PSYCHOTHERAPIES

The Real World Guide to Psychotherapy Practice, *edited by Alex N. Sabo and Leston Havens. Cambridge, Mass., Harvard University Press, 2000, 337 pp., $42.00.*

This courageous book is less a guide than a time capsule from our besieged profession at the millennium and a plea for keeping clinically informed humanism in the mental health practitioner's armamentarium. Daring to be incomplete and provisional (like real life), it presents psychotherapy not as a disembodied system of knowledge but as a changing part of a changing culture.

Real worlds are particular in space as well as time, and this book comes from the Boston area. Massachusetts is among the most affluent of the United States, and its major metropolitan area continues to support a thriving private practice community of analytically oriented therapists. On the other hand, the state and the health insurers that do business there have done a better-than-average job of dismantling mental health care as we used to know it for those citizens who need any help paying for it. Harvard's Cambridge Hospital sits astride these two aspects of the local scene, and so the writers of this book, who are affiliated with Harvard, know only too well the contrast between what treatment at its best can be and what it often is.

The book falls into two (intermingled) halves. The chapters by Havens, Sabo, and James Gustafson, taken together, approach being an integrated textbook on modern, dynamically informed, eclectic psychotherapy. Havens's contributions (one on forming effective relationships, one on treating psychoses, and three commentaries) are lucid and deserve every bit of the praise they have received. The relationship piece in particular distills some of the best of his book *Making Contact* (1). Havens is one Harvard treasure who has continued to get his hands dirty in the day-to-day training of psychiatric residents, and it shows. I salute his decision to throw his energy into a mainstream project like this book, whose influence on psychiatry as a whole will be greater than that of one more literary/philosophical book about therapy for a smaller audience of initiates. Still, when one of our greatest teachers feels the need to advise mental health practitioners to find common interests with their patients (p. 18), I wonder whether it is already too late. Didn't they go into the business to get to know people in the first place?

Alex Sabo's chapter on the relational aspects of psychopharmacology (written with Bliss Inui Rand) and his chapter on working with borderline patients reflect the sort of humble and practical psychiatric wisdom that has gotten lost in today's drone of drug marketing and academic science-as-usual. I want to hear much more from this author, who recalls to me the best of my own attending supervisors back in residency—true physician/therapists.

James Gustafson's chapter, ostensibly on brief psychotherapy, is in fact a cogent abstract of the "dilemma theory" he has spent much of his career, and several books (2, 3), developing. Gustafson presents a world view or meta-theory of the entire psychotherapeutic enterprise that I have found original and important enough to study and write about at length (4), so I am not the best judge of how well this particular summary comes across, but it appears entertaining and accessible enough to lure readers into making a more thorough acquaintance with Gustafson's work.

The other half of the book is a loose collection of topical essays. There is one on group work with violent men, one on chronically traumatized patients, one on dialectical behavior therapy (good but slightly out of place here owing to its behavioral science tone), and one on emergency situations. The piece titled "Psychotherapy With People Stressed by Poverty," by Janna Malamud Smith, stands out as both helpful and moving. Alfred Margulies's chapter on "Our Psychoanalytic Legacy: The Relevance of Psychoanalysis to Psychotherapy," otherwise admirable, concludes with a prediction that psychotherapy's future will part company with the "neurological subspecialty" of psychiatry, which will be "largely irrelevant" to it (p. 311). Must we sell the farm so soon? Most of the other contributions to this volume, in fact, try to demonstrate the continuing mutual relevance of traditional psychotherapy and medical psychiatry.

Since history isn't over yet, the role this time-capsule collection will play in the ongoing story of psychotherapy is uncertain. If it succeeds in helping save the practical psychodynamic/eclectic therapy developed largely by North American psychiatrists over the last half-century, this will be in part because it draws people back to the work of Havens and Gustafson and because its success encourages the likes of Sabo to write more. If, on the other hand, the objectifying forces of the market prevail, at least this book will ensure that the great era of psychotherapy ends with more bang and less whimper. For now, *The Real World Guide to Psychotherapy Practice* helps those of us in active practice by maintaining a humane alternative consensus within which we (and our patients) can operate. It defends our identity as psychotherapists rather than mindless cogs in the "health care delivery" machine.

References

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Handbook of Psychotherapy and Religious Diversity, *edited by P. Scott Richards and Allen E. Bergin. Washington, D.C., American Psychological Association, 2000, 516 pp., $39.95.*

The editors begin by stating that "the alienation that has existed between the mental health professions and religion for most of the 20th century is ending. The influence of the naturalistic, antireligious assumptions that once gripped the field have weakened, and there is now a more spiritually open Zeit-

geist." Seizing the opportunity to respond to the Zeitgeist, the editors attempt to provide therapists (either secular or presumably ignorant of other creeds) with a core knowledge base of the world's main religions. It is an ambitious task with the goal "to add our voices to those of other scholars and practitioners who, in recent years, have urged mental health professionals to acquire greater competency in religious and spiritual aspects of diversity."

In an attempt to educate their audience, the editors present statistical charts, diagrams, tables, and an extensive reference list. Anyone unfamiliar with their patients' specific religious beliefs and faith community will find this tome worthwhile. It is no substitute, however, for empathy and good listening skills. It is hard to imagine any competent therapist not asking questions about his or her patient's spirituality (it is mandated by the Joint Commission on Accreditation of Healthcare Organizations to assess a patient's spiritual needs and develop a spiritual "treatment" plan as needed). This tome should not be used as a substitute for good therapeutic technique. Spiritual issues may arise anywhere along the continuum of psychotherapy and must be managed differently at each stage. Moreover, learning details about a specific religion's credo and how a faith-based community operates tells us nothing about how our patients understand and live out their creed and relate to their faith community.

The danger of this book is that it may be taken too literally as a cookbook to treat problems that don't exist for our patients. It also assumes that followers of Christian, Jewish, Muslim, or ethnic-centered faiths will know and live out all the details of their faith's belief systems and rituals. This may be one of the most serious errors of the book, that is, not recognizing how individualized and idiosyncratic are an individual's religious beliefs and practices within any religious context. Reading about a person's faith is no substitute for listening to how our patients live out their faith, often in confusion and contradiction to some of their faith's core belief structures.

