instead of "the action or habit of estimating as worthless."

What is most sobering and deflating for psychiatrists and other medical professions about this book is that it forces self-examination of our own psyche and motives and our prickly, overdefensive overreaction. The phenomenon described by Zachar was also described by Thomas Maeder in "Wounded Healers" (1). Zachar exposes the ugly misanthrope hiding under those who approach the emotionally troubled from a cold, clinical, biomedical, scientific perspective. Sue Erikson Bloland, the daughter of the great psychoanalyst Erik Erikson, described her father as a very distant, insecure man who pushed his own children away when they needed him most and who eschewed psychotherapy for himself (2). Sir Lawrence Olivier (3) stated that he was most at ease on the stage, where he could wear a costume and a facial disguise like a fake nose, moustache, or beard because they allowed him "the shelter of an alien character" that enabled him "to avoid anything so embarrassing as self-representation."

When I was in training, one of my "biologically oriented" professors often demeaned psychotherapists as "quacks and pseudoscientists" because "therapy never works." I asked him whether his misanthropy made him ineffective as a therapist, which would lead him to the conclusion that therapy does not work.

Don't You Believe It! by A.J. Hoover (4) is a catalog of the 30 logical fallacies most human beings are prone to, including 1) slippery slope thinking, 2) argument of the beard, 3) argumentum ad elenchii or begging the issue, 4) argumentum ad hominem or dismissing a fact because it is espoused by a reputedly stupid or widely known disreputable quack or immoral person, and 5) poisoning the wells or attempting to refute an argument by discrediting in advance the source of the evidence for the argument.

One by one, like dominos, Zachar fells one materialist tenet after another. He even administers a coup de grace for Nancy Andreasen and the Churchlands by reminding the reader that before their more recent, inglorious mutations into scientists they were aesthetically sophisticated Ph.D.s in English literature or philosophy.

Most psychiatrists and other materialist readers will be angered by Zachar's systematic and efficient dismantling of those who would be known as "scientific." Zachar shows his true colors—if not his finest moment—by reminding us that psychiatrists really do not need to dumb themselves downward to align themselves with mainstream medicine. Rather, it should be the other way around: the rest of medicine can develop compleat physicians by adopting the psychiatrist's Shakespearean breadth of interest in understanding the total human condition. Physicians need to be reminded that we treat more than just diseases.

Like Minoru Yamasaki, the architect of the World Trade Center, let us all begin with the end in mind. Yamasaki wrote that those buildings were supposed to be a "representation of man's belief in humanity, his need for individual dignity, his beliefs in the cooperation of men, and through cooperation, his ability to find greatness" (5). Zachar calls us to a table of dialogue, tolerance, and consensus, not the intolerance and "take no prisoners" attitude of Osama Bin Laden and his goons.

If I know Nancy Andreasen, she will read this book and encourage us to follow Zachar's call. I hope our materialist colleagues will follow her example and not fall victim to A.J. Hoover's logical fallacy number 30, pigheadedness, the ultimate fallacy—refusing to accept a proposition even when it has been established by adequate evidence.

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PC, M.D.: How Political Correctness Is Corrupting Medicine, *by Sally Satel, M.D. New York, Basic Books, 2000, 304 pp., $27.00.*

As one of the bastions of the American establishment, medicine has long been an inviting target of the countercultural forces first spawned by the New Left of the 1960s. Seen as insular, arrogant, elitist, and a guardian of the patriarchal social order, medicine was one of many obstructions to the implementation of an emerging socially activist philosophy in which the failure to thrive of disaffected elements was to be solely attributed to oppressive forces in society as a whole.

In recent years, following their failure to radically restructure American institutions in the Vietnam War and post-Vietnam War years, many left-wing 1960s extremist activists have pulled back to redoubts in the universities. There, as tenured faculty, they have promoted their liberationist ideologies recast as a new victimology facilitated by multiculturalism, rejection of competitive meritocracy, and repudiation of fixed truths and individual autonomy. In such a determinist scenario, victim populations have little or no individual responsibility for their life situations; nor do they have the means to elevate themselves, outside of a wholesale restructuring of society that emphasizes redistribution of wealth and power.

According to Dr. Satel, it has now fallen to the public health schools of the universities to apply the New Age truths to the redress of the physical and mental illnesses of those identified groups whom medicine has allegedly improperly diagnosed or is itself oppressing through its continued failure to embrace a treatment philosophy employing radical social change.

Dr. Satel is a lecturer at Yale University School of Medicine, staff psychiatrist at a Washington drug treatment program, and scholar at the American Enterprise Institute. Her extensive contributions to academic journals and the lay press alike on a wide spectrum of medical and psychiatric issues have opposed the increasing tendency to assign victim status to an ever broader range of identified afflicted subgroups. She understands that in so labeling people we may be relegating them to chronic debilitating dependency, waiting for external change that may never come. Even worse, in blaming society alone for their ills, we may be withholding individualized treatment better able to minimize disability and suffering than politically inspired measures in pursuit of larger societal goals.

Among the more shocking but representative examples cited in *PC, M.D.* of how illness in one victim group is being cynically subordinated to the larger purpose of "redesigning society" is the statement attributed to Sally Zierler of Brown University's Department of Community Health that AIDS is a "biological expression of social inequality." Speaking at the 1998 annual meeting of the American Public Health Association, Zierler's recommendations for curbing the AIDS epidemic were reportedly all in the area of promoting social and economic justice rather than in the area of care of the self.

It is indeed fitting that in this book a practicing psychiatrist should be sounding the clarion call of alarm signaling the dangers to health care and patients of implicitly allowing the counterculture to negate the scientific basis of medicine and the role of individual accountability in the promotion of diseases in which choice plays a part. At the heart of psychiatry's optimistic ethos is the near universally held belief that self-exploration in psychotherapy facilitates growth in autonomous functioning and enhancement of both motivation and capacity for healthful choices in living.

In first writing "Opiates for the Masses" (1), Dr. Satel took issue with those who support heroin maintenance and then-U.S. Health and Human Services Secretary Shalala's endorsement of needle exchange programs for addicts. She objected to a philosophy of "harm reduction," which contends that drug abuse cannot be avoided and "consigns [addicts] to their addiction, aiming only to allow them to destroy themselves in relative 'safety' and at taxpayer expense."

In *PC, M.D.,* Dr. Satel expands on her earlier article to caution that acceptance of drug addiction in the United States may soon reach the "zenith" it has attained in the Netherlands, where addict activists believe that "drug abuse is a hu-

man right and the government has a responsibility to make it safer to be an addict." In such a scenario, "addicts represent a class of oppressed citizens," notwithstanding that it is their own behavior that leads to their oppression. Dr. Satel also expresses a similar concern over the destigmatization of pregnant mothers who take crack cocaine, another group of substance abusers who are ambivalently being pressed for change. She introduced this theme in "The Fallacies of No-Fault Addiction" (2). Although the well-meaning might find favor in arguments supporting the avoidance of coercive measures in both of these groups, in reality they are much in accord with victim politics, which detracts from the need to change of those who are dysfunctional and sapping their will to do so.

