



***Working With Families in Medical Settings: A Multidisciplinary Guide for Psychiatrists and Other Health Professionals*, edited by Alison M. Heru. New York, Routledge, 2013, 254 pp., \$54.95 (paper).**

Family therapy is at the top of any list of things psychiatrists know are important and yet avoid. There are many reasons for this. Psychiatry residency requirements mention the need to expose residents to family therapy, but they are vague as to what or how much this exposure should be. Thus, with limited training in family interventions, the average practicing psychiatrist is often reluctant to venture beyond the doctor-patient dyad, citing theoretic stances or confidentiality concerns. This tendency to ignore family members belies common sense, given the degree that most of us depend on our loved ones for both practical and emotional support when we are ill.

This is all the more true for psychosomatic medicine. When consulting in the medical setting, it is not unusual for the psychiatrist to enter a patient's room and find it filled with family members. And what does the consultant do? Ask them to leave, of course. Which may be reasonable for a first contact, but how often does the psychiatrist take the time to subsequently include the family in the interview process for more than a perfunctory history check?

This book aims to address this practice gap—the gap between what we know we should do and what we actually do—head on.

It is organized in three sections. The first summarizes family theory and research as it pertains to the medical setting. Putting together this section must have been a challenge, given the many studies from various fields that bear on the issue of how a family can influence an individual's health. The discussion of protective and risk factors is interesting, but most relevant is the review of evidence-based interventions. It can be hard to generalize, as the studies range from the acute (e.g., recovery from coronary artery bypass surgery) to the chronic (e.g., chronic lower back pain), but it seems that regardless of the illness, family interventions help on many levels. Not only do they help coping, but they also improve medical outcomes. The idea that families should be involved in any illness is reinforced by several meta-analyses that show improved mortality rates for patients with diseases such as cardiac illness, stroke, diabetes, or HIV.

The second section looks at various models for involving families in the health care system. One example of an innovative approach is family-centered care, which can be

seen as an extension of patient-centered care. This approach includes families in activities such as ward rounds and intensive care treatment planning meetings. It has been adopted by a number of medical centers with various degrees of success, and there is thoughtful consideration of the reasons for success or failure. Other chapters consider specialized interventions for specific situations, for example, helping medical teams deal constructively with disruptive families.

The final section focuses on systems theory, particularly the McMaster approach. In these chapters, the authors describe methods for family systems assessment and then present a stepwise approach to interventions, from simple inclusion to psychoeducation and family systems therapy.

The book does a good job considering both the theoretical and the practical, and it is clearly designed to give the reader useful concepts and skills that can be easily adopted. It is well organized, and each chapter generally begins with a list of the points it will cover and ends with a detailed summary (thus following Carnegie's advice to tell us what they are going to say, say it, and then tell us what they said). In between, there are many tables and bulleted lists to highlight the major points. These points are further illustrated with excellent case examples.

This book should be required reading for any psychiatrist pursuing a career in psychosomatic medicine. Beyond that, it should be of interest to any mental health care professional treating patients in the medical setting. Given that the future psychiatrist will likely be expected to be a practitioner of collaborative and integrative care, the audience for this book might just include all of us.

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*The author reports no financial relationships with commercial interests.*

*Book review accepted for publication October 2013 (doi: 10.1176/appi.ajp.2013.13101363).*

***Clinical Guide to Depression and Bipolar Disorder: Findings From the Collaborative Depression Study*, edited by Martin B. Keller, M.D., William H. Coryell, M.D., Jean Endicott, Ph.D., Jack D. Maser, Ph.D., and Pamela J. Schettler, Ph.D. Washington, DC, American Psychiatric Publishing, 2013, 234 pp., \$58.00.**

This book presents a summary of some of the clinical findings of the Collaborative Depression Study, a 31-year longitudinal follow-up of patients with mood disorders treated in various settings. At the time this book went to press, the study had generated 285 research reports. The authors, who have participated in the study, do an excellent job of summarizing the mountain of data that has emerged from it. Each chapter ends with a brief summary of clinical implications of the findings.