Little attention is given to the ways organized religion and faith-based systems may originate or perpetuate mental illness through discouraging needed drugs or therapy. Moreover, many religious institutions may support patriarchal systems that dominate and subjugate women, may teach inaccurate, pseudo-scientific views of sexuality (or evolution), and may perpetuate damaging superstitions that encourage obedience and authoritarian rule when agency and personal response may be needed. During marital crises in which changing male and female roles are at issue, an institutional religious response may be harsh. Knowing that some of the core teachings of our patients' religious belief structures may increase the severity of their symptoms, how are we to respond? Some of the case material in the handbook suggests that a correct therapeutic approach, even from a religious standpoint, may be in conflict with the core aspects of the religion.

Currently, religion and prayer are in vogue among some groups of therapists. Some therapists may be drawn to spiritual practices because of their frustration with ordinary therapeutic technique or a personal need to connect emotionally with their patients' souls. When therapists reach this stage, the possibility of boundary crossings and violations increases. Some ministers and pastors may be drawn to psychological science and psychotherapeutic techniques because their personal experiences with parishioners led them to feel that their religious methods are inadequate to address psychopathology. Some of these ministers may incorporate psychological insights into their liturgy and sermons, while also looking for therapies that can be grafted onto religious texts. The psychological-religious landscape is complex, and the potential for doing harm to our patients by mixing spiritualism with psychotherapy should not be underestimated.

The warning in the final chapter of this book against the clinician's becoming "overwhelmed or even confused" by the "breathtaking…religious landscape of North America" seems a bit patronizing. Actually, the summary tables in this chapter suggest a more monolithic view of the diverse religions in that landscape. Most religions share similar negative attitudes regarding the role of women, sexuality, contraception, premarital/ homosexual/extramarital sex, and divorce. Issues of abortion, suicide, and euthanasia are also viewed in a negative light. Religious intolerance of diversity is not discussed.

The summary table 19 will probably become the centerpiece of this tome, which would be unfortunate because of the way the belief systems of the different religions are oversimplified and stereotyped. A review of therapy recommendations listed in table 19 for religiously diverse groups is discouraging. Latinos, we are told, should not be treated in individual therapy because individualist intervention approaches are less congruent with the Latino collectivist world view. We are also told to use a developmental approach with Hindus, empathic understanding with African Americans, supportive meditative practices with Buddhists, cultural therapy with Muslims, spiritual prayer and spiritual self-disclosure with Latter-day Saints, relaxation training and rational emotive therapy with Seventh Day Adventists, motifs of healing and internalized God representations for Catholics, supportive spiritual growth for the Eastern Orthodox, collaboration with pastoral care and some secular approaches with mainstream Protestants, spiritual interventions and some secular therapy for Evangelical and Fundamentalist Protestants, no psychological interventions that are contrary to Pentecostal scriptural understandings, and, finally, psychodynamic and other cognitively oriented approaches with Conservative and Reform Jews, and spiritual interventions for Orthodox Jews, who are seen as having mixed feelings about psychodynamic therapy. Such a summarization is not only confusing but also misleading and stereotyping, wrongheaded, and possibly destructive. I tried to envision what a managed care treatment plan might look like as a result of these recommendations.

Given the way many faith communities have crossed or violated so many boundaries of their parishioners and how insensitive some organized religions have been to the victims of clergy abuse, it seems fair to say that before any rapprochement can be made between faith and psychotherapy, it is equally as important for faith traditions to become less paternalistic, authoritarian, xenophobic, and isolative in order to allow their parishioners access to the mental health care they need.

The mental health field is dominated by pleas from all sectors for competency in all areas of mental health. If the editors support specific competencies in religion for therapists, I suggest that they also support competencies for clerics who offer

psychotherapy to their parishioners. For a dialogue to take place, there must be portals of entry into such a dialogue from all positions. The effort to deepen one's spirituality and develop a sense of agency may eventually lead a patient either toward or away from mainstream religion. Either outcome must be acceptable (by both parties) if therapy is to have any meaning.

For the most part, we should not be giving our patients legal or financial advice and certainly not religious advice. Therapists who pray with their patients, read the Bible with them (for therapeutic purposes), use touch as a form of religious healing, and give sermons to their patients are probably treading on thin ice. When my religious patients are at a religious impasse we may reach out to their faith system and enjoin their minister to provide spiritual guidance. In many situations the impasse may still exist after the consultation. As psychotherapists we strive to maintain good boundaries in therapy. Our patients rely on our expertise and our ability to maintain good boundaries, to use good clinical judgment and diagnostic skills, and to do them no harm. Unfortunately, these issues are not fully addressed in the *Handbook of Psychotherapy and Religious Diversity* and are ignored with respect to Christianity (in the subject index, the word "Boundaries" is indexed only for African Americans, Buddhism, and Judaism). The strengths of this book are in the rich mixtures of facts and clinical vignettes that help clinicians question their hypotheses and listen more closely to their patients' needs.

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Negotiating the Therapeutic Alliance: A Relational Treatment Guide, *by Jeremy D. Safran and J. Christopher Muran. New York, Guilford Publications, 2000, 260 pp., $32.50.*

The quality of the therapeutic alliance is the most powerful predictor of success in psychotherapy. Given the inevitability of stresses, strains, and breakdowns in that alliance, the identification and repair of these difficulties are among the most important skills for the psychotherapist to acquire. The publication of *Negotiating the Therapeutic Alliance* will make it easier to communicate this skill to trainees and colleagues.

This book is an unusually thoughtful and pragmatic contribution, with excellent theoretical material illustrated by useful clinical transcripts. Safran and Muran and their colleagues have conducted years of research on the therapeutic alliance in both Canada and the United States. They have developed a model of psychotherapy based on their synthesis of contemporary thinking in relational psychoanalysis. Their discussion of the therapeutic alliance and its vicissitudes draws heavily on this school of thought.