The seriously mentally ill are not exempt from accountability for socially unacceptable or threatening behavior. Recounting in her current book the tragic circumstances prompting the passage in New York of "Kendra's Law" in late 1999, which mandates involuntary outpatient commitment of the potentially dangerous mentally ill, Dr. Satel fails to take credit for her editorial promotion of such a measure earlier in the year, which may well have influenced the outcome. Braving the expected opposition of civil libertarians, in "Real Help for the Mentally Ill" (3) she found herself on the right side of emerging public opinion. In this instance, as in the case of recalcitrant drug addicts, Dr. Satel allied herself with the position that even those who are dismissed as intractable can both respond to and benefit from the concern implied in society's efforts to treat them, even if coercively, while safeguarding public safety.

In a commentary titled "Are Women's Health Needs Really 'Special,'? " (4), Dr. Satel proved herself unafraid to take on her psychiatric peers when they appeared to support the emerging popular myth that women have been systematically excluded as subjects of research. In *PC, M.D.* she meticulously cites study after study in debunking this politically correct canard still firmly ensconced in university, government, and some medical circles. Further, she continues to decry the marginalization that "special" issue designation creates for women as well as "increasingly popular 'feminist therapy,' a victim-oriented form of psychotherapy that interprets women's distress as a product of patriarchy"—the latter by implication consigning the ills of individual women, as with other victim groups, to externally mediated societal causation not amenable to individual growth or change.

Although "indoctrinologists," Satel's term for those who are driven by ideology and not by science, have yet to exercise control over mainstream medicine, she admits they are making steady progress in that regard. However, her description of the burgeoning successes of oppression-based feminist therapy and multicultural counseling, in which "psychological distress is a product of conflict between the individual and the sexist and racist society in which the patient lives," should give us cause for even greater concern. Increasingly, our institutions are being battered and we are being encouraged to think of ourselves as members of one or another oppressed minority group, be it of gender, sexual orientation, race, ethnicity, illness, or disability.

PC, M.D. ends on the author's encouraging note that "fortunately, there are built-in limits to the corrupting influence of PC medicine," in that the American people continue to expect and receive the best in medical care. This assurance, however, may not long continue to hold sway. Those who labor in senior leadership positions in medicine are aware of an almost palpable malaise in both private and institutional medical practice that has somewhat to do with the current fiscal straits of both physicians and hospitals. It is more a result of the daily grinding away of moral authority by regulators, accrediting bodies, government agencies, and payers, all reflecting to an unknown degree a slow but steady suffusing of society by at least some of the increasingly prevalent negative forces of which Dr. Satel writes. Eventually, if not now, the average American will feel the result, and some may suffer. If the doctors are not allowed to provide the right care, who will?

In closing, Dr. Satel deserves praise for the good works she continues to pursue in this and other efforts to remind all of us that in keeping with the age-old precepts of the Hippocratic oath and of all like-minded physicians, the patient comes first, before all else.

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Severed Trust: Why American Medicine Hasn't Been Fixed, *by George D. Lundberg, M.D., with James Stacey. New York, Basic Books, 2001, 321 pp., $26.00.*

George Lundberg, you recall, who had been editor of *JAMA* for 17 years, was fired by the American Medical Association (AMA) in 1999 because he published, during the impeachment trial of President Clinton, an unsolicited, peer-reviewed study from the Kinsey Institute in which 59% of an Indiana college student sample said they did not consider having had oral sex as having "had sex." Lundberg comments, a bit grandly, on the "irony" (p. xii) that "the Monica Lewinsky affair resulted in the loss of my job, but not Bill Clinton's" (p. xii). Whether his dismissal could be laid to a puritanical standard to which Surgeons General and medical editors but not network television is held, or a partisan political offense, is not discussed, but the book does clearly convey that the life of a medical journal editor is far from a stuffy and scholarly refuge from perils of the front lines of practice. In fact, all but one of his 13 predecessors had been "fired, forced to resign or retired under pressure" (p. x), and Lundberg always knew that at some point he too would fall to some conflict.

The book is not intended as autobiography but as a "medical memoir…of what has happened to medicine during the last 50 years" (p. 1). It seems to be one man's attempt to seek moral direction amid buffeting by political winds and warring interests. Lundberg was an Army pathologist for 11 years. As the joke goes, the pathologist knows everything but too late, and a pathologist's modus operandi is suited to the editor's evaluative task. Lundberg presents his opinions on complex issues as judgment calls. In a speech at the Wharton benefit

for the Columbia consultation-liaison service on May 15, 2000, he peppered his animated talk with apothegms such as, "There is no alternative medicine—only medicine" and, "The plural of anecdote is not data." Despite his attitude about anecdotes, he presents one in his book about having had back pain before a talk that was cured in a half hour by an acupuncture needle in his ear. He distinguishes between his early bias against chiropractic theory and evidence that practicing chiropractors may ease back pain. He published a 10-year-old schoolgirl's project that debunked "therapeutic touch" (pp. 116–117), however, incurring the ire of the 70,000 nurses trained in it, and finds homeopathy "preposterous and totally absurd" (p. 118).

Lundberg contends that Medicare hospital funding should be tied to a 30% autopsy rate so we can learn from our mistakes. He links what he complains about in modern medicine's approach to end-of-life care to the right-to-life movement and argues for assisting patients to seek a humane death by simply refusing fluids rather than the "ghastly machines" (p. 240) of Jack Kevorkian. He recounts the more old-fashioned handling of the deaths of each of his parents as "letting nature take its course" (p. 220). Other issues taken up, all with ethical implications, are physician influence group seminars put on by the pharmaceutical industry and abortion, on which he took a "neutral editorial position" (p. 224), although he opposed federal intervention in the practice of late-term abortion, which the AMA went along with. He opposes boxing, extreme fighting, and handguns and favors a treatment approach to illegal drugs.

The book is breezily written, easily read, and, of course, well edited. It provides an annotated history of the important issues in many recent debates in mainstream medicine, all of which have a psychiatric dimension. There is a regrettable lack of psychiatric citation or even the appearance of the word "psychiatry" in the index. The words "mental health" appear twice on page 74 in the context of insurance coverage being dropped. There is much discussion of insurance issues, favoring coverage for prevention and catastrophe.

Lundberg is now Editor-in Chief and Executive Vice President of Medscape, the leading Internet medical information provider, and he has cogent things to say about ethics, payola, and privacy in cyberspace.

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The Social Psychology of Stigma, *edited by Todd F. Heatherton, Robert E. Kleck, Michelle R. Hebel, and Jay G. Hull. New York, Guilford Publications, 2000, 450 pp., $50.00.*

Written by psychologists for "psychologists, sociologists and others concerned with the nature and impact of stereotyping and discrimination," this thought-provoking, in-depth volume resulted from a guided discussion meeting of invited world authorities at Dartmouth's Minary Center.

The book is divided into three sections: The Perceiver, The Stigmatized, and The Social Interface, each with four or five chapters concerning distinct major subtopics, e.g., chapter 5, "Ideology and Lay Theories of Stigma: The Justification of Stigma," chapter 8, "The Hidden Costs of Stigma," and chapter 13, "Stigma and Self-Fulfilling Prophecies." The authors go far beyond delineating the ancient Greek practice of burning a mark or brand, i.e., a stigma, into a criminal or slave's skin or the American Puritan use of the scarlet A. They deal with issues of stereotyping and prejudice experienced by individuals and groups of different sex, gender role, age, sexual orientation, religion, race, ethnicity, physical traits, and sociocultural background, which result in far-reaching social and psychological consequences and psychiatric symptoms and syndromes (e.g., posttraumatic stress disorder).

