Clinical Practice

From Detached Concern to Empathy: Humanizing Medical Practice, *by Jodi Halpern. New York, Oxford University Press, 2001, 115 pp., $37.95.*

George Bernard Shaw once remarked, "Christianity might be a good thing if anyone ever tried it." Empathy in physicians, like true Christianity, world peace, and even managed care, is an idea that everyone applauds in the abstract. Anyone who attends daily rounds, however, soon realizes that empathy is a concept primarily enshrined in commencement speeches, white-coat ceremonies, and elegies for great physicians. In clinical practice, commitment to empathy is honored more in the breach than in the observance.

This apparent hypocrisy requires a rigorous examination of why empathy is essential to good care, why so many who practice this virtue must do so in secret, and why the social and intellectual organization of medicine so often discourages its development and expression. Jodi Halpern, a practicing psychiatrist and a well-trained philosopher, explores the contradictions between the empathic ideal and modern medical practice. Her analysis reflects a unique blend of clinical experience and scholarly rigor, derived from two decades of experience, research, and reflection. The result is a concise volume that links cognitive science, medical ethics, and the philosophy of knowledge into a clear, clinically relevant narrative accessible to any interested physician.

Dr. Halpern begins and ends with the bedside dilemma of the caring physician, who must make difficult judgments on behalf of patients who are already anxious, angry, in pain, or depressed. The prevailing medical wisdom assumes that such judgments are best made from a position of detached concern, what Halpern describes as "detachment with a veneer of tenderness" (p. 25). Patients' emotions do not directly indicate the extent or nature of their underlying disease—the expression of pain, for example, derives from culture, expectation, and past history as much as from degree of tissue damage. Physicians' emotional responses to patients are similarly idiosyncratic. To achieve reliability, objectivity, and reproducibility in medical intervention, the argument goes, the physician must learn to factor out all these unique elements and rely on the evidence of controlled observations of group responses.

From Detached Concern to Empathy gently exposes the fallacy of this argument, demonstrating the critical role that patients' emotions play in the process of many diseases and in physicians' treatment decisions. Patients' emotions affect their motivation to pursue and follow treatment as well as their ability to accommodate to the necessary losses of chronic disease. In a more basic sense, emotions are an organizing principle of cognition, so that patients and physicians both think differently depending on their mood. Rather than compromising good judgment, Dr. Halpern argues, empathic understanding of a patient's experience and the physician's awareness of his or her own emotional state in response to it enhance clinical reasoning and improve patient outcome. Moreover, this type of empathy is not some mysterious process of merging that develops over years of psychotherapy. As her examples show, bedside empathy can be cultivated to good effect in relatively brief encounters with unknown patients.

Dr. Halpern makes her argument with both clinical examples and reference to scholarly works in philosophy and cognitive science. She speaks most directly to general physicians and physicians in training. Psychiatrists, especially those of us who teach future generalists, have much to learn from her reflections, especially her conclusions about how to foster empathic capacities in ourselves, our colleagues, and trainees. Few of us will ever read Heidigger, Wittgenstein, Descartes, or even Lacan—for that you need a Ph.D. in philosophy. Dr. Halpern went to the trouble and expense of getting one, and the result is a concise, closely reasoned, and gracefully expressed analysis and resolution of an important problem in clinical medicine. This book should prove of great value to those who hope to preserve and cultivate the values of clinical care within the frame of scientific rigor and social accountability in which we must all practice.

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Psychiatry as a Neuroscience, *edited by Juan José López-Ibor, Wolfgang Gaebel, Mario Maj, and Norman Sartorius. New York, John Wiley & Sons, 2002, 330 pp., $92.00.*

Psychiatric Diagnosis and Classification, *edited by Mario Maj, Wolfgang Gaebel, Juan José López-Ibor, and Norman Sartorius. New York, John Wiley & Sons, 2002, 294 pp., $92.00.*

Psychiatry in Society, *edited by Norman Sartorius, Wolfgang Gaebel, Juan José López-Ibor, and Mario Maj. New York, John Wiley & Sons, 2002, 291 pp., $92.00.*

All practicing physicians ought to be compelled, as a condition to renewal of annual relicensure, to review books like these three in their respective areas of practice and have that review published worldwide. Not only would that exercise keep them informed; it would keep them grounded and inspired.

Ralph Waldo Emerson once said that the act of reading a book involves a two-way street of serious responsibility: one that belongs to the author and the other to the reader, who needs to be smart enough and diligent enough to understand or attempt to understand the author's message and its context. In the six decades that I have been an interactive human voyager, I have been amazed at how the *res* does not necessarily *ipsa loquitor*, that "shared" beliefs and traditions are not necessarily shared.