The authors divide difficulties into 1) disagreements on tasks and goals and 2) problems associated with the relational bond. They discuss and illustrate how to recognize these problems and how to "metacommunicate" (communicate about the transactions or implicit communications that are taking place) in a manner that brings the problem into focus between therapist and patient. They organize ruptures in the alliance into subtypes characterized by either withdrawal or confrontation. For each subtype they propose a model in which recognition of markers of such ruptures is followed by a sequence of interventions. These interventions are not cookbookish; instead, they are process-oriented, and their precise form will emerge from the unique context of each psychotherapeutic endeavor. The valuable and cogent descriptions of the stage process model could enrich any psychotherapy curriculum.

The book's seven chapters discuss the history of the therapeutic alliance and its recent reconceptualization, the authors' fundamental assumptions and principles in their approach to psychotherapy, understanding alliance ruptures and impasses, therapeutic metacommunication, stage process models of resolution of alliance rupture, brief relational therapy, and a relational approach to training and supervision. The authors display a gift for expressing difficult concepts with clarity. They say so much so well that I found myself wishing they had written a longer and more comprehensive text.

Negotiating the Therapeutic Alliance is steeped in the concepts, values, and world view of relational psychotherapy. It is less a freestanding study of the therapeutic alliance per se than a guide to approaching psychotherapy from a relational perspective. For the reader who embraces the relational paradigm, this may be congenial. However, for readers unfamiliar with the relational paradigm, those who find the relational perspective a useful addition to our understanding but not sufficiently comprehensive to serve as the cornerstone of the psychotherapeutic endeavor, and those who are strongly committed to an alternative model, some of the authors' emphases, omissions, recommendations, and examples may seem problematic and/or off target.

Nonetheless, this book has so many strengths, addresses so many important issues so well, has so much wisdom, and offers so much of value to those who teach psychotherapy that it belongs in the library of every mental health professional who practices or teaches psychotherapy.

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SUICIDE

Comprehending Suicide: Landmarks in 20th-Century Suicidology, *by Edwin S. Shneidman, Ph.D. Washington, D.C., American Psychological Association, 2001, 272 pp., $39.95.*

This book is a review of selected articles or textbook chapters written during the past century. The author, Edwin Shneidman, has spent a lifetime researching suicide. He feels that these selected works are among the best from the 20th century. Specific criteria are not listed to explain why these particular writings were chosen, but Dr. Shneidman says these works will be useful for "fresh insights" for suicide researchers and others interested in this topic. Dr. Shneidman is currently an emeritus professor of thanatology at the University of California, Los Angeles. He has published several articles and books about suicide.

The book is divided into five general sections: Historical and Literary Insights; Sociological Insights; Biological Insights; Psychiatric and Psychological Insights; and Insights on

Survivors and Volunteers. Thirteen articles or books are reviewed in the five sections. Each chapter contains a brief review of the selected book or article. Following this review, parts of the original work are reprinted. Authors represented in the book include Minois, Alvarez, Durkheim, Dublin, Iga, Stoff and Mann, Karl Menninger, Baechler, Aaron, Maltsberger and Goldblatt, Cain, Varah, and Colt.

Much of the book is devoted to writers who seem to view suicide from the psychological perspective. The sociological section of the book has three chapters. These works are more data based. The biological insight section has only one chapter. Much of the book is written in a lyrical style, both by the original authors and by Dr. Shneidman. The data-oriented sociological chapters are prosaic in style and discuss studies that were conducted several decades ago. These studies appear not to have had the benefit of current-day improvements in statistics and assessment. They also lack the improved understanding of methodological limitations of certain kinds of population sampling techniques and interviews.

In summary, those readers who would like to explore suicide from a psychological, personal, or philosophical view may enjoy the brief historical snippets of selected text and articles about suicide contained in this book. Readers who want more data-oriented or biological insights about suicide should fire up their web browser or head to their friendly corner medical library for other reviews, texts, or scientific articles about suicide.

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CHILD/ADOLESCENT PSYCHIATRY

Anxiety Disorders in Children and Adolescents: Research, Assessment and Intervention, *edited by Wendy K. Silverman and Philip D.A. Treffers. New York, Cambridge University Press, 2001, 402 pp., $64.95 (paper).*

Most psychiatrists who assess and treat child patients see anxious children daily. This comprehensive book serves to stimulate the clinician to view the phenomena we encounter in office practice from several perspectives.

The editors, Dr. Silverman of Florida International University and Dr. Treffers of the Leiden University Medical Center, have worked with the presenters at a May 1997 international research conference to produce a well-integrated volume. In addition to the 12 chapters based on presentations at the conference, they have included four others. One of the added chapters is a historical overview of how anxiety and its disorders in children and adolescents were viewed before the 20th century. In this chapter the editors remind us of the importance of societal factors in the appraisal of many clinical presentations.

The other three added chapters consider the neuropsychiatry underlying pediatric anxiety disorders, child-parent relationships (with emphasis on attachment theory), and the pharmacological treatment of pediatric anxiety. Most of the authors of the additional chapters are North American, but the conference-based chapters were prepared by a diverse international group representing five European countries and Israel.

Of particular interest is the chapter by Drs. Fonsecca and Perrin, who discuss the classification and assessment of childhood and adolescent anxiety disorders. They contrast the DSM/ICD categorical approach with the dimensional view of anxiety as occurring on a continuum of severity. Taking developmental and cultural factors into consideration, they conclude that "a comprehensive assessment should include several self-report measures for the child and a structured interview." Epidemiology is reviewed by Dr. Verhulst, who emphasizes the prevalence findings in the general population (6%–10%) and contrasts that with the 2% who were evaluated as functionally "handicapped."

Clinicians will naturally gravitate toward the two chapters that discuss the treatment of anxiety disorders. Drs. Silverman and Berman review the research literature on psychosocial interventions. The excellent review of pharmacological treatment of pediatric anxiety disorders is written by Drs. Stock, Werry, and McClellan. With a table on benzodiazepines and a table on a variety of other medications, this chapter could well serve as a concise reference for clinicians of all disciplines.

The last chapter, written by Dr. Klingman of Israel, considers prevention of anxiety disorders and has posttraumatic stress disorder as its main focus. Dr. Klingman relates his experiences in helping families and children go through traumatic events successfully (i.e., with minimal resultant anxiety). His five-level model of prevention serves to provoke our thoughts of how we can help today's children as they develop in these troubled times.