The goals of their study of stigma within the "larger context of general social-psychological processes" was based on three basic dimensions: 1) perceiver (the stigmatizer) and target (the victim), 2) personal and group-based identity, and 3) affective, cognitive, and behavioral responses.

The editors' premise is quite challenging: "from the social psychology standpoint," the authors consider "stereotyping normal, a result of people's cognitive abilities and limitations and of the social information and experiences to which they are exposed." Furthermore, they argue that the "process of stigmatization can be nonpathological depending on the social context and physical environmental influences."

As psychiatrists, we know that stigma can threaten psychological and physical health depending on many personal and sociocultural factors. Our overarching understanding of stigma by perceivers and victims affects our understanding of and care for our patients in direct service and in health care policies. Ample discussion is focused on affective, cognitive, and behavioral reactions to stigmatization. This discussion is useful to clinicians who must remain aware of these reactions in clinical care so they can inform their psychiatric patients as the patients experience first-hand the results of stigmatization that affect their treatment and recovery.

This multiauthored text is thought-provoking and insightful; it merits and demands careful reading. All mental health professionals, especially psychiatrists, can glean ideas that will provoke rethinking our frustrations about ongoing stigma toward our patients, their illnesses, and the availability of equitable funding to care for them as well as stigma directed toward us as their competent physician-caregivers. Too often, psychiatrists are stigmatized in that we are not always seen and treated equitably as "real doctors" by physician colleagues, insurance companies, patients, and their significant others.

Finally, the challenge to earnest readers is to strategize effective responses to the fact the authors offer that "stigmatization can be a result of threat, but it requires social communication and sharing on the one hand, and individual distortions and enhancements on the other." We must not read this important book passively but, rather, take the authors' visions and act in unison constructively to benefit all.

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PSYCHODYNAMIC THEORY

Psychodynamic Psychiatry in Clinical Practice, 3rd ed., *by Glen O. Gabbard, M.D. Washington, D.C., American Psychiatric Press, 2000, 597 pp., $79.95.*

The publication of DSM-III in 1980 marked a sharp transition in the United States from a psychodynamic understanding of psychiatric illnesses to a strictly phenomenological, theory-neutral, voyeuristic description of conditions in "behavioral medicine." This neo-Kraepelinian nomenclature is more behaviorally precise, more globally communicable, more biologically attuned to psychopharmacological treatment, and more practically exploitable by commerce and managed care. Of apparently minimal moment, it leaves out only—as Saul Bellow put it in a different context—that which the living man is preoccupied with—"such questions as who he is, what he lives for, what he is so keenly and interminably yearning for, what his human essence is" (1). Small price to pay for greater statistical certainty. *Psychodynamic Psychiatry in Clinical Practice,* Glen Gabbard's assertive account of the "moral obligation to be intelligent" (2) in the practice of psychiatry, tells the magnitude of the price we paid for that transformation and brings us back to where we are supposed to be.

"Psychodynamic psychiatry is an approach to diagnosis and treatment characterized by a way of thinking about both patient and clinician," writes Dr. Gabbard, "that includes unconscious conflict, deficits and distortions of intrapsychic structures, and internal object relations and that integrates these elements with contemporary findings from the neurosciences" (p. 4). Dr. Gabbard goes on to describe, in quick succession, the work of Freud, the unconscious, and the topographic model of the mind; the Nobel-prize-winning work of Eric Kandel with the marine snail *Aplysia californica*; preliminary evidence that in lower species (crayfish) social clues in the environment influence how the neurotransmitter serotonin affects the organism; recent findings in Finland that psychodynamic therapy may have a significant impact on serotonin metabolism; the work of psychoanalysts Melanie Klein, Otto Kernberg, and Heinz Kohut; and the infant developmental theories of Margaret Mahler and Daniel Stern (no relation to this reviewer).

Dr. Gabbard, whose earlier co-authored books include *Management of Countertransference With Borderline Patients* (3) and *Boundaries and Boundary Violations in Psychoanalysis* (4) is no stranger to expressing his views about the gargantuan finagling and deceitful practices of managed care companies that express contempt for some psychiatric patients (5) and adversely affect these people, their families, and those who treat them(6). He has written a solid, technically attuned book that is realistic, reliable, and sound.

First published in 1990, *Psychodynamic Psychiatry* sold 33,000 copies in its previous two editions; translations were published in four foreign languages: Italian, Spanish, Portuguese, and Japanese. One of the better decisions for the current edition was to eliminate the subtitle "The DSM-IV Edition," a subtitle that in reality was an oxymoron. The book is divided into three approximately equal sections: Basic Principles and Treatment Approaches in Dynamic Psychiatry (168 pages), Dynamic Approaches to Axis I Disorders (213 pages), and Dynamic Approaches to Axis II Disorders (192 pages). This is as it should be, since patients and psychiatrists spend so much of their time in psychotherapy with idiosyncratic traits of personality functioning.

The early chapters of the book provide background, beginning with theories of dynamic psychiatry; patient assessment; description of individual, group, family/marital psychotherapy, and pharmacotherapy; and hospital and partial hospital treatments. Dr. Gabbard states,

> Above the din of optimistic proclamations about the genetic-biochemical basis of all mental illness, another cry can be heard, one that is growing in intensity. Groups of psychiatric residents in biologically oriented programs complain that they know all about neurotransmitters but do not know how to talk to their patients. Freshly trained private practitioners ask analysts for consultation and supervision when their patients fail to respond to medications. Even patients are beginning to demand that they be listened to rather than simply medicated. (p. 20)

Expanded or new descriptions in the first section are concerned with the unconscious and current memory research, mind and brain, post-Kohut contributions, postmodern views, developmental considerations, and mechanisms of change. The discussion of Kohut's bipolar self and the narcissistic transferences he defined (pp. 44–48) are far too succinct in 4 pages for beginners to understand the theory and appreciate the far-reaching practical consequences it entails in the conduct of psychotherapy. Then again, Margaret Mahler in less than 1 page (p. 54) and Daniel Stern in 1 page (p. 55) cannot be properly understood and appreciated. So much of Margaret Mahler's work can best be grasped through her graphic descriptions of individual child-mother interactions during the various developmental phases she postulated. For an appreciation of Daniel Stern's theories, examples of some of the very sophisticated experimental observations of infants are necessary as well as an explanation of what a representation of interactions that have been generalized (self with other as a subjective experience) is. This can be done (7), but not in the very abbreviated space assigned to these tasks by the author. The very brief description of Mahler's work is particularly regrettable because there is an important reference to her in connection with the psychodynamic understanding of borderline personality disorder (p. 419). Missing are Kernberg's structural interview and structural diagnostic criteria for neurotic, borderline, and psychotic personality organization (8); on page 39 Kernberg is linked to borderline personality disorder instead of borderline personality organization. Ambivalence, object constancy, and borderline personality organization are not listed in the index.

Along the way Dr. Gabbard introduces schizophrenia; affective, anxiety, and dissociative disorders; paraphilia and sexual dysfunctions; substance-related and eating disorders; and dementia and other cognitive disorders. There is a new general introduction to affective illnesses and a generously expanded discussion of dissociative disorders. The psychodynamics of suicide (pp. 211–214) and treatment of the suicidal patient (pp. 222–227) are largely unchanged but immensely helpful.