It is appropriate that a forum such as the 11th World Congress of Psychiatry (Hamburg, Germany, Aug. 6–11, 1999) was the basis for these books. One of the founding fathers of the World Congress was José López-Ibor of Madrid, and Dr. López-Ibor, Jr., one of the editors of these books, just ended his term as President in Yokohama, Japan. Dr. López-Ibor, Sr.,

died in 1991, and Pedro Ruiz, M.D., wrote about him in the *American Journal of Psychiatry* (1).

Psychiatry as a Neuroscience, the first of the three books, must be read first because it provides insight into the very reason for being a physician-psychiatrist. The editors brought together 17 authors—eight from the United States, one from Italy, one from Switzerland, one from France, and the rest from the United Kingdom. The nine chapters cover such topics as genetic research in psychiatry, molecular and cellular biology research, brain imaging research, neurophysiological research, neuropsychological research, neurobiology in schizophrenia, biological research in anxiety disorders, and biological research in dementias. These chapters are not for speed-reading, but the rewards are great. I have personally used them as teaching tools.

Peter McGuffin's simplified tour of the mysteries of human genetics is both brilliant and evocative. On page 13, he skillfully maps the scary progress of gene mapping from the 1970s, when "classical" markers (6% coverage of genome) were discovered, to 2001, when 1.42 million single nucleotide polymorphism consortiums were set up. McGuffin reminds us of what Sheldon Kopp warned us of in his 1970 book (2): "Do not mistake new knowledge with advancement or progress because, for all we know, what all this could really mean is regress or deterioration."

Sedvall and Pauli's contribution on brain imaging research in psychiatry is must reading for every general practitioner and psychiatrist, not only to know how to order what test but why. I was riveted by their historical accounts of the origins of magnetic resonance imagers and X-ray machines. Their photographs make the arcane very accessible. The rest of the volume, for sheer thoroughness and scholarship, is rewarding.

The second volume, *Psychiatric Diagnosis and Classification,* is cumbersome and challenging. It includes 23 authors in 10 chapters. Eight authors are from the United States, five from Australia, three from India, one from the United Kingdom, three from Denmark, three from Luxembourg, and none from the Philippines, Russia, China, or elsewhere.

When I entered private practice in 1973, had you told me I would be treating a patient from Toronto, then one from New York, then another from Hong Kong, then another from the Philippines in the same day or in the same hour, I would say you were probably delusional. If you had asked me to tell you the differential diagnoses of *ma huang* psychosis from gamma-hydroxybutyrate withdrawal psychosis, I would think you were on some space odyssey. But not anymore! This is the reality of today's practice; we see patients with different cultural, religious, herbal, medicinal, hygienic, and food practices that affect our physical, spiritual, and emotional paradigms. It is almost impossible for a Western-bred psychiatrist or psychotherapist to understand the true violence of the traditional Japanese concept of "losing face"—to understand why a young Japanese patient would commit suicide for "losing face."

I had major problems with this volume. First was the language; second was the diversity of cultures and traditions represented. In their chapter, "Psychiatric Diagnosis and Classification in Developing Countries," R. Srinivasa Murthy and Narendra N. Wig of India say,

> Many Chinese psychiatrists believe the CCMD-2-R [Chinese Classification of Mental Disorders] has special advantages such as simplicity, stability, the inclusion of culture-distinctive and serviceable forensic categories, and the exclusion of otiose Western diagnostic categories. Linguistically, it is easier to use than the Chinese version of the ICD-10, which contains excessively long sentences, awkward terms, and syntactical problems.

Chapter 4 of this volume, however, is a gem. C. Robert Cloninger shows us how consensus can be gained regarding what on the surface appears like an insuperable quandary.

As to the third volume, *Psychiatry in Society*, it was the most painful for me to read. I am a Filipino. I was born in World War II and lived through the horror of it. I was trained to fight the Hukbalahaps and the Muslims. I treat three survivors of September 11, numerous homeless patients, and patients with posttraumatic stress disorder from Korea, Vietnam, the Gulf War, Afghanistan, and now Iraq. There are three Filipino psychiatrists for every 10 million population in the Philippines, yet Filipino psychiatrists who attempt to return to the Philippines come back to the United States in defeat. The moral and psychological quandary we face is dealt with head-on by this volume, without fear or second-guessing.