Research possibilities, the importance of complete, developmentally relevant assessment, and the need for improving and using preventive strategies for anxiety disorders are all brought to our attention in this book.

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Treating Anxious Children and Adolescents: An Evidence-Based Approach, *by Ronald M. Rapee, Ph.D., Ann Wignall, M. Psych., Jennifer L. Hudson, and Carolyn A. Schniering. Oakland, Calif., New Harbinger Publications, 2000, 195 pp., $49.95.*

For several years, the authors have been running anxiety disorder clinics for children ages 7 to 16 at the University of Queensland. Success rates with cognitive behavior therapy have been promising, with maintenance of moderate to marked improvements in 75% of the children for a year or more.

This is dramatic news from psychologists. Medical methods do not top this success rate. Antianxiety agents such as benzodiazepines are excellent for acute relief of intense anxiety, but they can be habit forming, requiring larger and larger doses in a small minority of users. Cognitive behavior therapy usually requires eight to 12 weekly sessions. After that the family and patient ("client") must continue to reinforce the therapy, often for several years or more.

Anxiety disorders last a lifetime and are contagious. Anxious children usually come from anxious families. Dr. Rapee and his colleagues warn mothers to be less protective, less in-

vasive. The mothers and fathers are required to take part in the treatment. These authors feel that group therapy is just as effective as individual and, of course, cheaper.

Generalized anxiety disorder and panic disorder were seldom seen in the children who came to the authors' clinic. Specific phobias, such as separation anxiety, were prevalent in the younger children. Social phobia and school phobia were prevalent in adolescents, and occasional cases of obsessive-compulsive disorder (OCD) were seen at all ages. The psychiatrist is likely to try clomipramine for OCD and gabapentin for severe social phobia. Dr. Rapee and his colleagues claim that they rarely have to refer a child or adolescent for pharmacology. Psychiatrists usually find it more efficient to use an antidepressant for major help and add cognitive behavior therapy if available. The authors also address social skills training and assertiveness training.

According to the authors,

> A negative life event may precipitate anxiety, but that anxiety can be exacerbated by the reaction to life events in someone who is temperamentally emotional.
>
> The anxious parent is likely to respond to a vulnerable child with excessive control and protections.
>
> Overprotection provided by the parent increases the child's tendency to perceive danger and to believe that he or she has no control over danger.
>
> The use of exposure is aimed at getting the child to approach feared situations and thereby learn to cope.
>
> Teaching the child to think more realistically can reverse the natural tendency to interpret situations as threatening.
>
> Relaxation techniques can reduce excessive arousal.

If you have been wondering what cognitive therapy is, in this book you have it in a nutshell. It is an excellent "cookbook" that can teach the psychiatrist step-by-step how to employ cognitive behavior therapy. I predict that most psychiatrists would not use this detailed method, were they to take the trouble to learn it, after practicing other forms of psychotherapy. Soon there will be better medication to calm pathological anxiety. Some medical schools are teaching cognitive behavior therapy to students, and some psychiatric residencies offer training in cognitive behavior therapy. There is talk of dopamine deficiency in anxiety, and the role of amygdala function in anxiety disorders is under exploration. In the meantime, some of us will refer patients with anxiety disorder patients to friendly psychologists with extensive experience in cognitive behavior therapy. Fluvoxamine has been approved by the Food and Drug Administration for anxiety disorders in children. The combination of cognitive behavior therapy with psychopharmacology has not been sufficiently researched. It may be a step forward.

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Childhood Disorders, *by Philip C. Kendall. Hove, East Sussex, U.K., Psychology Press, 2000, 229 pp., $49.95; $26.95 (paper).*

This very accessible introduction to the mental health problems of childhood is one of a series of books focused on clinical psychology. Professor Kendall's volume focuses on several aspects of developmental psychopathology and will be of interest to practitioners and researchers who desire a succinct overview of the current state of knowledge. The volume is clearly intended to strike a balance between the more cursory treatments in traditional textbooks and the more extensive levels of coverage in more specialized texts. It draws on both research and clinical experience, with a laudable emphasis on empirical research, in considering treatment options.

The book is divided into 12 chapters that include a discussion of models of childhood disorders; an overview of etiology, assessment, and treatment; a series of chapters on specific disorders; and, finally, a short summary and questions for the reader's consideration. The volume is well written and provides an excellent introduction to the field. The chapters are very readable and include references to current work. Coverage is balanced with a discussion of current and, sometimes, past controversies. The chapters on anxiety disorders and depression are particularly well done. Pharmacological management is reviewed as relevant, although, as with the rest of the book, not in great detail.

The limitations of the book stem from its brevity. The attempt at conciseness does, at times, make for some strange bedfellows, e.g., tic disorders, enuresis, and encopresis are all covered in one chapter. The depth of coverage is also understandably limited by the broad scope of the book and the attempt to be comprehensive in terms of topic coverage. The volume will be of greatest interest to beginning students and those who desire a readable introduction to the field.

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Handbook of Infant Mental Health, 2nd ed., *edited by Charles H. Zeanah, Jr. New York, Guilford Publications, 1999, 558 pp., $63.00.*

A pious Christian or Muslim needs and deserves a fine version of the Bible or Koran. A sea captain traversing the ocean should have a competent map. And every educated person who wants to assess, treat, or love a difficult baby must own a copy of this book. If you can't find helpful information summarized here, relevant to any important or special problem pertinent to children ages 0–3, then the data do not yet exist. Now in its second edition (the first appeared in 1993), this volume is a massive, encyclopedic work encompassing all aspects of infant mental health. It has three major themes: 1) "infants are both like and unlike older children and adolescents," 2) "infants must be understood within a developmental context," and 3) "the care-giving context of infancy is essential" (pp. viii–ix).