The final section on personality disorders has a greatly revised 50-page chapter on borderline personality disorder that includes medication strategies (Table 15-7, p. 430). This section also includes a largely unchanged discussion of narcissistic personality disorders presenting, in contrast to DSM-IV-TR, two types of narcissists, the oblivious and the hypervigilant (Table 16-2, p. 467), together with a clear comparison of Kernberg's and Kohut's approaches to the treatment of people with these disorders. A slightly expanded presentation of the antisocial personality with a continuum of antisocial and psychopathic behavior (Table 17-2, p. 499) is also included. Finally, there are unchanged but sharply observed and well summarized distinctions between histrionic and hysterical personalities, their contrast not captured by DSM-IV-TR or its predecessors because of their sole reliance on purely behavioral characteristics rather than on psychodynamic understanding. The review here of the management of erotic transferences is outstanding.

Three pivotal sources might be added to the discussion on the evolution of the term "borderline" in the chapter on borderline personality disorder. First, Adolph Stern (no relation) used the term "border line" first for these patients. Of the two articles he published as early as 1938 and 1945, the latter (9) is brief, brilliant, compassionate, empathic, incisive, and as clear today as it was about 60 years ago. Stern's recommendations for the psychotherapy of these individuals are along lines not dissimilar from those advocated by Dr. Gabbard.

Second, when Gunderson and Singer (10) published their memorable article on patients with borderline disorder on page 1 of *The American Journal of Psychiatry* in 1975 there were possibly 50 publications on these patients written by adult and child psychoanalysts, psychiatrists, and psychologists describing behavior, dynamic formulations, intuition, psychological test results, and symptoms in a welter of jargon and semantic confusion. It was a major achievement for Gunderson and Singer to be able to distill this material and identify the six coherent features they judged characteristic of most borderline patients according to most of the publications.

Third, it was then left to Spitzer et al. (11) to review the literature, contact such researchers as Wender, Kety, and Rosenthal on the one hand and Gunderson, Sheehy, Stone, Rinsley, and Kernberg on the other, and develop a 22-item set,which they mailed to 4,000 members of APA in January 1977. There were 808 usable responses, and these ultimately resulted in the first formulation of criteria for borderline personality disorder and schizotypal personality disorder. So great was the confusion before the work of Spitzer et al. that these authors could write, "Kety, Wender, and Rosenthal have acknowledged that although they are able to agree with each other in categorizing patients as having borderline schizophrenia, they are not confident that they could convey to others the clinical cues to which they are responding" (11). The same authors recalled that at the General Clinical Service of the New York State Psychiatric Institute, where Kernberg was director, "A few of the therapists claimed not to know well any nonborderline, nonschizophrenic patients!"

On the other hand, Dr. Gabbard refers to an article on "pseudoneurotic schizophrenia" by Hoch and Polatin (12) published in 1949—11 years after Adolph Stern's first article—in his discussion of the evolution of the term "borderline." I have always considered this article sensationalist, mostly without merit, and not contributing much of value. It misled a generation of psychiatrists and may have contributed to the broadening of the schizophrenic diagnosis and the tragic, unjustified categorization of perhaps hundreds or thousands of people as suffering from the disease on the basis of little evidence other than symptoms of ambivalence, anxiety, depression, hypochondriasis, identity diffusion, narcissism, obsessions, depersonalization, and derealization.

The heart of *Psychodynamic Psychiatry* is in Dr. Gabbard's braided summaries under the headings Psychodynamic Understanding and Treatment Considerations for each disorder. The author's intelligence and style allow each chapter naturally to unfold twin narratives: one about how these people got ill, the other about how they can be treated successfully. Attentiveness and patience in following his detailed, informed, and integrative discussions will be amply rewarded. Dr. Gabbard's descriptions are both captivating and complex, and the ultimate effect of this articulate, carefully wrought, and sober book is to stress how much easier it is to pigeonhole people and their problems into nosological schemes, or squeeze square pegs into round holes, than to conceive and carry out well-considered treatment plans and strategies.

When medical students first register at the School of Medicine of Case Western Reserve University in Cleveland they are given, free of charge, a laptop computer with electronic access to representations of every hour of the first 2-year core academic program with defined learning objectives and the educational materials, slides, journal articles, etc., they need to meet those objectives. I suggest that in a similar vein psychiatric residency training programs provide every entering resident with a free copy of this book. In due time that will surely improve psychiatric morbidity and mortality reports and psychiatric statistical and epidemiological data. Directors of the American Board of Psychiatry and Neurology ought to take note: no candidate should be Board certified in general psychiatry or child psychiatry who does not demonstrate an equivalent working knowledge of the core content and message of this invigorating and outstanding book.

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The Thaw: 24 Essays in Psychotherapy, *by Paul Genova, M.D. Pittsburgh, Dorrance Publishing Co., 2000, 142 pp., $13.00 (paper).*

Paul Genova's book is thought-provoking in various ways. It is a short book, a compilation of two dozen essays, all previously published, about psychodynamic psychotherapy. Evidently, these could be read separately, dipped into here and there, but, to be engaging in the ways I describe, I recommend reading them in sequence as a book.

Why do clinical anecdotes and narratives always seem to find enough interested readers to warrant their frequent publication? Autobiographical case histories may hold a similar interest. People must be curious about matters that are usually most private, particularly psychiatric case histories, which give readers a glimpse at what those most secretive doctors, psychiatrists, actually do and say. Readers can also compare their worries, pains, symptoms, and treatments with those of others. Physicians are fascinated by case histories, too, trained as they were by case study, clinical presentations, and clinical pathological conferences. Like moths to a light, they are drawn to the challenge of thinking about how they would have diagnosed and treated the patients described.

Thus, for a psychiatrist reading Genova's book about psychotherapy, part of the pleasure lies in the ongoing thoughts, emotional reactions, questions, insights, and mental disagreements and debates arising from his vignettes of psychotherapeutic encounters and his self-revealing and thoughtful, yet sometimes cryptic or open-ended, commentaries on them.

In this era of managed care, the latest DSM as Bible, and the emphasis on quick measurable symptom relief by appropriate medication and short manualized psychotherapies, one welcomes an experienced clinician's insistence on the persistent benefits of open-ended psychotherapy. It takes longer, and the effects cannot easily be measured, but newer methods, such as brain-imaging techniques, are opening a window on the likelihood that the shortcoming may be in the measuring techniques rather than the treatment method.

Genova is relentless in insisting that listening to patients and hearing them on their own terms within a therapeutic relationship reveal important and therapeutically valuable information, and that there may be compelling gains other than symptom relief. He holds fast to only a few basic theoretical premises: the importance of wishes (i.e., drives); attachments; unconscious forces in shaping behavior; and developmental and subsequent experience in influencing current life. A strength of his approach to patients is that he really listens to them without filtering what he hears through just one theoretical approach. His understanding and interventions make use of a range of "schools," from several psychoanalytic ones to cognitive behavioral and even some Eastern philosophical; nor does he spurn psychopharmacological relief when called for. He expresses great interest in dreams and their communications but pays surprisingly little attention to transference and countertransference as such. A few times he is inventive in the use of himself and his intuition, not determined by any identifiable theory. He is honest about psychotherapy not being able to help some patients, and he acknowledges his own defeats.