Leon Eisenberg sets the tone with chapter 1, "The Impact of Sociocultural and Economic Changes on Psychiatry." To stir our conscience and make us aware of the importance of never ignoring the imperative of social remedies to a lot of medical maladies, he quotes Bertolt Brecht's *Life of Galileo:*

> One of the chief causes of poverty in science is imaginary wealth. The purpose of science is not to open the door to an infinitude of wisdom, but to set some limits on the infinitude of error.

In the second chapter, German psychiatrist Heinz Häfner doesn't even allow us to catch our breath; he immediately asks us how fair we are to the mentally ill who are poor. Häfner deftly takes us on an intellectual and emotional historical tour of the evolution of thought in governmental attitudes toward health care of social classes throughout time.

Glyn Lewis and Ricardo Araya from the United Kingdom then take up the topic of globalization and mental health, and the succeeding chapter by José M. Bertolote et al. discusses "The Impact of Legislation on Mental Health Policy."

This volume is a fitting wrap-up of what surely is a proud valedictory for a robust, enviable group of renaissance psychiatric role models. No legislative policy maker, no physician, no mental health worker can afford not to study this volume assiduously. As the anthropologist Margaret Mead said in a lecture at the University of Iowa, "Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has."

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Handbook of Child and Adolescent Systems of Care: The New Community Psychiatry, *edited by Andres J. Pumariega and Nancy C. Winters. San Francisco, Jossey-Bass, 2003, 547 pp., $80.00.*

This book is the product of the Work Group on Community-Based Systems of Care of the American Academy of Child and Adolescent Psychiatry (AACAP). The group has made enormous contributions to the care of children, adolescents, and families; critical issues that govern care; and the professional and national agenda on service delivery. Since its inception in 1994, the group has published pivotal works on managed care; treatment outcomes; training in child and adolescent psychiatry; care of infants, toddlers, and preschool-age children; measurement of child and adolescent needs for services; juvenile justice and mental health; issues of confidentiality; and more. The vision of AACAP in forming this group, the seriousness with which the group has taken its charge, and its products to guide policy, training, and clinical care are truly remarkable.

This handbook is the most recent product of the work group. The focus on systems of care refers to ways in which children and adolescents with social, emotional, and behavioral problems can be served. The systems involve a broad range of community-based services; involvement of the family; flexible and individualized care; interagency and service communication, coordination, and planning; cultural competence and sensitivity of the providers; accountability (e.g., program evaluation and outcome); and prevention and early identification.

The book includes 21 chapters organized into four sections: Conceptual Foundations of Systems of Care, Integrating Clinical Modalities Into Systems of Care, Working Across Populations and Settings, and Administration and Evaluation of Systems of Care. The first section includes contributions on the history of community care, a conceptual framework for providing care for children and families, family advocacy, collaborations needed across disciplines and agencies, and cultural competence required to provide care. The second section discusses pharmacotherapy, evidence-based community interventions, and case management. The third section covers different systems of care (e.g., juvenile justice and school-based services), special populations (e.g., youth with comorbid disorders, foster children in child welfare), and the collaboration required of community systems with primary care. The final section discusses systems of care in relation to federal, state, and local government, managed care, legal mandates, outcome evaluation to improve quality, and training of child psychiatrists and other mental health professionals for systems of care.

This book provides a model as well as a mandate for organizing the delivery of services and for evaluating their outcomes to ensure they are achieving the intended effects. The implications are broad in the integration of training, service delivery, policy, and legislation but also concrete in the description of the ways services can be organized, delivered, and evaluated. We have needed guidance on providing clinically sensitive, cost-effective, evidence-based, and comprehensive services. This book charts the course very well. It is also pivotal for training because it conveys the many roles, opportunities, and needs of child psychiatry and related disciplines and the range of possibilities for having an impact on different facets of service delivery.

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PSYCHOTIC DISORDERS

Bipolar Disorder Demystified: Mastering the Tightrope of Manic Depression, *by Lana R. Castle. New York, Marlowe & Co., 2003, 426 pp., $15.95 (paper).*

In keeping with the book's subtitle, the foreword by Peter C. Whybrow, M.D., refers to mania and depression as "disorders of the brain's emotional gyroscope—that balancing bar that enables us to navigate the high-wire of the circus that is human society." Pretty heady prose, but consistent with Lana Castle's style of self-disclosure about her bipolar disorder, premenstrual syndrome, lupus, hypothyroidism, and substance abuse, as well as stressors including divorce, thefts, break-ins, two rapes (described rather graphically), and her sister's suicide.