Since I can't find fault with the textbook's comprehensive, marvelously written, and well-edited contents, I am restricted to questioning the choice of words for the title. The book's contents are clearly focused on abnormalities and pathology of child development, not on "health." The term "mental health" is borrowed from a persistent but odd term still used in adult and adolescent psychiatry. Health resides in humans so transitorily that the use of this cheerful designation seems like a timid sop to the ancient fear, superstition, and impenetrability associated with mental illness. Since the editor, Charles Zeanah, asserts that the multidisciplinary field of in-

fant psychiatry has now "come of age," can't we call a spade a spade by using nouns like "disease" or at least "disorder"?

To return to the book's contents, it contains contributions by 72 distinguished authors and is divided into six sections and 36 chapters. Section 1, Context of Infant Mental Health, tracks the infant through its psychological birth, showing how the infant's primeval connection to the pregnant mother is neurobiologically transformed into a relational network between infant and care providers, which include the parents, siblings, and even therapists. Potential injuries that can threaten the newcomer's existence (i.e., maternal mental illness or substance abuse, premature birth, poverty, or the consequences of adolescent parenting) are described in section 2, Risk and Protective Factors.

Section 3, Assessment, contains four chapters devoted to the psychological assessment of infants and toddlers, followed by the book's fourth and longest section (158 pages), Psychopathology, which investigates early psychopathology. Here are found topics such as mental retardation, autism, posttraumatic stress disorder (quite a long stretch from the adult diagnosis), aggressive behaviors, and depressive conditions. There is a sophisticated research report from the Human Infant Sleep Laboratory at the University of California, Davis, by T. Anders et al., summarizing the current understanding of child sleep disorders.

Section 5, Intervention, is too brief in the light of rapid recent multiplication of pharmacological interventions for emotionally ill children. But its chapters do consider several individual and group therapy methods of treatment as well as institutional strategies. Its five chapters are thematically diverse. For instance, there is a fine, evidence-based chapter by L. Beckwith comparing programs designed to prevent child psychopathology that fail with those which succeed. A quite different kind of chapter by T. Field is devoted to the topic of massage therapy for infants, an intervention justified so far by speculations rather than by explanations of its biological effect. Quantitative research is amply highlighted in other parts of the book. The final and sixth section deals with applications of infant mental health concepts to national U.S. policies governing child care, divorce and custody, and development of standards for the education and training of future specialists in this fast-growing subspecialty of child psychiatry.

The book has about 2,000 bibliographic references. I am proud to be represented by a solitary publication. Sigmund Freud is also cited only once, and he too would have considered it an honor to be included.

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SUBSTANCE ABUSE/ADDICTIONS

Hooked: Five Addicts Challenge Our Misguided Drug Rehab System, *by Lonny Shavelson. New York, New Press, 2001, 256 pp., $24.95.*

This is the first time in many years of reviewing for the *Journal* that I have had the pleasure of reading a work that I simply could not put down. The comments on the back jacket by professionals, well-known personalities, and book reviewers use phrases such as "intelligence, compassion, brilliance," "crucially important," "a terrific read," and "brings home the reality of addicts' lives." It is all of these things and more. Dr. Shavelson, an emergency room physician, photojournalist, and author, would have produced a wonderful and compelling volume had he only described the lives of his five addicts over the 2.5-year period covered in this book. In addition, however, he has done his research on addiction, funding, and outcomes. This research is woven into the narrative with ease, and he is able to make his case relative to the dysfunction of the drug rehabilitation system in San Francisco and throughout the United States. Dr. Shavelson single-handedly does for substance abuse and dual diagnosis what the Institute of Medicine did to highlight inadequacies in the general delivery of health care in this country.

Dr. Shavelson is a wonderful, compassionate observer who clearly was present but, with one small exception, did not interfere in the life events of his subjects as they unfolded. If his presence created a Hawthorne effect, it had to be negligible. This latter shows his great sensitivity, both as a journalist and as a physician.

Dr. Shavelson meets the subjects of this book, his people, at a walk-in intake clinic shortly after San Francisco began a program of open placement for all addicts. He notes that the number of addicts in the United States has dropped significantly in the last decade, but the use by the remaining addicts has escalated dramatically. The five individuals who form the substance of this book illustrate some of the most severely addicted people in the user community. They have great pain and pose great challenges to those who engage them in treatment.

Dr. Shavelson follows his people through a series of encounters with the rehabilitation system. He recounts both their successes, great and small, and their relapses, also great and small. He is insightful and incisive in his description of the rehabilitation system. His final chapter is titled, "Afterward: Does Treatment Work?" The first paragraph of that chapter reads, "When I began this book, the question 'Does treatment work?' formed the tiniest seed of inquiry. It soon blossomed into a prickly rose. The closer I moved to smell the flower of rehab, the more sharply I felt the thorns."

Every single medical mental health and addiction professional, as well as funders, bureaucrats, and decision-makers, should make this book required reading. These individuals should listen to Dr. Shavelson's suggestions and work toward making them a reality. I know I will!

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Relapse and Recovery in Addictions, *edited by Frank M. Tims, Carl G. Leukefeld, and Jerome P. Platt. New Haven, Conn., Yale University Press, 2001, 420 pp., $45.00.*

Relapse and recovery in the addictions refer to patient-centered, posttreatment events that signal the success or failure of the treatment effort. The 50 contributors to this volume have furnished us with a compendium of work on this topic. Older studies emphasized pretreatment demographic and clinical factors that predict relapse or recovery. The studies of some of the authors included in this book have carried the

field to its next logical step: identifying treatment factors that minimize relapse and favor recovery.

The 17 chapters address many subjects relevant to the course and care of the addictions: self-help groups, coerced treatment, case management, motivational interviewing, contingency contracting, pharmacotherapy strategies and agents, and the relative efficacy of the different social pressures or psychological rationales for maintaining recovery. Reviews of the literature are not merely described but also critiqued. The field itself receives criticism for its reluctance to employ or replicate promising therapies (e.g., disulfiram for cocaine abusers who drink, emetic aversive conditioning in cocaine addiction). The spiritual and self-help dimensions of recovery and relapse get some attention. The editors, in selecting chapter authors, have taken a holistic approach in relating relapse and recovery to a wide range of disparate factors: the environment, the variable courses of addiction, available pharmacotherapies, and the criminal justice system. In guiding the authors, the editors underscored the importance of theory to the entire enterprise.

