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The author reports no financial relationships with commercial interests.

Book review accepted for publication April 2009 (doi: 10.1176/appi.ajp.2009.09040509).

***Philosophical Issues in Psychiatry,** edited by Kenneth S. Kendler, M.D., and Josef Parnas, M.D., Dr.Med.Sci. Baltimore, The Johns Hopkins University Press, 2008, 424 pp., $60.00.*

I vividly recall the coy smile of one of the senior inpatient attending psychiatrists during a morning report as one of the junior residents, presenting a newly admitted patient diagnosed with schizophrenia, was asked to discuss the disorder's etiology and began to recite the latest neuroimaging findings and candidate gene linkage studies. "You know," he said, "they still have not found the 'schizochete,' and they have been looking for it since I was a resident."

Meaningful analyses of the complexities involved in psychiatric epistemology are hard to come by. Typically, explorations into important issues in psychiatry that might help the discipline refine its understanding, explanations, and ultimately its clinical utility tend to deteriorate into either dichotomized nature versus nurture debates or adoptions of bland "biopsychosocial" models, which essentially posit that it's all just really complicated, so why bother?

As a result, fundamental questions about psychiatry's philosophical underpinnings remain largely unexamined. Kendler and Parnas undertake this exploration in a readable, cogent manner in *Philosophical Issues in Psychiatry*. The book grew out of a conference held in Denmark in 2006, and each chapter is preceded and followed by a brief commentary by either an author or an editor in an effort to both summarize the major points and capture the interactive spirit of the original presentation. The chapters are further arranged into three major sections—causation, phenomenology, nosology—each of which focuses on a subject at the interface of psychiatry and philosophy.

Upon learning that I would be reviewing a philosophy book, I was not thrilled. Thoughts of dense, inaccessible text and irrelevant topics materialized. However, after reading a few chapters those thoughts quickly dissipated. The authors go to great lengths to ensure that the book is accessible for those with a limited background in philosophy.

Many clinicians might find themselves asking the question that the authors pose in the introduction of the book: Why does a busy clinician with loads of patients need to understand anything about philosophy? The answer is that practitioners will get not only an increased appreciation of the factors implicated in complex behaviors like depression but also an enhanced understanding of causality in complex systems and the problems this poses for reductionist understandings of psychiatric disorders. Additionally, with DSM-V on the horizon and increased attention focused on psychiatry's grouping of disorders, one of the book's most interesting chapters centers on "Psychiatric Systematics" and offers insightful comparisons between psychiatric nosology and its counterparts in chemical taxonomy (the periodic table) and biological taxonomy (genus/species).

In the Mishna, Rabbi Tarfon taught, "You are not obligated to finish the task, neither are you free to neglect it." In this spirit, Drs. Kendler and Parnas's book is an invitation into an oft-neglected area of psychiatry, an exploration of the philosophical underpinnings and its attendant complicated and multifaceted issues.

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The author reports no financial relationships with commercial interests.

Book review accepted for publication April 2009 (doi: 10.1176/appi.ajp.2009.09040508).

***Understanding Addiction as Self Medication: Finding Hope Behind the Pain,** by Edward J. Khantzian, M.D., and Mark J. Albanese, M.D. Lanham, Md., Rowman and Littlefield, 2008, 192 pp., $39.95.*

In the early years of my training, the field of psychiatry underwent a cataclysmic transformation from a psychoanalytical to a neurobiological perspective. I remember heated arguments during the changing of the guard—analysts insisting that an understanding of the individual's personal dynamics were critical to change while the young Turks belittled this outmoded and therapeutically fruitless approach. The expectations for the new era were unequivocal—psychotropic medications promised relief from the misery of psychosis, anxiety, and depression, and developing neuroimaging techniques would uncover the pathophysiology of mental disorders and guide their diagnosis and treatment. Although the biological approach has since yielded dramatic advances in both the biologic underpinnings and treatment of psychiatric disorders, many of the hopes and expectations of this approach remain unfulfilled.

Our understanding of the addictive disorders has followed a somewhat different path, albeit with similar conceptual dissonance. Until the publication of DSM-III in 1980, alcohol and drug dependence were classified as personality disorders and generally considered a by-product of non-substance-related psychopathology. Although originally proposed by Benjamin Rush in 1784, it was Bill W. and Alcoholics Anonymous that began to popularize the notion of addiction as a medical disorder. The description of the brain reward pathways in the 1950s initiated an explosion in our understanding of the neurobiologic mechanisms underlying reward and addictive processes. Treatment strategies have since focused on 12-step, cognitive-behavioral, and motivational enhancement techniques and/or medications. As experienced with other psychiatric disorders, the individual intrapsychic aspects of the addiction were often ignored, and coexisting psychopathology was considered a consequence, not a precursor, of substance use.