Castle provides a firsthand experience with the pleasures and perils of bipolar disorder and the struggles to bring it under control. She then expands to a comprehensive and generally understandable exposition on diagnosis, differential diagnosis, etiology, and treatment. Mental illness myths are confronted and dispelled, bad-parenting myths destroyed, and great efforts made to destigmatize the illness. Cogent advice is provided about getting help and providing help.

The treatment sections range from medical treatments (medications, ECT, transcranial magnetic stimulation, and vagus nerve stimulation) to psychotherapies, alternative and complementary approaches, and lifestyle adjustments such as exercise and nutrition. From my perspective, delving into spirituality and transcendence, creative/expressive therapies, self-actualization, and the like goes a bit afield from bipolar disorder itself, but lay readers may feel otherwise.

On the downside, the book contains enough inconsistencies and inaccuracies to make me reluctant to provide a strong endorsement unless these are corrected in a second edition. For example, it is debatable whether bipolar II is a "milder form" of bipolar disorder given the potential severity of major depressive episodes. Here are a few more incorrect statements: Hypomania "may or may not include delusions or hallucinations" (p. 75). "When the adrenal glands don't stimulate the pituitary gland to produce enough cortisol..." (p. 91). "Extending from the axon are multiple dendrites..." (p. 109). Monoamine oxidase destroys "neurotransmitters remaining in the synaptic cleft" (p. 112). "Blood vessel dilation, causing paleness of the skin" (p. 114). Psychopharmacologists "hold doctoral degrees, usually in psychology or pharmacology" (p. 188).

The medications appendix should be cleansed of errors such as propranolol listed as a monoamine oxidase inhibitor, a Wellbutrin daily dose of 200–600 mg, reboxetine as a selective serotonin and norepinephrine reuptake inhibitor, carbamazepine blood levels of 10–13 mg/ml, valproic acid levels

of 44.6–126 g/ml, NaSSAs defined as "noradrenergic and specific serotonergic receptors," and "not applicable" and "varies widely" statements about half-life.

These comments may seem needlessly picky, but they are in keeping with the intent of the author and publisher to "ensure that the information presented is accurate and up-to-date." All in all, I found it to be a rather decent book, but one in need of polish.

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Hearing Voices: Embodiment and Experience, *by Lisa Blackman. London, Free Association Books, 2001, 266 pp., $55.00; $25.00 (paper).*

Approximately 60%–70% of patients with schizophrenia experience auditory hallucinations of spoken speech. These experiences respond poorly to pharmacotherapy in perhaps 25% of cases and produce high rates of distress and disruptions of behavior and judgment. This book turns this conventional view on its head by challenging the wisdom of viewing hearing voices as an indication of illness rooted in the biology of the brain. The book, which is written by a cultural historian with a long-standing interest in the delineation of subjective states, begins by noting the difficulties in objectively attempting to define characteristic features of auditory hallucinations that reliably identify the experience as pathological. These difficulties arise because auditory hallucinations can also arise from drugs, alcohol, and transitional states between sleep and waking. Moreover, some people who do not have an obvious mental illness still "hear voices" with an entirely clear sensorium. States of religious or creative inspiration seem to induce these experiences, for instance. Joan of Arc described hearing voices of saints telling her to free her country from the English. The German poet Rainer Rilke heard the voice of a "terrible angel" amid the sound of a crashing sea after living alone in a castle for 2 months. This experience prompted his writing the famous *Duino Elegies*. Where and how should the clinician draw the line between these experiences and the voices of schizophrenia?

The author notes that sensory qualities of the experience—loudness, vividness, whether voices are external or internal, degree of self-control—do not always provide good indicators. Instead, psychiatrists tend to rely on the disruptive effect of these experiences on the individual's functioning in the world when ascribing pathology. The author takes great offense at this assessment criterion because it entails judgments based on social convention of what is "normal functioning," a slippery business according to the likes of Foucault, whom the author relies on heavily. Instead, her view is that people hearing voices should not be labeled as ill at all but taught to embrace voices as an essential and not terribly negative aspect of their unique personal experience. Although she endorses the cognitive behavior therapy focus on helping patients take control of their voices, Blackman objects to cognitive behavior therapy because it often uses distraction and refocusing, which cause patients to further disenfranchise themselves from their voices.

The author's alternative view arises from her work with the Hearing Voices Network, "an international group of voice-hearers who are challenging the notion that voices must be lived and experienced purely as signs of disease and illness" (p. 5). This self-help organization brings "voice-hearers" together to share experiences, provide support, and encourage alternative methods of coping outside the realm of psychiatric practice. According to the author, many people participating in this organization come to view voices as a kind of a gift rather than an affliction. First-person anecdotes are offered as evidence for the usefulness of this alternative approach.