Clinical investigators of the addictions will want to read selectively from this volume. Its emphasis on critique of past studies, theory, sampling, and methods of data collection will appeal to this audience. For those new to the field, the authors cite hundreds of studies and include many lucid tables and figures. In several places, authors highlight the kind of studies that they believe are needed.

Practitioners, however, will not perceive obvious new ways of reducing relapse and enhancing recovery beyond those already in the literature. This is not a "how to" book. As several authors make clear, we are still struggling with elemental considerations, such as agreement on criteria for relapse versus lapse versus recovery. In their meta-analyses, several authors point out the discrepancies and failures to replicate that have dogged progress in the addiction field.

Predictably, the authors have to stress certain dimensions of addiction to narrow their topic. Cocaine and heroin receive primary attention; tobacco, alcohol, and cannabis are mentioned in passing. Addicted adolescents get an entire chapter; women and middle-class men receive short shrift. The chapter on research on relapse and recovery in Europe contains important and interesting data; the ample literature from Asia is virtually ignored. Urban addicts in the public sector occupy center stage; rural addicts and those seen in private practice are seldom mentioned. One chapter on managed care nicely examines the potential advantages and liabilities of minimizing relapse in that setting but falls well short of a manifesto that would convince the fiscal czars dominating our national private health care.

In sum, the authors have done a service to the field by pointing up our limited knowledge regarding treatment factors that affect the courses of addiction.

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Brain Imaging in Substance Abuse: Research, Clinical, and Forensic Applications, *edited by Marc J. Kaufman, Ph.D. Totowa, N.J., Humana Press, 2001, 425 pp., $135.00.*

Psychiatrists come across colorful pictures of imaging data with increasing frequency in the articles they read, pharmaceutical advertisements they scan, and conferences and grand rounds they attend. Many of these psychiatrists, no doubt, wonder how these images are generated, what they really represent, and what they reveal about the diagnosis, treatment, and prognosis of psychiatric illness. This book provides answers to these questions in the process of comprehensively reviewing the current place of brain imaging in substance abuse.

The book is clearly organized. The first three chapters are devoted to explaining the techniques involved in producing and interpreting EEGs, positron and single emission tomographs, and magnetic resonance images (MRIs). Each of these chapters is written clearly with most technical details at the level of the informed nonexpert physician. All major subcategories of imaging are covered, including tomographic EEG, functional MRI, magnetic resonance spectroscopy, and dynamic susceptibility contrast MRI. A realistic and measured account of the types of physiological and clinical knowledge gained from these technologies is outlined. At the same time, the multiple technical, methodological, and statistical problems that are yet to be resolved and that greatly inhibit the reliability, validity, and practical use of the data produced are forthrightly acknowledged.

The next three chapters are devoted to an exhaustive review of the use and value in substance abuse research of each imaging technology. General and relevant comments are made about the difficulties in conducting such research given the limitations of both imaging technology and substance abuse clinical research methods. These chapters are followed by a summary of the imaging studies relevant to alcohol, benzodiazepines, opiates, stimulants, marijuana, hallucinogens, and solvents. One is left with the impression that there are few consistent imaging findings in substance abuse research (with several notable exceptions). However, the authors appropriately remind the reader that most imaging technologies are less than 10 years old and have only recently and sporadically been applied to substance abuse.

A chapter follows on neuropsychological testing in substance abuse. Its value in a book on imaging is explained satisfactorily by the close relationship between behavioral function and neuroanatomy. Although providing a credible summary of neuropsychological test findings in subjects using various substances, this chapter provides no information or speculation linking these data with imaging data.

The final chapter on neuroimages as legal evidence is relevant to the physician reader and provides an excellent overview of the current scientific and forensic status of imaging technologies. It also provides a cogent reminder to overly enthusiastic interpreters of available data, especially psychiatrists, that

> a field of research may be technologically advanced but methodologically immature, generating exciting hypotheses but few broadly generalizable findings and little normative data. Such is decidedly the case for neuroimaging techniques to study cognition and mental illness.…Neuroimaging findings in the areas of cognitive neuroscience and mental illness are essentially group effects of small magnitude; the imaging literature has yet to produce any tests or techniques that are sensitive and

specific enough to reliably diagnose cognitive deficits or psychiatric disorders.

The book ends with a well-designed structured bibliography of 128 pages containing 1,350 references followed by a thorough, logical index.

What does this book teach psychiatrists trying to make sense of the images of brains with which they are increasingly presented? The clear message is that the powerful techniques used to produce these images have great research and clinical potential but remain of limited value for clinical psychiatrists seeking guidance on how to care for their patients with substance use disorders. However, development of neuroimaging techniques is occurring rapidly, and their utility and probable necessity for adequate patient care are not far off. This book will greatly assist clinicians, teachers, and researchers in understanding the underlying structure of this evolving revolution in psychiatric knowledge.

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Drug Abuse: Origins and Interventions, *edited by Meyer D. Glantz and Christine R. Hartel. Washington, D.C., American Psychological Association, 1999, 489 pp., $49.95.*

This book provides an excellent overview of the current scientific knowledge and societal influences underlying our working models of etiology, issues, and treatment of drug abuse. In their preface, the editors describe the progress of this work:

> In 1996, the National Institute on Drug Abuse (NIDA) and the American Psychological Association (APA) cosponsored a special conference on drug abuse held in conjunction with the APA annual convention in Toronto, Canada. Leaders in their fields were invited to present not only their latest research, but also some new and forward-looking observations as well as theoretical speculations about their fields. That meeting served as a springboard for this volume. (p. xxiii)

The book is divided into two sections, Origins and Interventions; however, the boundary is blurred in many of the chapters. Most of the chapters provide discussions of both etiology and intervention. The volume provides not only a general overview of the field but also some views on specialized areas in drug abuse, such as drug abuse in ethnic minority women (by Kathy Sanders-Phillips), HIV prevention (by Thomas J. Coates and Chris Collins), and therapeutic communities (by George De Leon). Meyer D. Glantz et al. contribute a thorough review on the etiology of drug addiction (chapter 1), George F. Koob et al. contribute a lucid summary of the neurobiology of drug abuse (chapter 8), and David F. Musto's chapter on the impact of public attitudes on drug abuse research in the 20th century (chapter 3) is a great read—he discusses certain societal beliefs that adversely affected the research (and the researchers) during the early 20th century.