An important finding of the Collaborative Depression Study that patients and astute clinicians have always known (but not always paid attention to) is that the standard definitions of response (50% improvement) and remission (depression or mania rating scale scores that are about two-thirds better but not zero), which are the primary outcome measures of the clinical trials on which we all base treatment choices, are not satisfactory outcomes. Most of us would not be satisfied with feeling better but not well, and any residual symptoms greatly increase the risk of major relapse and recurrence. Even mild, subsyndromal symptoms are associated with significant levels of impairment, which is an independent predictor of relapse. Indeed, the observation that “many individuals have residual subsyndromal symptoms and disabling psychosocial impairment when recovered from major episodes of depression for at least 2 months” (p. 169) indicates that the true meaning of “recovery” does not apply to many patients. The investigators point out that residual depressive symptoms deserve as much aggressive attention as the less common residual manic and hypomanic symptoms in bipolar disorder, and they suggest that antidepressants may not worsen the course of all cases of bipolar disorder. However, they are not yet able to reassure us about which bipolar disorder patients can and which cannot tolerate ongoing treatment with antidepressants. Despite the widely acknowledged need to treat mood disorders early and aggressively, to combine pharmacologic and psychological therapies, and to reduce the risk of relapse by continuing whatever treatment is effective acutely, mood disorders remain undertreated.

It will come as no surprise that past suicide attempts, especially those with high intent, increase the risk of suicide in the future, as do anxiety and substance abuse. The Food and Drug Administration and some professional groups should review data indicating that antidepressants not only do not increase the risk of suicide, but they reduce it. It may be less apparent that around one-quarter of patients with a diagnosis of major depressive disorder will go on to develop bipolar disorder. Risk factors for such conversion include psychotic symptoms, family history of bipolar disorder, early onset of depression, and subsyndromal hypomanic symptoms. Results of the Collaborative Depression Study suggest that it may be possible to treat alcoholism at the same time as mood disorders, but each active disorder makes the other more resistant to treatment.

Anyone who has passed the American Board of Psychiatry and Neurology oral examination knows not to diagnose a personality disorder in a patient with an active mood disorder, and the Collaborative Depression Study supports the belief that assessment of personality by the patient and others is state dependent. It may be less well known that the secular trend toward increased incidence of depression in more recent generations can skew estimates of the heritability of depression because parents tend to have a lower prevalence of depression than their children.

The Collaborative Depression Study has been at the forefront of psychiatric diagnosis throughout its course, and its findings include features of unipolar and bipolar disorders that alter course, such as anxiety, psychosis, and substance abuse. However, it relies heavily on the categorical diagnoses that have largely continued from DSM-IV to DSM-5. An enormous amount has been learned, but it is still not possible to determine whether patients with early-onset depression and a history of trauma, for example, have a different course and require different treatment approaches than other patients, or whether depressed patients who experience dissociation have a course similar to those with psychosis. And since most studies are of monotherapy or of combinations of a single medication with a single psychotherapy, we have no empirical guide to the combinations of therapies that are necessary for patients with more complex mood disorders. Yet the *Clinical Guide to Depression and Bipolar Disorder* offers the most current information that is available in a single place—and certainly the most readable source for investigators and clinicians. It is a clear springboard for the next generation of studies of mood disorders.

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*Dr. Dubovsky has received research support from Hoffman-La Roche, Janssen, Lilly, Otsuka, Pfizer, Research for Health in Erie County, Inc., Sumitomo, and the Tower Foundation.*

*Book review accepted for publication October 2013 (doi: 10.1176/appi.ajp.2013.13101308).*

***Comprehensive Care for Complex Patients: The Medical-Psychiatric Coordinating Physician Model***, by Steven A. Frankel, James A. Bourgeois, and Philip Erdberg. Cambridge, United Kingdom, Cambridge University Press, 2012, 201 pp., \$90.00.

In one sense, the title says it all. It introduces the reader to what will be the foremost themes of the book. How can we provide comprehensive care in our modern health care climate? And how should this help us to treat our more complex patients? The answer to both, according to the authors, is in the subtitle: by using the medical-psychiatric coordinating physician model.

But what is meant by “comprehensive care”? In explaining this, the authors consider the way health care was, how it is, and what it could become. Historically, health care was a dyad: the doctor-patient relationship. Although we may yearn for this romantic image, it is clear that the days of the country doctor who meets all of his or her patients’ needs are long gone, and in the modern era, the health care system comprises a large team of various primary care and specialist doctors, as well as an assortment of various other professionals. Although this health care team is, ideally, all very impressive, in reality it is a mess. There is usually little effective communication between different providers, and the various treatments prescribed occur independently of and, at times, at odds with one another. With this in mind, the authors sketch out a plan for the future, one of coordinated care in which the providers can function like a true team.