I am a great advocate for anything that truly helps people who suffer from hearing voices. Having studied these experiences extensively, I agree with the author that there is much to be learned by talking with patients at length about their voices. I am consistently surprised to learn that in spite of years of treatment, patients have never actually been asked to describe them—what they sound like, the actual verbal content, when and where these experiences occur, what makes then better or worse, etc. And I remain very impressed by how much there is to be learned about these experiences—how they are different from ordinary verbal thoughts and how each person has learned to accommodate and adjust to them. On the basis of these discussions, I have come to hypothesize that voices are made worse by two specific factors. First is extreme social isolation—the failure to engage in meaningful verbal discourse with people in the real world. Voices often are turned on by the absence of these experiences in the ordinary world, perhaps analogous to a phantom limb phenomenon. Second, high levels of emotionality, especially negative emotions, appear to worsen voices. It is therefore not surprising to me that the Voice Hearers Network could provide benefit to some people—a social network is restored that provides meaningful discourse, and negative emotions provoked by voices are reduced or eliminated. Yet I have no hesitation in ascribing illness to the individuals who approach me to enroll in our treatment trials (1, 2). Often they have been ravaged for years by extremely disruptive and repetitive hallucinations to the point of extreme despair and suicidality. One patient described hearing voices as being in a constant state of mental rape. This patient, if given a choice between viewing voices as a gift or just getting rid of them, would, I suspect, embrace the second alternative in a heartbeat.

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PSYCHONEUROENDOCRINOLOGY

Psychoneuroendocrinology: The Scientific Basis of Clinical Practice, *edited by Owen M. Wolkowitz, M.D., and Anthony J. Rothschild, M.D. Arlington, Va., American Psychiatric Publishing, 2003, 588 pp., $69.00 (paper).*

After more than 50 years, the field of psychoneuroendocrinology remains vibrant, as indicated by a steady stream of new research findings and textbooks summarizing its advances. The editors of this volume, in their introduction, set it apart from other treatises by indicating its goal is "to show how the principles and emerging findings of psychoneuroendocrinology can inform modern clinical practice and lead to new breakthroughs in future practice." The contributors were asked "to provide, where appropriate, clinical guidelines for the management of patients." I reviewed this text with this clinical orientation in mind.

The editors have assembled authors of prominence who have contributed extensively to the psychoneuroendocrine research literature. There is reasonably inclusive coverage of topics, organized along standard endocrine-axis lines. The sections are Introduction, Peptide Hormones, Adrenocortical Hormones, Gonadal Hormones, Thyroid Hormones, Laboratory Testing, and Stress. Within each section there are one to four chapters. Many of the chapters emphasize clinical relevance; these mainly cover the psychiatric manifestations of primary endocrine disturbances (adrenal, thyroid, gonadal) and exogenous hormone administration. Endocrine treatments of psychiatric diseases, other than optimizing hormonal status in psychiatric patients with concomitant endocrinopathy, are generally more tenuous and thus get less coverage. I will highlight just a few chapters.

Following the editors' introduction, Lindley and Schatzberg review the history of psychoneuroendocrinology from ancient times to the present. This is a daunting task, and although the authors touch on many interesting historical points, from ancient concepts through organotherapy to modern endocrinology, there are some important omissions. For example, although Geoffrey Harris is given rightful recognition for first providing evidence of hypothalamic factors that influence pituitary function, there is no mention of the two Nobel Laureates, Roger Guillemin and Andrew Schally, who initially isolated hypothalamic peptide hormones. Later parts of the chapter are imbalanced as well. For example, in a narrow section on hypothalamic-pituitary-adrenal (HPA) cortical activity in depression, the chapter authors and/or volume editors are cited 12 times. This historical review thus begins in an informative and balanced way but ends with a skew toward the authors' own work.

Sack et al., in a relatively short but informative chapter updated from one published 7 years earlier, discuss the concept of chronobiology and melatonin as a "hormonal darkness signal" in humans. Administered before its endogenous nocturnal increase, melatonin advances the circadian clock; administered before its decline at the end of the nocturnal period, it retards the circadian clock. The use of melatonin in night-shift workers and to combat jet lag is discussed, as are its pharmacokinetics, safety profile, and the development of melatonin analogs. This chapter is nicely oriented toward clinical relevance.