For 30 years, an often lone voice encouraging the examination of the psychodynamic processes in addicted patients has been Edward J. Khantzian. In *Understanding Addiction as Self*

Medication, Dr. Khantzian and his long-time colleague Mark J. Albanese explain and enlarge upon the "self-medication hypothesis" and posit that intrapsychic disturbances and affect dysregulation are a primary precipitant and perpetuator of substance use. Furthermore, the self-medication hypothesis proposes that the pain and suffering provoking the initial substance use should be addressed as an integral part of treatment. Although the consideration of comorbid psychiatric problems is now the norm, this is a relatively recent development and has been influenced, at least in part, by Dr. Khantzian. Yet even the current embrace of "dual-diagnosis" patients does not attend to the primary theme of the self-medication hypothesis: namely that substances are used as adaptive attempts to alleviate emotional suffering and repair self-regulatory deficiencies. As noted by the authors, "the self-medication hypothesis of addiction is rooted in the inner experience of those who suffer from it," and exploring an addict's reasons for using a substance can be a crucial path toward recovery. This approach continues to be generally unpracticed in most addiction programs, as treatment is typically provided in a group setting, and even individual therapy seldom considers the intrapsychic meaning of the substance use itself. Missing from *Understanding Addiction*, unfortunately, is empirical evidence supporting the effectiveness of the self-medication hypothesis psychodynamic approach (although the utility of treating coexisting psychopathology is now well documented).

The second major supposition of the self-medication hypothesis is that a patient's specific drug of choice is reflective of their need to self-medicate a particular feeling state. Opioids are chosen for their ability to suppress aggression and rage, stimulants to escape depression and a feeling of emptiness, and sedatives and alcohol to undo inhibition. The authors have developed these formulations based on their own clinical experience and offer multiple vignettes. While one's own experience should not be ignored, new information is often selectively screened to further support one's own perspective. Although the authors attempt to address this deficit, the chapter devoted to empirical evidence is wanting. Many of the studies discussed in this chapter refer to Khantzian and colleagues' own anecdotal experience, and the true empirical studies referenced offer little support for an affect-driven drug choice. Not mentioned is the extensive literature revealing a complex of genetic, behavioral, and environmental factors that increase the risk of substance use in at-risk youths but do not predict a specific drug of use. This aspect of the self-medication hypothesis may therefore guide the reader to search for conflicts and affects that are absent and to ignore potent pathology that does not conform to the proposed paradigm. The book itself includes anecdotes that are not consistent with this aspect of the self-medication hypothesis (i.e., Loretta becomes addicted to prescription opioids as a way to cope with daily stressors, not to suppress anger, pp. 112–113).

Understanding Addiction is an easy and often engaging read and will primarily be useful for patients, families, and perhaps addiction therapists. Multiple case study vignettes are provided to assist readers' comprehension, although these case studies are often too brief to provide an in-depth understanding of the interplay between a patient's intrapsychic dynamics and their drug use. To the authors' credit, they emphasize both the importance of other contributions to addictive disorders, such as genetic, social, and family influences, and the need to utilize a wide range of treatment approaches, including agonist therapies and other medications. In addition, nicotine and marijuana are given substantial attention. Neurobiological considerations are discussed throughout the book, if somewhat haphazardly, although the authors consider the neurobiological and self-medication hypotheses as either/or explanations, as opposed to compatible and overlapping. It would have been a powerful argument, for example, if the authors had offered a biologic foundation for the effects of specific drugs on identified affect states.

In a disease commonly approached with biologic reductionism, cognitive-behavioral simplicity, or 12-step dictums, perhaps the most important contribution of *Understanding Addiction* is to remind us of the distinct experience, personal history, and intense suffering of the addicted patient.

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The author reports no financial relationships with commercial interests.

Book review accepted for publication March 2009 (doi: 10.1176/appi.ajp.2009.09030399).

Before Prozac: The Troubled History of Mood Disorders in Psychiatry, *by Edward Shorter. New York, Oxford University Press, 2008, 320 pp., $29.95.*

According to Edward Shorter, one of the unfounded decisions that created grim consequences for the public health was the premature abandonment of older drugs that held promise as antidepressants and their replacement by less effective antidepressants, particularly the selective serotonin reuptake inhibitors (SSRIs). In a reversal of the usual scenario, the bad guys in this tale are not the drug companies but the Food and Drug Administration (FDA) and, to a lesser extent, the academic psychiatrists who concoct DSM. The drug companies are portrayed as hapless victims of an imperial FDA overstretching its regulatory authority.

Shorter, a prolific medical historian, provides a detailed, lively history of what has been called the "first set" of psychotropic drugs—the antipsychotics, anxiolytics, and antidepressants that showed up in the 1950s. Of course when they first appeared, these drugs weren't known by those terms. Readers of a certain age will remember major tranquilizers and minor tranquilizers, energizers, and thymoleptics. And that's one of the points of this book. We don't know what these drugs are really good for, so we can't decide what to call them. Shorter reminds us that the phenothiazines have pretty good antidepressant activity; he quotes the redoubtable Jonathan Cole: "I have so far never seen a published study...of an antipsychotic versus placebo in depression that wasn't positive. I think most of these drugs work across a spectrum of cases and are not anywhere near as specific as the nomenclature suggests they are." (p. 149).

The development of the first set of psychotropics is set out in rich detail. We hear about the battles between the drug industry, attempting to keep old drugs on the market and bring out new ones, and the FDA and other government agencies, convinced that both old and new drugs were dangerously ad-