And what are "complex patients"? Initially, they are defined as patients whose symptoms do not respond to our "normal" medical approaches. This is often because their medical illness is complicated by psychiatric factors. However, the authors soon expand this definition to include the many other types of complexities, including various psychological, social, and systems issues that can affect the straightforward delivery of care. As they broaden their definition, we begin to wonder which patients are *not* complex. One is forced to consider the possibility that the only patients who are "straightforward" are the ones we haven't thought about enough and that "simple" patients represent a figment of our failed imaginations.

Much of the book is devoted to describing the importance of collaborative care, and there is already a good deal written about this subject. So what makes this book different? The answer is in the subtitle: the concept of the medical-psychiatric coordinating physician model (or MPCP; beware, as there are a good deal of unfamiliar acronyms of which the reader will have to keep track). Every team needs a leader. In many of the current collaborative care or medical home models, psychiatrists are relegated to the sidelines. However, the authors suggest that psychiatrists' unique skill set makes them the ideal persons to integrate the many data points our system generates into a coherent narrative. If some of the unconverted ever hear this sermon, this book might stir some controversy. That said, the authors back up their contention with example after example of how psychiatrists are best suited to appreciate each level of complexity that may challenge a treatment team.

Along the way, the reader is introduced to important techniques and concepts meant to guide the budding medical-psychiatric coordinating physician model, including the concept of "tuning," which means using varied bits of objective and subjective information to hone in on the "truth" of what is really going on with a patient, and SOPA (self-other rapid assessment), a method for monitoring oneself and one's treatment, as well as various strategic approaches for dealing with patient (and sometimes practitioner) resistance.

This method of operationalizing one's approach to complex patients is reason enough to read this book. However, the book also serves a greater purpose. Here, the title does the book an injustice, as it gives one the impression that this will be a somewhat dry, technical manual. What a surprise then, to encounter the book's disarmingly engaging prose. The tone is often conversational, even mischievous at times, often written in the first person and addressing the reader directly—the prose feels more like the transcript of an unusually erudite soliloquy from a gifted colleague (although there are three authors, it is largely written with a single voice). This is a book meant to be enjoyed cover to cover.

Perhaps most compelling are the exquisitely rendered case studies employed throughout the book. For those who bemoan the loss of this art, rest assured, the authors here present robust cases, full of nooks and crannies that are unfailingly honest in their depiction of the foibles of both patients and doctors. The cases are put to excellent use, and the authors frequently return to them throughout the book to illustrate increasingly deeper points.

Who should read this book? Most practically, it is aimed at those interested in psychosomatic medicine and collaborative care, as the book focuses on the complexities that lie on the (imaginary yet practical) body-mind interface. However, this book serves a greater purpose as it meditates on the doctor's role in modern medicine. My sense is that medical students, residents, and many of my colleagues all hunger to see themselves as more than useful technicians in the machine that is modern health care. This book helps us refocus on what it means to be a true healer.

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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.2013.13101331).

***Management of Treatment-Resistant Major Psychiatric Disorders**, edited by Charles B. Nemeroff, M.D., Ph.D. New York, Oxford University Press, 2012, 384 pp., $89.99.*

While the notion of treatment-resistant psychiatric disorders may bring to mind narrowly defined subsets of severely ill individuals not normally encountered by the average mental health care provider, the definition employed in this volume is considerably more encompassing, to include patients who experience persistent psychiatric symptoms with impaired functioning despite one or more adequate treatment trials. The book chapters represent thoughtfully distilled tutorials on how to manage everyday clinical challenges across the major psychiatric disorders, including a range of mood and anxiety disorders, schizophrenia, substance abuse, and insomnia, as well as anorexia/bulimia nervosa, personality disorders, and one chapter on childhood mood and anxiety disorders.

It is interesting to compare how treatment resistance is approached across the various disorders. For major depression, formal treatment-resistant staging methods have been articulated both in the United States and internationally. Large-scale clinical trials, such as the Sequenced Treatment Alternatives to Relieve Depression Study, have unequivocally established the high prevalence of treatment resistance for people with major depression, and evidence-based treatment algorithms for treatment-resistant depression are beginning to emerge. Despite the modest added efficacy of each subsequent antidepressant, it is also encouraging to note that the 10-year remission rate approaches 90%. Schizophrenia is another diagnosis that has a formalized definition of treatment resistance, which emerged from the need to determine the appropriateness of patients who could be considered for clozapine therapy. While clozapine was approved over 20 years ago in the United States, the schizophrenia chapter makes it clear that there remains a dearth of proven options beyond clozapine for treatment-resistant schizophrenia. And although not emphasized in the text, it continues to be the case that only a fraction of clozapine-eligible patients ever receive a clozapine trial for reasons that appear to have less to do with the risk of actual side effects but rather with the burdens and hurdles associated with ongoing hematological monitoring.

Most other disorders do not have formally defined treatment-resistant subtypes, but the prevalence of persistent and debilitating symptoms is a ubiquitous problem. For example, in patients with anorexia nervosa, the authors emphasize that almost every patient has very difficult-to-treat symptoms, that full remission is rarely achieved, and that most patients have at least some "treatment resistance." Similarly, in the chapter on personality disorders, Dr. Gabbard emphasizes that personality disorders have always been difficult to treat and that the term "treatment resistant" could also be designated "more difficult than usual." This chapter offers a surprisingly hopeful assessment of the long-term outcome for patients with treatment-resistant personality disorders. For example, a recent 10-year prospective study of patients with borderline personality disorder, funded by the National Institute of Mental Health, found that over 90% of patients achieved remission of symptoms that lasted at least 2 years, although somewhat over 30% of remitted patients subsequently experienced a relapse. Furthermore, at least seven distinct psychotherapeutic approaches for borderline personality disorder have demonstrated efficacy in randomized controlled trials. This therapeutic armamentarium should help practitioners individualize treatment approaches for their patients.

Given that most psychiatric disorders are chronic and relapsing, this book represents an unusually practical text that combines standard treatment protocols with less conventional but eminently usable treatment suggestions for recalcitrant symptoms. All practicing psychiatrists and more advanced trainees can benefit from having this book on their shelf.

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Book review accepted for publication October 2013 (doi: 10.1176/appi.ajp.2013.13101338).

Correction

In the article "A Double-Blind Randomized Controlled Trial of Augmentation and Switch Strategies for Refractory Social Anxiety Disorder" by Mark H. Pollack, M.D., et al. (Am J Psychiatry 2014; 171:44–53), the structured assessment used to make the initial diagnoses was the Mini-International Neuropsychiatric Interview, meaning reference 11 should have been the following:

Sheehan DV, Lecrubier Y, Sheehan KH, Amorim P, Janavs J, Weiller E, Hergueta T, Baker R, Dunbar GC: The Mini-International Neuropsychiatric Interview (MINI): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. J Clin Psychiatry 1998; 59(suppl 20):22–33