Rothschild, one of the volume's editors, discusses the HPA axis in relation to psychiatric illness. Curiously, the bulk of his chapter covers only the dexamethasone suppression test. This test is not in widespread use currently, although a number of investigators, including me, believe it has been shelved prematurely. The only other topic in Rothschild's chapter is a short discussion of the treatment of depression with antiglucocorticoid drugs, e.g., cortisol synthesis inhibitors. These drugs have not been incorporated into clinical practice because they are only modestly effective, and generally only in the 30%–50% of depressed patients who have elevated HPA activity. Rothschild mentions the progesterone (and, at high concentrations, glucocorticoid) receptor antagonist mifepristone for treating psychotic depression. Mifepristone currently is approved for terminating early pregnancy. Notwithstanding the lack of confirmatory double-blind studies of its antidepressant efficacy, its limitation in treating depressed women of childbearing age is obvious, but this limitation is not discussed. Also troublesome is Rothschild's undisclosed financial interest in Corcept Therapeutics, which is attempting to establish mifepristone as an antidepressant. As one of the editors of this volume, Rothschild had the opportunity to set a standard for disclosing financial conflicts of interest in book chapters, but he did not do so.

The chapters on gonadal hormones are particularly well integrated, covering menstrual-cycle-related and perimenopausal affective disorders (Rubinow and Schmidt), postpartum psychiatric disorders (Weinstock and Cohen), psychotropic effects of gonadal steroids in women (Halbreich et al.), and psychiatric effects of anabolic-androgenic steroids in men and women (Pope and Katz). With regard to this last chapter, it would have been of interest to include a discussion of the commonality of symptoms between, and distinguishing characteristics of, syndromal depression and "andropause" (or, more accurately, androgen decline in aging men), because fatigue, depressed mood, and low sex drive are being hailed in lay advertisements as symptoms of low testosterone that may require hormonal therapy.

In sum, this book has the usual advantages and disadvantages of a multiauthored volume. It fulfills to various degrees the editors' goal of clinical relevance, a number of chapters being informative in this regard, but a few unduly reflecting their authors' own interests. Although the book is a good overview of many standard aspects of psychoneuroendocrinology, it does not uniformly inform the practitioner, especially the psychiatrist. This also partially reflects the current state of the art, psychoneuroendocrinology being primarily a multidisciplinary research field. Although much of the information in this book has been presented elsewhere, it is gathered together in a manner convenient for the reader.

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PSYCHOTHERAPY

Boundaries and Boundary Violations in Psychoanalysis, *by Glen O. Gabbard, M.D., and Eva P. Lester, M.D. Arlington, Va., American Psychiatric Publishing, 2003, 222 pp., $29.95 (paper).*

Originally published in 1995 as a guide to the perplexed psychoanalyst, this book has now been reissued in accessible paperback format by American Psychiatric Publishing in recognition of its relevance to general psychiatrists and, indeed, to all mental health professionals. The issue of boundaries and boundary violations transcends disciplinary lines; all professionals who assume a therapeutic or fiduciary position are inevitably confronted by the ethical, legal, and technical questions that govern their relations with those whom they serve. It is these questions that Drs. Gabbard and Lester address in this thoughtful, scholarly, and humane volume, which should be required reading for all who seek to care for persons in distress.

The authors begin with a general discussion of the concept of boundaries as developed in the psychoanalytic literature over the years since first adumbrated by Freud himself. They consider both internal (or intrapsychic) boundaries and external (interpersonal) ones; it is, of course, the latter that will be of greater importance to the practitioner. They devote a chapter to the exposition of what they call the "psychoanalytic frame"—that is, the formal structures and conditions under which the therapeutic relationship is (or should be) conducted and that would be pertinent to any psychotherapeutic situation.

The bulk of the book is given over to extended consideration of specific types of boundary violations, both sexual and nonsexual, each instructively illustrated by clinical vignettes taken from actual psychoanalytic experience. The authors delineate four types of therapists who may be prone to such violations: the psychotic; the predatory, psychopathic, or perverse; the "lovesick"; and the masochistic. It is in the interaction with particular kinds of patients, especially those who have suffered experiences of sexual traumatization or severe deprivation in their earlier lives, that such violations are most likely; therapists who are themselves suffering from personal losses or other disruptions in their lives are particularly susceptible.

Above all, the authors emphasize the ubiquity of countertransference phenomena in all therapeutic encounters and the fact that all of us are potentially at risk. The need for careful and constant self-scrutiny and for timely and appropriate consultation with colleagues is underscored. They emphasize that the use of supportive techniques neither requires nor justifies the erosion of professional boundaries. Further, they make a strong case for the maintenance of such boundaries in the posttermination period; in their words, " posttermination sexual relationships should be regarded as unethical and clinically ill-advised in virtually every situation" (p. 149).