There are two chapters written specifically about theoretical models: Dante Cicchetti's chapter, "A Developmental Psychopathology Perspective on Drug Abuse," and José Szapocznik and J. Douglas Coatsworth's chapter "An Ecodevelopmental Framework for Organizing Influences on Drug Abuse: A Developmental Model of Risk and Protection." The latter chapter is well integrated with the other chapters on drug abuse interventions and provides a good framework for the chapters on prevention (one by Zili Sloboda and one by Gilbert J. Botvin).

All in all, I found this book to be informative on many levels—theoretical, ethical, scientific, and clinical. Through the contributions of its many experts in the fields of drug abuse research, this volume clearly describes the current progress in the research community, the current state of drug abuse prevention and treatment, and the challenges that lie ahead of us.

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GERIATRIC CARE

Psychiatric Medications for Older Adults: The Concise Guide, *by Carl Salzman, M.D. New York, Guilford Publications, 2000, 171 pp., $30.00.*

Perhaps the biggest growth in the practice of mental health over the last two decades is in work with older patients, particularly geriatric patients in nursing homes and assisted living centers. This group of adults over 65 years of age will continue to grow with the aging of the large population born during the 10 years after World War II. In its second decade of development as a specialty, geriatric psychopharmacology is coming to maturity with recent publications. Dr. Salzman's *Psychiatric Medications for Older Adults* is one of these. The book is indeed concise (it can be read rapidly in about 2 hours), and it covers all the questions and problems I see on a daily basis in my geriatric work. The book is coherent and orderly: a first chapter on basic issues and chapters 2 through 7 on depression, mania, anxiety, sleep disorders, dementia, and agitation and psychosis. In the appendix are two very useful tables listing medical drugs that interact with psychiatric drugs and drug interactions among psychiatric drugs. Psychiatrists involved in geriatric practice could consult this information daily.

Two basic issues in using psychiatric medication that Dr. Salzman highlights in chapter 1 are that it usually is better to "start low and go slow" when prescribing and that many older adults under 80 may need doses similar to those for a middle-aged adult because they are often relatively healthy. In other words, start low, go slow, but keep on going to get the desired effect. Most people older than 80 do not need the higher dose.

The first of the six chapters on psychiatric conditions is on depression. Twenty-five percent of nursing home residents have clinical depression or depressive symptoms. Dr. Salzman discusses major depressive disorder, dysthymic disorder (persistent mild depression), suicidal ideation and intent, masked depression (depression masked as illness), and delusional depression (major depression with psychotic thinking). The frequently seen delusions are paranoid ("I'm being punished by someone"), somatic ("I have cancer that nobody

is telling me about"), and nihilistic ("I'm hopeless"). I would add a fourth delusion I've seen often, a grandiose or hopeful delusion ("I'm getting married tomorrow" or "I'm moving to my house tomorrow").

Dr. Salzman provides a good description contrasting the cognitive impairment associated with depression and dementia. Patients with depression complain constantly about memory impairment when it is only mild, but patients with dementia deny or try to conceal their memory impairment.

The last half of the chapter on depression describes the uses, side effects, and cautions with tricyclic antidepressants, selective serotonin reuptake inhibitors (SSRIs), monoamine oxidase inhibitors (MAOIs), stimulants for apathy and withdrawal (methylphenidate can be very effective at low doses), and ECT (also very effective in serious late-life depression). SSRIs are probably most preferred for older adults as the initial drug of choice. For more severe depression that doesn't respond to SSRIs, tricyclic antidepressants and MAOIs are often successful (remember to start low because of the anticholinergic side effects with tricyclic antidepressants and orthostatic hypotension with MAOIs). The use of mood stabilizers such as lithium, divalproex sodium, carbamazepine, gabapentin, and lamotrigine to treat severe depression and mania is discussed. Finally, Dr. Salzman discusses the treatment of bipolar disorder with low starting doses of antidepressants (monitoring for acceleration into mania) and mood stabilizing drugs. I have found low doses of divalproex sodium (100–200 mg) to be very useful combined with an antidepressant for depressed and irritable patients.

The chapter on mania discusses the mood stabilizing drugs (lithium, divalproex sodium, carbamazepine, lamotrigine, and gabapentin). Initial treatment is to start with low doses. Lithium is effective but harder to tolerate for the elderly, so caution is advised. Elderly patients with rapid cycling bipolar disorder do not respond well to lithium. Divalproex sodium with an additional neuroleptic is usually effective. Lamotrigine, an anticonvulsant, can be very effective for mania and bipolar disorders but, again, it needs to be started at low doses (12.5–25.0 mg). I've seen remarkable improvement in patients taking this medication who have previously not done well with lithium.

In the chapter on treating anxiety, Dr. Salzman suggests that benzodiazepines with short half-lives (alprazolam, lorazepam, and oxazepam) are almost always preferable to benzodiazepines with long lives (diazepam, chlordiazepoxide, and clonazepam). Although benzodiazepines are overprescribed and inappropriately prescribed, they can also be very useful in restoring the quality of life for the elderly person. These medications are effective and safe, especially when doses are kept low. Long-term use can be very helpful, but it should be noted that the aging process increases sensitivity to benzodiazepines. Monitoring the patient might reveal that the dose can be reduced over time.

Sleep disorders are probably the most common complaint of older people. Sedating antidepressants, like trazodone (or nefazodone hydrochloride for chronic insomnia) are often useful. Benzodiazepines are also discussed. Neuroleptic medications, such as olanzapine at low doses (2.5–5.0 mg.), can also be effective.