It is not surprising, then, that an experienced psychotherapist will find repeated occasions for surprise, questions, and disagreements with Genova, without ever questioning his integrity or his respectful and serious intent to help his patients. Being in the trenches with such a colleague makes this reading enjoyable. I found it more questionable whether the book has a place for training psychotherapists. They, too, are likely to enjoy the book, but it is not a book of instruction for good therapy. The interactions and interventions work for Genova but might even be dangerous if adopted out of context by a therapist with less experience. I am sure that Genova would agree that his book cannot take the place of work with patients, good supervision, and wide reading in applying theories and finding one's own way.

To summarize, this is not a book from which one is likely to learn new and practically useful therapeutic approaches. It is a short, easy-to-read book in which psychotherapists are likely to feel in congenial but provocative company.

KATHLEEN M. MOGUL, M.D.
Newton, Mass.

PSYCHOPHARMACOLOGY

Pharmacotherapy for Mood, Anxiety, and Cognitive Disorders, *edited by Uriel Halbreich, M.D., and Stuart A. Montgomery, M.D. Washington, D.C., American Psychiatric Press, 2000, 804 pp., $85.00.*

There are several excellent current psychopharmacological texts; therefore, just what is distinctive and useful about this new volume? The editors are both well-known. Halbreich has been active in psychoendocrine research for many years and is a leading figure in international organizations. Montgomery is one of the most prolific British clinical psychopharmacologists and has often been in the forefront of therapeutic advances. In keeping with these editors, this book has a distinctly international flavor. This is all for the good, because it is easy to fall into parochial ways of thought, and travel is always broadening.

Among the authors, certain authorities from abroad are well-known, even in the Colonies. We have all learned to look forward to stimulating discussions by Florian Holsboer, Herman Van Praag, Robert Belmaker, Herman Westenberg, Johan Den Boer, David Nutt, and Joseph Zohar; in fact, there are too many to list. Canada, Israel, England, Greece, Spain, the Netherlands, Germany, and Estonia are represented. There are some novel ideas and approaches here.

Theoretical discussions attempt to help the reader understand complex interrelationships rather than focusing on simple monovariable theories. Holsboer presents a detailed review of the hypothalamic-pituitary-adrenal (HPA) axis, but he also points out that a corticotropin-releasing hormone (CRH) precursor can inhibit the CRH-induced release of ACTH, as well as several puzzling findings concerning thyroid-HPA interactions.

The contribution of Yvon Lapierre et al. shows discontent with the current U.S. syndromal diagnostic system. These authors argue that advances in therapeutics have driven psychopathological nosology, but that knowledge of specific receptor actions provide a better point of entry to understanding and treatment, even if these do not imply an etiological relationship. Van Praag also argues that DSM confounds severity with depressive phenomenology, since chronicity and premorbid personality characteristics are not related to syndromes. Van Praag protests diagnostic splintering; he argues that validity studies should have taken precedence over all the others and that the concern for measurement reliability neglected the subjective experiential world of the patient. Van Praag would have us give up the morass of comorbidly occurring syndromes and, in fact, the concept of disease entities to focus on the functional impairments that incur the psychopathological state, such as aggression dysregulation.

If we knew the brain functions that allow us to cogitate, emote, and behave, then Van Praag's suggestion would resonate. But to replace DSM with a functional psychopathological approach seems premature.

This volume is a valuable complement to the more how-to-do-it books and is recommended for thoughtful reading. It also includes useful practical advice.

DONALD F. KLEIN, M.D.
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Antidepressants, *edited by B.E. Leonard. Boston, Birkhauser Verlag, 2001, 150 pp., $120.00.*

Anxiolytics, *edited by M. Briley and D. Nutt. Boston, Birkhauser Verlag, 2000, 181 pp., $112.00.*

Antidepressants and *Anxiolytics,* two books in the Milestones in Drug Therapy series edited by Michael J. Parnham and Jacques Bruinvels, can become a valuable asset to researchers, pharmacologists, and psychiatric clinicians interested in the study of mood, psychotropic medications, and the CNS. The editors of both of these books have enlisted very knowledgeable international authors to present their topics concisely and with a serious reader in mind.

I am not familiar with other volumes in the Milestones in Drug Therapy series, but if they are as well done as these two the series editors will have gone a long way toward providing valuable resource tools for very complex topics. Each book can be read as a stand-alone volume, but reading them sequentially provided a clearer picture of the intricate weave of our human biology than reading either one alone.

In a sense, our understanding of the relatively subjective mood states of anxiety and depression has advanced as a result of the elucidation of the objective and more quantifiable world of psychopharmacology and related fields. This becomes clearer when considering the scores of drugs, receptors, agonists, antagonists, other elements, and still hypothetical mechanisms and substances that are discussed in these two volumes.

The editor of *Antidepressants,* B.E. Leonard, has set as his goal to effect through elucidation greater success in the treatment of the millions of people who suffer from depression. He has brought together 14 international scholars from 11 research groups to discuss clinical and preclinical topics. The book is divided into four sections. The first three chapters discuss clinical issues and offer valuable information on long-term outcomes, a discussion of early effects, onset to apparent improvement, and the limitations of currently available antidepressants.

The second section, which consists of two chapters, discusses the mechanisms that contribute to the rate of onset of action and response as well as second messenger calcium signaling in antidepressants and depressive disorders. The third section, with three chapters, considers biological markers, the hypothalamic-pituitary-adrenal axis, neuroendocrine markers, and the possible role of brain cytokines in depressive disorders.

The final section looks to the future of antidepressant medications and includes a single but thorough chapter discussing current novel medications and the possible future of antidepressants whose actions would be far beyond those of our current limited choices. The discussion of nondrug treatments and the ever-controversial role of genetic studies is perhaps too brief but in no way detracts from the chapter or the book.

Antidepressants is well worth owning and reading for the serious biologically minded clinician or researcher. The chapters are well referenced, succinct, and technical. The authors and the editors have created a very valuable book.

Anxiolytics, edited by Briley and Nutt, is also a well-conceived and ably written book. The 11 chapters and 25 authors review anxiolytic medications over the decades, current views of anxiety disorders, the medications most commonly used clinically, and the research pathways that we hope will lead us into new eras of understanding and treating these disorders.

The standard or prototypical medications such as benzodiazepines, buspirone, tricyclic antidepressants, monoamine oxidase inhibitors, and selective serotonin reuptake inhibitors are reviewed historically as well as clinically and pharmacologically. These perspectives begin to give the reader a sense of the interrelatedness and complexity of depressive and anxiety disorders as well as the physiological overlap that entwines these two areas.

Anxiety disorders are discussed, some more thoroughly than others, and medication choices are compared on the basis of drug profiles as well as clinical trials. There are chapters on benzodiazepine receptors, glutamate receptor ligands, specific serotonin receptors considered to be important, and speculations on the future of anxiolytic medications.

Anxiolytics, like its companion volume, *Antidepressants,* can be a valuable resource for those interested in the technical, historical, and speculative world of psychopharmacology. I heartily recommend both books to biologically oriented

psychiatrists, psychiatry residents, researchers, and interested clinicians.