Finally, the book offers a well-considered discussion of the difficulties encountered in attempts to deal with such situations when they are brought to external attention. They propose a set of guidelines for their management that, though specifically tailored for the psychoanalytic community, can readily be extended and applied by other professional groups. The aim, in all cases, is to adjudicate the matter as humanely as possible so as to protect the interests of the patient while seeking appropriate therapeutic or disciplinary management of the offending therapist.

Ultimately, the authors remind us that we are not dealing here with "good guys" versus "bad guys"; violations of boundaries are not respecters of gender, sexual orientation, or even quality of training. They recommend the institution of courses in professional ethics in training programs and decry the alarming decline in the quantity and quality of teaching and supervision of psychotherapy in psychiatric residency programs. This book should be carefully studied by every psychiatrist, psychiatric educator, and psychotherapist, both for the protection of their patients and students and for their own self-interest.

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Schema Therapy: A Practitioner's Guide, *by Jeffrey E. Young, Janet S. Klosko, and Marjorie E. Weishaar. New York, Guilford Publications, 2003, 407 pp., $45.00.*

In this highly engaging volume, Young and colleagues offer a robust clinical model and a compelling treatment protocol for the whole spectrum of personality disorders. Young's work has its roots in Aaron T. Beck's model of cognitive behavior therapy. Yet *Schema Therapy* is an integrative approach, one that contains intriguing possibilities for integrating cognitive behavioral, psychoanalytic, and experiential approaches to treatment. Striving to develop "the bible" of schema therapy (p. vii), Young and colleagues have written a rich and important addition to the psychotherapy literature. But it is an addition that is not without its controversial elements.

At its heart, the book takes a developmental perspective on the formation and treatment of personality disorders. The lack of a developmental theory in cognitive behavior therapy has long been problematic when cognitive behavior therapy has left the confines of theory and treatment of axis I disorders. Young and his colleagues argue that the core beliefs, affects, and problematic interpersonal and coping patterns that characterize personality disorders frequently have at their center developmental difficulties.

Young draws heavily on psychoanalytic developmental models in *Schema Therapy*. In particular, he develops a theory of "modes" as central to understanding the development and maintenance of maladaptive personality patterns. This theory, and its clinical applications, will look familiar to those with a psychoanalytic background, particularly those acquainted with Paul Federn's theory of ego states and with Federn's student Eric Berne, who developed transactional analysis during the 1950s and 1960s. If this derivation is intriguing, there is at least one potentially disturbing implication in basing an ostensibly empirically supported treatment on earlier, psychoanalytically derived models. Young and colleagues make frequent reference to "offending parents" in the etiology of personality disorders, particularly for borderline personality. Although Young speaks of temperament as creating a vulnerability to developing borderline personality, he and his coauthors come close to making parental neglect and abuse an a priori cause of borderline pathology. One is reminded of

Fromm-Reichmann's unfortunate term "the schizophrenogenic mother." Those steeped in an empirical tradition, and Young is among them, must be vigilant to avoid the excesses of earlier, punitive, and erroneous causal attributions.

In terms of treatment, the shortcomings of brief cognitive behavior therapy with personality disorders are addressed through an eclectic blend of standard cognitive therapy, psychoanalytic, experiential, guided imagery, and Gestalt techniques. In addition, the therapy relationship is deemed paramount in creating a climate of safety, in which enduring change becomes possible. Young and colleagues generally maintain the collaborative and respectful stance toward patients that characterizes standard cognitive therapy, as developed by Aaron T. Beck. Young argues that "limited reparenting" may be advised in some cases, a contention that may spark debate within the field. But the volume deals with this issue in a manner that is respectful of patient autonomy and dignity.

This is a must-read book for all those interested in personality disorders and in psychotherapy integration. Its strengths are legion, and its controversial contentions should spur much-needed debate and even more-needed research.

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Handbook of Art Therapy, *edited by Cathy A. Malchiodi. New York, Guilford Publications, 2003, 461 pp., $48.00.*

This book is exactly what the title purports it to be, a handbook of art therapy. The editor is obviously the driving force behind the production of this book. I found it to be very interesting, attractively printed, and with some nice illustrations. It tells you everything you have ever wanted to know about art therapy. I discovered there is an American Art Therapy Association, of which Malchiodi is a member of the Board of Directors, and a journal of this association called *Art Therapy,* of which she is a past editor. The second appendix to the book describes the American Art Therapy Association. It includes the ethical standards involved in art therapy and gives an idea of the complete requirements for being a registered art therapist. A board-certified art therapist has completed the requirements for registered art therapist and has also passed a certification examination administered by the Art Therapy Credentials Board. The parallel to psychoanalytic training in the formal psychoanalytic institutes is striking. Clearly, an effort has been made to educate and certify those individuals who wish to carry out art therapy.