The final two chapters deal with dementia and with agitation and psychosis. Atypical neuroleptics (risperidone, olanzapine, and quetiapine) are first-choice medications for agitation and psychosis. When they are ineffective, divalproex sodium and carbamazepine can be used, especially for severe anger. I have found that risperidone and olanzapine increase the symptoms in Parkinson's patients who are agitated and psychotic but that quetiapine has a better effect. Antidepressants added to neuroleptics can also be very useful. The old-line, typical neuroleptics such as haloperidol and thioridazine rather than atypical neuroleptics need to be considered in more severe and intractable cases of agitation. The potential side effects (extrapyramidal symptoms, oversedation, anticholinergic side effects, and, possibly, delirium) need to be monitored.

Overall, I found this concise guide to be very readable and useful. I now carry it with me to work. I would like to add a few comments about two issues that I think are important in using psychiatric medications. First, I often see patients started on two psychiatric drugs, like olanzapine and fluoxetine, at the same time, and I think this is poor practice unless it is an acute situation. How do you know what drug is working? Psychiatric medications should be changed one at a time so you can better judge their effect. Second, it has been my experience that most severely ill psychiatric patients can usually be managed with one, two, or, at most, three medications. For example, an antidepressant with an atypical neuroleptic for depression and agitation, a mood stabilizer with an atypical neuroleptic for agitated psychosis, and a short-acting benzodiazepine with an atypical neuroleptic for agitated Huntington's chorea can often be effective. It is my experience that if you use more than three psychiatric medications you have problems with increased agitation and oversedation.

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Geriatric Mental Health Care: A Treatment Guide for Health Professionals, *by Gary J. Kennedy, M.D. New York, Guilford Publications, 2000, 347 pp., $39.00.*

How I wish that I had written this book. Somehow, old-age psychiatry has always tended to attract the writers and editors of two opposite kinds of book: enormous doorstop reference volumes and flimsy touchy-feely offerings. So there's always a huge potential market for a good textbook to bridge this gap, not least because the majority of older people with mental health problems are being treated by generalists or by specialists still in training. I would seriously recommend this book to any nurse or physician who looks after old people in hospitals (general or psychiatric), in nursing facilities, or at home. Gary Kennedy has produced a comprehensive, up-to-date, and evidence-based textbook that is accessible to nonspecialists, and he's done it without watering down his material to the point where specialists will find the text too thin.

The usual suspects (dementias and delirium, anxiety and depression, psychosis and mania) are covered well and in a practical and informative manner. There's an excellent section in the chapter on psychosis and mania within which Kennedy considers how best to achieve a therapeutic alliance with the patient and his or her family. In clinical reality, this is much more useful than advice on choice of an individual antipsychotic, but I can't recall reading such a clear and sensible account of this important skill in another book.

Chapters on personality, somatoform, and pain disorders, on alcohol and substance abuse, and on sleep disturbances are of equally high quality. The reader will also find a refreshingly nonageist view throughout regarding the availability and usefulness of the full range of treatments for psychiatric disorders in older adults. For example, brief and long-term psychotherapies get appropriate coverage alongside pharmacological treatments for anxiety and depression. The book winds up with chapters on legal and ethical issues and mental health consultation in the general hospital, home, or nursing home. The single-author format is rare these days and works very well. Help from colleagues who have been generous with their time in reviewing individual chapters for the author has added to the book's value, and there is nothing of the lopsidedness of content seen in rival volumes. The slightly awkward title really doesn't do credit to the content and quality of the book. *Geriatric Mental Health Care* is a title that might give an unfortunate impression of covering practices that are not absolutely bang-up-to-date.

It's difficult to glamorize the psychiatry of later life, but those of us in this field have to be very careful what we call ourselves and our specialty. For many years, old-age psychiatrists (as we currently call ourselves) in the United Kingdom referred to themselves as "psychogeriatricians." This made us sound like we had trained in geriatric medicine before developing a major mental illness. The current U.S. vogue for the term "geriatric psychiatrist" is no better and doesn't always sit well with the appearance of many eminent practitioners. No one illustrates this better than the author himself. Kennedy, we learn, was born in 1948, but his photograph on the back flap of the book jacket reveals him to be remarkably youthful despite a suspect taste in bow ties. Such comments are motivated by pure jealousy on my part. This is a great book, and my own copy has already been "borrowed" by a junior colleague. I fear I won't see it again.

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Corrections

In a letter by Kewalsing Jangbahadoer Sing, M.D., et al. in the January 2002 issue ("Neuroleptic Malignant Syndrome and Quetiapine," Am J Psychiatry 2002; 159:149–150), there was an error in the dose of quetiapine reached after gradual titration. The actual dose should be "200 mg b.i.d."

The article "Negative Symptoms in Temporal Lobe Epilepsy" by Kiesa Getz, M.S., et al. (April 2002, pp. 644–651) contains an error in text on page 647 and an error in Table 5 on page 648. In the Quantitative MRI Volumetric Data section on page 647, the sixth sentence should read: "In addition, compared to the epilepsy patients without negative symptoms, the epilepsy patients with negative symptoms had a higher total CSF volume, but the difference did not reach significance." The table below should replace Table 5 on page 648.

TABLE 5. Volumetric MRI Measures of Temporal Lobe Epilepsy Patients With Negative Symptoms, Matched Patients Without Negative Symptoms, and Healthy Comparison Subjects

	Temporal Lobe Epilepsy Patients						Comparisons		
	With Negative Symptoms (Group A) (N=23)[a]		Without Negative Symptoms (Group B) (N=23)		Comparison Subjects (Group C) (N=23)				
Volumetric Measure (cm^3)	Mean	SD	Mean	SD	Mean	SD	Group A Versus Group B (p)[b]	Group A Versus Group C (p)[b]	Group B Versus Group C (p)[b]
Total tissue volume	1028.9	20.0	1049.7	21.1	1092.9	21.0	—	<0.05	—
Total gray matter	629.6	12.1	636.1	12.7	628.9	12.7	—	—	—
Total white matter	399.3	11.1	413.6	11.8	464.0	11.3	—	<0.05	<0.05
Total CSF	133.1	10.4	106.5	11.0	86.7	10.9	<0.10	<0.05	—

[a] Patients with no positive symptoms as assessed by the Scale for the Assessment of Positive Symptoms (19) and one or more negative symptoms as assessed by the Scale for the Assessment of Negative Symptoms (20).
[b] Statistical test results (F values) available from authors.