MARK H. FLEISHER, M.D.
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The Antidepressant Survival Program: How to Beat the Side Effects and Enhance the Benefits of Your Medication, *by Robert J. Hedaya, M.D. New York, Crown, 2000, 292 pp., $24.00; $12.95 (paper).*

The author, a clinical psychopharmacologist and frequent lecturer, has written this book principally for members of the general public being treated for depressive disorders but with a recommendation that it be given to their physicians to read as well. For treating physicians, some brief sections and an appendix with scholarly references are included. Stating that 30% to 80% of patients who are taking selective serotonin reuptake inhibitors are "significantly impaired in their ability to function in their jobs or relationships," the author presents his "Antidepressant Survival Program" for maximizing antidepressant response while minimizing adverse effects (sleep disturbance, fatigue, weight gain, and sexual dysfunction). The Antidepressant Survival Program is a group of specific recommendations concerning diet, exercise, stress reduction, play, and spirituality; there are also suggestions for possible food allergies and detailed laboratory testing for nutritional, endocrinological, and gastrointestinal deficiencies or imbalances. Dietary recommendations include avoiding the "toxic foods," alcohol, caffeine, chocolate, sugar, and refined flour and keeping intake of simple carbohydrates low and protein adequate to prevent hypoglycemia and overeating.

The recommendations for exercise, stress relief, play, and spirituality are sensible and pragmatic. However, I feel meditation is discussed too briefly. The author, somewhat off the mark, asserts that Buddha's first Noble Truth is that "everything is in a state of continual change." The four Noble Truths were originally offered in a form that a physician might follow (diagnosis, cause, possibility of remedy, and treatment plan). The first Noble Truth is that life is *dukkha* (Pali), often translated as "suffering" but more accurately meaning that although one may experience pleasures, life is nonetheless characterized by a sense of unsatisfactoriness, significantly related to impermanence.

The text begins simply but leads into more sophisticated discussions. Most information appears accurate, although some assertions of frequently missed biological imbalances and the evidence-based value of some treatment recommendations are beyond my knowledge. For example, the author states, "At least 80 percent of my patients have abnormal functioning of the adrenal system and about 30 percent have disturbances in the thyroid system." He also says, "Nine out of ten of my patients have a deficiency in at least one of these trace minerals." The author has treated more than 300 patients with his program and says that "80 to 90 percent [of those] who faithfully follow the program achieve the desired result." This is gratifying, but not noted are how many could or would not faithfully follow either his initial 5-day program or his full program, and it would seem that controlled trials should be attempted and reported.

This book is generously laced with encouragement, illustrative case examples, and strong predictions of likely benefit, which might help motivate and offer hope to those who are not fully recovered from depression. I particularly liked the chapter titled "Forging a Relationship for Healing With Your Doctor." Despite reservations, I came to like this inspired effort and feel that one would do well at least to be acquainted with its contents, since our patients may soon be bringing in a copy.

WILLIAM M. GREENBERG, M.D.
Ramsey, N.J.

The Science of Marijuana, *by Leslie L. Iversen. New York, Oxford University Press, 2000, 283 pp., $29.95.*

The author is a distinguished British pharmacologist. His book is timely in view of the controversy over the medical use of cannabis and the recent U.S. Supreme Court decision against it. The last few lines of the text are from a *Lancet* editorial in November 1995 to the effect that cannabis is a political football, the evidence is that it is not a hazard to society, but "driving it further underground may well be" (p. 268).

Before he quotes that editorial opinion, Professor Iversen examines cannabis from every angle, beginning with its history. He is a lively writer with a talent for clarity. Any educated reader will understand him, even when he is dealing with pharmacology and physiology. Throughout the book he uses passages from other publications to support and illustrate. In the history portions, he includes users' firsthand accounts since the early nineteenth century. For centuries man has cultivated and used the hemp plant for purposes other than to extract tetrahydrocannabinol (THC).

Professor Iversen reviewed 158 books, articles, and governmental commission reports. Because the use of marijuana for medicinal reasons has been so controversial for so long, there have been studies commissioned by several countries as well as organizations such as the American Medical Association.

In the chapters on the pharmacology and CNS effects of THC, the psychoactive ingredient in cannabis sativa, Professor Iversen discusses the differences between routes of administration and the effects of THC on various organs as well as motility, posture, and pain sensitivity. He covers naturally occurring cannabinoids, sites of action in the brain, laboratory studies on humans and animals, subjective reports, and the questions of tolerance and dependence.

Next, he addresses the medical uses of marijuana for pain, AIDS wasting, cancer chemotherapy, multiple sclerosis, glaucoma, epilepsy, asthma, mood disorders, and sleep. He gives his conclusions while acknowledging that the subject has not been studied in a scientifically rigorous way. Then he takes up the question of safety. Is marijuana toxic? What about long-term exposure compared with the acute effects? Is it teratogenic? Is there a fetal marijuana syndrome analogous to fetal alcohol syndrome? Professor Iversen weighs in on these and other questions, including the special problem of the fact that smoking marijuana is still the most effective route of administration.

He takes up the recreational use of THC and deals with its prevalence, patterns of use, potency of various preparations, and the question of whether it leads to dependence on it and

other illicit drugs. He describes customs of cannabis use in different cultures around the world.

In the final chapter, "What Next?" Professor Iversen reviews the 1944 report commissioned by Mayor La Guardia of New York after cannabis had gained the reputation as a "killer drug" with the help of the Federal Bureau of Investigation (p. 244). Its conclusions were largely ignored by public opinion. Even *JAMA* blasted it in an editorial. There was a similar study in England reported in the late 1960s and one in Canada a couple of years later. He describes the Dutch Experiment, which decriminalized cannabis use under limited conditions. He discusses the campaign for medical use of THC and the possibilities of developing routes of administration that would be as effective as smoking.

Reading this volume is a perfectly painless way to learn all that you have ever wanted to know about cannabis.

WILLIAM R. FLYNN, M.D.
Napa, Calif.

Drug Effects on Psychomotor Performance, *by Randall C. Baselt, Ph.D. Foster City, Calif., Biomedical Publications, 2001, 475 pp., $109.00.*

There are some books that, by their genetic code, are meant to sit on a shelf and be referred to on occasion rather than read. This volume is a quintessential example of that category. Nevertheless, such infrequently used volumes can be exceptionally useful.

In this age of spurious litigation, when every possible person is held responsible for a negative outcome except the individual who is truly responsible, it is wise for the psychiatrist to have information readily available. Courts have held pharmaceutical companies liable for the homicidal acts of patients receiving selective serotonin reuptake inhibitors. The psychiatrists who prescribe such medications can be held legally responsible as well. This modification of the Twinkie defense (i.e., "The Zoloft made me do it") is upon us.

The intent of this volume is to list alphabetically a broad variety of available psychoactive drugs, both legal and illegal. The CNS effects of each drug are described, with a particular focus on effects on psychomotor performance. Other side effects are also described, such as agitation, insomnia, and anxiety. A list of published articles supporting the findings described is included. It would have been of greater benefit to the clinician if the author had included more data on variables other than psychomotor performance.

One can quickly learn the number and nature of the psychometric studies that have been performed on these compounds. The greatest immediate value of these data is to assist the practitioner in evaluating the potential motoric effects of a particular drug on driving, operating dangerous equipment, etc. From the parochial perspective of the psychiatrist, it would be valuable to have a few citations on aggressive behavior. Parenthetically, it is fascinating that the courts recognize the unpredictability of future violent behavior, except in the case of prescription drugs, where the evidence in support of their role is trivial.

In summary, this volume is easy to use and has useful information. Access to it, if not possession, will be of value to clinicians.