In a subjective statement that reminds me of some of the early reports in psychoanalysis, Malchiodi says, "The countless individuals I have been privileged to work with over the last 20 years have repeatedly demonstrated to me how art expression is effective as both a form of therapy and a method of nonverbal communication" (p. ix). She goes on to explain that since there is increasing pressure to complete psychiatric therapy in a limited number of sessions, "Many therapists find art expression helps people to quickly communicate relevant issues and problems, thus expediting assessment and intervention. For this reason alone, helping professionals are increasingly using drawings and other expressive art tasks in therapeutic intervention" (p. xii).

Malchiodi offers this handbook to provide a clear overview of the field of art therapy and how it is practiced, and the volume certainly meets that goal. Malchiodi admits it is still difficult to define art therapy. Certainly some "therapists" see it as a way to help verbalizing thoughts and feelings, etc., and as such it forms an adjunct to psychotherapy. "Others see art itself as the therapy; that is, the creative process involved in art making, whether it be drawing, painting, sculpting or some other art form, is what is life enhancing and ultimately therapeutic" (p. 2). This latter definition differentiates art therapy from standard psychometric art practices such as the Draw-a-Person Test.

What is art therapy all about? As one peruses this book, one begins to understand Malchiodi's comment, "Although most contemporary practitioners do not take a strictly psychoanalytic, analytic, or object relations approach to art therapy, elements of these philosophies are present in many contemporary art therapy approaches to treatment" (p. 56). This sentence is actually the underlying premise of the book. That is to say, the enormous variety of psychotherapeutic approaches are thought of as "philosophies," and there always seems to be an art therapist to be found who will practice in accordance with any of these philosophies. So, for example, we have chapters on psychoanalytic, analytic, and object relations approaches; humanistic approaches; cognitive behavior approaches; solution-focused and narrative approaches; developmental art therapy; expressive arts therapy and multimodal approaches; and so on. No real distinction is made among these "philosophies" as to which might be best—it appears to be a matter of taste and choice.

Art therapists seem to practice in two ways as far as their actual therapeutic endeavors are concerned. I got the impression that Malchiodi has a private practice and has patients directly referred to her for art therapy. On the other hand, many art therapists are attached to psychiatric units in hospitals and work in an ancillary fashion as members of a therapeutic team of helping professionals. The basic procedure for some seems to be to have the patient create various artworks in various modalities and then for the art therapist, hopefully with the help of the patient, to try to figure out what they mean.

From the vignettes in this book one gets the impression that a good deal of wild interpretation goes on. There is nothing in the requirements to be an art therapist involving a personal therapy or psychoanalysis for the art therapist before trying to interpret the artwork of others. Of course, those art therapists who use the art modalities simply to encourage the expression of feelings without attempting to interpret the meanings of the material do not need this kind of training.

Many clinical application examples are given in the handbook. Art therapists work with children, adolescents, adults, groups, families, and couples. The book is excellent here because it gives short chapters describing each of these clinical situations and how the art therapist might function.

I have already discussed the second appendix on the Art Therapy Association; the first appendix describes "art-based assessments" such as diagnostic drawings. This aspect of art therapy is much closer to psychometrics and of course offers more standard diagnostic aids. Each chapter in the book has a nice "conclusions" section that briefly summarizes what has been said in the chapter. I learned a great deal in this nicely organized book about the amazing things that people do in

the name of therapy and the variety of approaches and philosophies that have ancillary art therapy attached to them or are used as a form of primary treatment by art therapists. For anyone interested in art therapy this will be the definitive volume.

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

Corrections

There was an error in the abstract of an article by Shelly F. Greenfield, M.D., M.P.H., et al., published in the September issue of the *Journal* titled "Who Comes to Voluntary, Community-Based Alcohol Screening?" (Am J Psychiatry 2003; 160:1677–1683). In the Results section, the number of college sites in the fourth line from the bottom of the paragraph should actually be 367.

There was an error in a Letter to the Editor published in the September issue titled "Prognosis of Anorexia Nervosa" (Am J Psychiatry 2003; 160:1708). The author's name should be spelled Walter Vandereycken, M.D., Ph.D.

The study featured in the article "Effects of Typical, Atypical, and No Antipsychotic Drugs on Visual Contrast Detection in Schizophrenia," by Yue Chen, Ph.D., et al. (October 2003; 160:1795–1801) received additional federal grant support from NIMH (MH-49487).