ROBERT CANCRO, M.D.
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Theory and Treatment of Depression

Treatment of Depression: Bridging the 21st Century, *edited by Myrna M. Weissman, Ph.D. Washington, D.C., American Psychiatric Press, 2001, 400 pp., $64.00.*

Dr. Weissman, one of the world's leading researchers in depression, was President of the American Psychopathological Association at its 89th meeting and served as editor of this excellent compilation of papers presented at that meeting. The book surveys past research accomplishments, looks ahead to new research directions, and concludes with a review of current biological and psychotherapeutic treatment strategies. The chapters reviewing the past accomplishments and future directions provide a superb overview and summary for the researcher and clinical scholar in the field of depression. For example, David Healy reviews the past development of antidepressant drugs and then looks ahead to new genetic and neuroimaging techniques that are increasingly guiding the development of antidepressant drugs. In a complementary chapter, Robert Michels surveys the changes over the past three decades in diagnosis, clinical understanding, and health care delivery for the treatment of depression.

The heart of this volume is three chapters that provide the reader with an expanded understanding of recent research developments and the progress toward a neurobiological understanding of depression. Charles Nemeroff and Mike Owens review work (primarily theirs) on the role of peptides in depression. Steven Hyman and Steven Moldin discuss the genomic tools that are increasingly applied to the study of major depression, the impact of the human genome project and gene mapping, and the future of genomically informed therapeutics. David Kupfer and Ellen Frank synthesize what has been learned about the maintenance treatment of depression and its relationship to clinical markers of neurobiological function such as EEG sleep variables. Each of these chapters is a small gem.

The treatment chapters provide an overview of the psychotherapies, pharmacotherapies, and biological therapies of depression. These reviews are not extensive summaries of past clinical trials. Rather, they synthesize available antidepressant and psychotherapy efficacy studies in a historical context. Accordingly, they are not useful as a treatment primer but nicely survey past, present, and future directions in the treatment of depression.

Treatment of Depression: Bridging the 21st Century is not a volume for all readers, but it can serve as a historical marker as well as a guidepost pointing us to the future. In its pages, we can concisely see where the study of the etiology, diagnosis, and treatment of depression originated, grew to a mature

science, and now leaps forward into an era of brand new science and technology.

CARL SALZMAN, M.D.
Boston, Mass.

Scientific Foundations of Cognitive Theory and Therapy of Depression, *by David A. Clark and Aaron T. Beck with Brad A. Alford. New York, John Wiley & Sons, 1999, 494 pp., $75.00.*

This book details the scientific research that has been done to document, support, prove, disprove, and/or explain Aaron Beck's cognitive theory of depression. Although the word "therapy" is included in the title, this book is not about therapy, nor is the word "therapy" included in the index or any of the section titles. It has 54 pages of references. Aaron Beck is listed as the lead author in 41 of the references, although many of his papers and books are on applications of cognitive therapy rather than scientific studies of the validity of the constructs of cognitive theory.

The authors, to their credit, describe the evolving process of change and modification of the cognitive theory of depression in response to questions, criticisms, and new findings since the early 1960s, when Beck published his initial formulations. For example, complicating research on depression, the authors note that "pure" depressive states may be quite rare, with up to 75% of depressed patients showing comorbidity. Anxiety disorders co-occur in up to 50% of depressed individuals. Other changes that modified the Zeitgeist of cognitive behavior theory were Beck's incorporation of Bandura's social learning theory concepts, which rejected the strict and oversimplified stimulus-response assumptions of behaviorism; aspects of Seligman's learned helplessness model; and Albert Ellis's rational emotive therapy, which included the notion that irrational beliefs and negative thinking underlie psychological disturbances. As further research cast doubt on some of Ellis's ideas, rational emotive therapy became less a part of Beck's cognitive theory.

Beck rejected the psychoanalytic concept of inwardly directed anger or retroflexed hostility as important constructs in depression, having determined that they were not well supported by clinical studies. He evidently did not view the patient's "conscious negative verbalizations" and/or suicide as retroflexed hostility.

The research of Beck and his followers described in this book has struggled for years with the question of what came first, the chicken or the egg. Do cognitions stimulate emotions or do emotions lead to particular cognitions? Are persistent negative schemata depression or does depression bring forth negative schemata?

The authors and their critics raise the persistent question of whether laboratory research with sharply defined questions and fairly simple designs leading to clearcut answers can explain what goes on in the uncontrolled, naturalistic real-life situation. The authors correctly conclude they need more ecologically valid and powerful methodologies to answer these questions.

For example, cognitive theory does not explain why certain negative ideas in depression persist in the face of energetic and concerted logical attack. It does not address the impact of persistent correction of faulty cognitions on patients in general or on the self-esteem of depressed individuals in particular or the function of faulty cognitions or constructs in the patient's inner world of being. For example, do they represent enduring attachments to important figures that are tied to the patient's sense of integrity or are they part of a magical belief system that the patient is convinced represents the pathway to ultimate redemption?

This is an honest book as far as it goes, but it is persistently and perennially one "why" away from providing the reader with a truly profound understanding of major depression.

HAROLD I. EIST, M.D.
Bethesda, Md.

Active Treatment of Depression, *by Richard O'Connor. New York, W.W. Norton & Co., 2001, 272 pp., $35.00.*

This is a rather provocative book written by a psychotherapist and apparently intended for psychotherapists. I am not certain I am the right person to review it because the message clearly is less intended for me than for other clinicians. In the introduction, Dr. O'Connor states, "This is a book for mental health professionals who treat patients with depression. I am a therapist who suffers from depression myself."

The tone of this book is quite critical toward the usual treatment that therapists provide for depressed patients. The initial three chapters, "What Is Depression?" "The Disease That Causes Itself," and "The Functional Symptoms/Skills of Depression," set the stage for the remaining 11 chapters, which deal with assessment and treatment of patients with depression. Each chapter has some case material in it to help make the point of the particular chapter.

The first three chapters review the current status of diagnosis and treatment of depression in the United States. The review is, in my mind, a bit too critical. Dr. O'Connor sees the glass as half empty. I would prefer to see it as half full. I agree with him that more research needs to be done to determine the effectiveness of treatment in patients. I also agree with a major point that he makes that manualized therapies restrict the therapist to perform within the confines of a particular approach.

However, the alternative is to have no way of being able to assess whether a therapy is useful for patients, since therapies would then be individually grounded on the basis of the technique of the individual therapist. This indeed was the situation before the National Institute of Mental Health (NIMH) organized research into therapies such as cognitive behavior therapy and interpersonal psychotherapy for the treatment of depression. These therapies are not perfect, but adherence to the principles and guidelines from the treatment manuals will provide at least something of a standardized treatment. If that therapy is effective, at least we know how to approach relapse or recurrence. If that therapy is less effective we know what was delivered so we can treat the patient in an alternate way.

I like to think of psychotherapy as being like branded medications. When one is treated with a medication one gets a standard pill with research behind it to indicate its clinical utility, likely efficacy, and likely side effects. In my view, the same should hold true for other treatments, including psychotherapy. Having taken histories from a number of patients and asked what kind of psychotherapy they received, for the

most part what they seem to be getting is supportive therapy. There are absolutely no data about the efficacy of this therapy for depression, nor is there any standardization of this type of therapy. Why pay money for a treatment if the treatment is not standardized and not shown to be effective?

Dr. O'Connor's position is that therapists need to break loose from analytic traditions and be more inventive in their treatment. This may be fine for him, but I don't know that his therapy is otherwise defined so that I could suggest to a patient of mine that whatever type of therapy Dr. O'Connor espouses is apt to be effective or indeed reproducible. Here again, I disagree very strongly with his major point: although I agree that therapy needs to be individualized, to some extent this is more like adjusting the dose of medication than providing a different therapeutic stance for every depressed patient who comes through the door.

Furthermore, I think Dr. O'Connor dismisses too quickly the research that has been done into therapies for depression, not only with cognitive behavior therapy and interpersonal psychotherapy but also with the cognitive behavioral analysis system of psychotherapy. He also seems to be unaware of current initiatives to expand psychotherapy research into the "component parts" of cognitive behavior therapy. For example, we are currently conducting a study of "behavioral activation," a therapy developed by the late Neal Jacobson. This study is funded by NIMH.

Some of the points Dr. O'Connor makes are well-taken and I think will be useful to people who are involved in the treatment of depressed patients. The tone of the book, to me, is quite negative and surprisingly jarring. However, because it was jarring it caused me to think about the role of people who treat individuals with depression and how we approach our patients. The provocative nature of Dr. O'Connor's book makes it useful for individuals involved in the treatment of depressed patients to read. I doubt this book would be helpful for others, such as medical students or patients.

DAVID L. DUNNER, M.D.
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Unholy Ghost: Writers on Depression, *edited by Nell Casey. New York, William Morrow (HarperCollins), 2001, 299 pp., $23.00.*

Dramatic advances in neurobiology and psychopharmacology, commingled with the influences of managed health care, have conspired to eclipse the historic centerpiece of psychiatry—the art of listening. When the importance of language to organizing and communicating the contents of the mind is marginalized and clinical events are compacted into the formulary of DSM-IV, our field is significantly diminished. *Unholy Ghost* is a ready antidote to such diminutions—a collection of 22 astute and beautifully written essays on depression by writers whose lives carry the imprint of that illness. Editor Nell Casey's choices highlight the variegated textures of depressive symptoms and the reflections to which they have given rise.

Many chapters are simply touching, eloquent reports of a depressive episode, what triggered it, its course, what helped and what didn't, and the afterview. I have always held that novelists were the first psychoanalysts, and the depths of psychologically sophisticated wisdom apparent in these pages is impressive and refreshing. Russell Banks, unlikely to have read Tom Ogden or the Kleinians, discovered in intimacy with his depressed wife a "third person, who was neither of us…smiling beneficently between us, with an arm draped across our shoulders…our mutual creation containing both our pasts and our personalities." Banks's chapter is not the only one to document that depression of one partner can insinuate itself into the life of the other and stay there. Donald Hall was married for 23 years to Jane Kenyon, whose poetry constitutes the foreword to this book and who had bipolar disorder. He was her dedicated caretaker, and 13 months after her death he suffered his first manic episode, which felt to him very much "her ghost."

Chase Twitchell reflects on the private language of his childhood depression and the interplay of language, poetry, and thinking toward an evocative definition of poetry. He reasons that when language is pressed into the service of depression, poetry becomes "the ultimate art of self-annihilation." Edward Hoagland has obviously speculated a lot on self-annihilation, and he reviews the pros and cons of suicide to conclude that, of all the many variables, speculation itself is "the high risk activity…animals neither speculate nor commit suicide." One is reminded of Allen Wheelis's famous, nonpsychoanalytic advice to an analysand in one of his novels: "Don't dwell on it." Unspeculatively, Lee Stringer tells how depression and substance abuse interwove to create a timeless regression that lasted the better part of a decade. Without any treatment, he finally worked his way out of the hole, alone, by writing.

Not everyone gets well. Sometimes improvement is fearsomely slow and incomplete. Such was the case for David Karp, whose depression was so stubborn that he considered himself "a career depressive." Over the years he tried all the drugs, co-counseling, self-help books, and finally, reluctantly, psychotherapy. Each thing helped, but only a little, and so his attitude toward psychiatry remained a mixture of hostility and dependency. Finally he realized that he was probably never going to be free of depression and that his struggle to be cured was central to his distress. Renouncing the expectation of a cure brought him considerable relief. Karp's theme is given a twist by Susanna Kaysen, who argues that people with depression are the only ones who see the world as it really is and that normal life contains a considerable amount of sadness that shouldn't be pathologized. Optimists are often fools, and pessimists have only pleasant surprises. This is clever, but Kaysen isn't referring to the same disorder that William Styron describes as "this dreadful and raging disease of horrible intensity.…An immense aching solitude." Styron faults Adoph Meyer's "tin ear for the finer rhythms of English" for having selected such a banal term as "depression" for a condition of such intrinsic malevolence. "The name prevents, by its very insipidity, a general awareness of how dreadful is the disease when out of control."

Styron's own illness seemed to have a sudden and inexplicable onset at the age of 60. First he experienced a distaste for alcohol, "which had been an invaluable senior daily partner of my intellect" for the previous 40 years. He was soon overcome by malaise, a sense of fragility, then hypochondria, agitation, and unfocused dread. His depression came to "resemble the diabolical discomfort of being imprisoned in a fiercely overheated room. And because no breeze stirs this cauldron,

because there is no escape from this smothering confinement…the victim begins to think ceaselessly of oblivion." Retrospectively he saw melancholy in his writing—"heroines who lurched down pathways toward doom"—long before his own fall. And so, when it finally came, "depression was no stranger. It had been lapping at my door for decades."

William Styron's tale is followed by a different telling of it by his wife Rose, who is a poet. She writes that after joyous early years of marriage he slowly became solitary and irritable, writing and drinking late into the night. On the eve of his 60th birthday he became "insanely hypochondriacal and saw THE END on every horizon." He stopped drinking, then stopped writing, and soon required her continual presence. When she realized that he was ill, she became "the scholar of his moods" and his overseer. She sustained him through a difficult and dangerous period, finally convincing him to enter a hospital, where he made his recovery. Styron believes that but for the devotion of Rose and others he might well have succumbed to the ghastly grip of hopelessness.

Larry McMurtry's depression following heart surgery was not so devastating, but it lingered and lingered. The only sense he could make of why he felt so changed, even long after the surgery, was to believe "that I had died for a few hours, been brought back to life, and now was attempting to live as someone similar to, but not quite exactly identical with, my real self.…Surgery contradicts the rules of survival, it is a Faustian bargain. You get to live, perhaps a long time, but not as yourself—never as yourself." It is surely true that "near death" experiences are particularly powerful, but we are all changing imperceptibly all the time, carrying our past with us, never exactly the same the next day. William Faulkner said it best: "The past isn't dead…it isn't even past."

The expanding universe of neuroscience has elucidated the mechanisms by which depression predisposes to more depression. We can localize and influence the structures that hold memory and regulate emotionality, but not yet those where meanings are conferred and sensibilities refined. Until that happens, and probably afterwards as well, we must safeguard the art of listening and indulge in the rewards of reading good books.

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Reprints are not available; however, Book Forum reviews can be downloaded at http://ajp.psychiatryonline.org.

Correction

In the references section of the editorial "A Call to Action: Overcoming Anxiety Through Active Coping" by LeDoux and Gorman (2001; 158:1953–1955), the name of the second author of first reference was incorrect. The name should be "LeDoux JE."