Psychological and Physical Trauma

Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870–1930, *edited by Mark S. Micale and Paul Lerner. New York, Cambridge University Press, 2001, 352 pp., $60.00.*

This book is a compilation of scholarly writings by a group of historians specializing in a newly emerging field of historiography—the study of trauma and, more specifically, the study of psychological trauma, viewed from the point of the professional historian. None of the 10 authors is a clinician or has worked in the field of behavioral sciences, i.e., none is a physician, psychologist, or social worker.

The book consists of four parts presenting a temporal as well as conceptual sequence to reflect the development of European and American thought about the nature and consequences of mental trauma. The authors focus almost exclusively on the role of medicine in understanding and managing trauma, but they place medical thinking in the context of scientific and sociocultural developments.

The book starts with the psychiatric consequences of railroad accidents in Great Britain and the United States, goes on to industrial (work) accidents and the development of disability legislation, then presents two chapters on classic papers on "traumatic neurosis" as conceived by Charcot and by Oppenheimer, and concludes with the role of psychiatry in World War I and its extension (mainly in the United States) in the postwar years.

The first question confronting a physician-reviewer of this book is, inevitably, What is there in a collection of historical studies for the physician and, by extension, any allied health professional? The answer is, More than we would expect. The fact that the authors are historians is an asset to the serious reader. The historical studies provide a detailed, chronological narrative about topics of clinical, forensic, and research interest: how do we view psychiatric symptoms following civilian and military trauma, what is the role of somatic and constitutional/genetic factors, how have physicians viewed hysterical or somatization symptoms versus simulation, what has the role of the physician been as disability examiner and as dual agent?

Although the book is a multiauthor compendium, the reader gets the history of psychological trauma in a coherent fashion. Depending on the reader's needs, he or she can use the data to advantage in his or her field of clinical practice or research with the facilitating context of historical background. The authors have largely stuck to their function as historians; therefore, clinically trained readers are free to lend their own clinical interpretations to the data. Comparing my own studies of psychiatry in World War I (1) with the composite picture created by several different authors in this book, I found historical affirmation of my thesis that Allied psychiatrists approached the traumatic syndromes in the military differently than their colleagues of the Central Powers. The democratic political base of the Western Allies encouraged a more sensitive, scientifically more open, and more humane approach than the more primitive, repressive measures practiced by German and Austrian psychiatrists, reflecting their countries' relatively more autocratic regimes and their own different roles as government agents. The paper by Bruna Bianchi on Italian psychiatry in World War I is particularly interesting in this regard. Italy was the exception among the Western Allies in that its autocratic form of government (where the psychiatrists were direct agents of the government, as they were in Germany) used methods more similar to those of their enemies (the Germans and the Austrians) rather than their Western Allies. The very convoluted paper on French military psychiatry, which contains very controversial views about the complexities and variations of French neuropsychiatry, nevertheless, because of historical documentation, confirms the persistence in France of democratic civil safeguards in spite of the pressures of military necessity.

Some of the chapters are difficult to read and digest, but all offer valuable information, and the book, overall, is a treasury for the interested and psychiatrically erudite reader. I found the best at the very end: the paper by Caroline Cox on American "shell-shocked" veterans and the impact of Dr. Thomas Salmon and the American Legion on our society ever since 1919 is refreshingly readable and should be of exceptional interest to any mental health professional. As Hausman and Rioch and I have previously proposed (2, 3), American military psychiatry learned from French military psychiatry during World War I and laid the foundations for modern community psychiatry. Cox's chapter continues the history of important postwar developments: the American Legion succeeded in humanizing society's attitude toward the mentally ill by bringing about Congressional action to provide psychiatric services and financial support for "shell-shocked" veterans.

In the wake of the World Trade Center terrorist attack, the proper understanding of psychic trauma is more important than ever before. This book, written and published before September 2001, puts psychic trauma into historical, "developmental" perspective. The diligent reader will profit from comparisons of past phenomena in their context with what we see today. History shows the constancy of posttraumatic psychiatric disorder across changing cultures and developmental levels in Western European and American populations. As shown by the historical studies gathered in this book, a great deal is known about reactions to trauma, but the astute clinical observations and the resulting theories by our illustrious medical predecessors were not adequately organized in a generally accepted body of knowledge.

The book, as a whole, shows the growing pains of a field of research and practice in psychiatry. The authors, being historians, correctly leave it to educated clinicians to take the valuable discoveries of the past and incorporate them into contemporary thinking. For that purpose, this book is a good source of historical information to be used judiciously and critically by the mental health professions.

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A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century, *by Ben Shephard. Cambridge, Mass., Harvard University Press, 2001, 487 pp., $27.95.*

Mr. Shepherd takes us from 1914 to 1999, marching through the terrors of war of the past century, with a British perspective. As a journalist, his writing is engrossing and moves across time attracting the interesting, the notable, and the informative. Mr. Shepherd has written widely on psychiatry and its history and has produced television documentaries for the British Broadcasting Corporation. To point out the missing information and the areas of controversy would require much time and space. However, the reader who embarks on this historical perspective piece will find much to keep his or her attention and, of course, much to wonder about and disagree with.

The first recorded case of "shell shock" was in February 1915. The term was already in use in the Army. The debate over the cause of these cases was "fierce." Shepherd notes that this debate was in the context of a change in world view in Britain. In the 1894 *Spectator,* it was noted that the words "nerve" and "nervous" had changed their meanings. At one time, "nerve" meant to have strength or force, and "nervousness" denoted courage and vigor. Now "nerve" had become "nerves" and "nervousness" meant timidity or cowardice. One "lost one's nerve." It was in this context that shell shock was born.

Mr. Shepherd describes cases and the social history of the times that led me frequently to consult the references cited to find the exact time, place, and origin of the statements. There is a rich streak of history that a historian might find wanting, but if one keeps in mind that this is a perspective piece, an extended editorial, then the history evokes "you have got to be kidding!" feelings in every chapter, particularly in the discussions of World War I (the first 200 pages).

The stories of World War II, Korea, Vietnam, and the Gulf War are in the later 200 or so pages. The Gulf War is barely mentioned, perhaps rightly because the closer in time to the present, the more difficult it is to get historical perspective. To my reading, the editorializing increases in the later half of the book, and, of course, some of one's own treasures are barely mentioned. There is little on the importance of the studies of prisoners of war after World War II, nothing on the Vietnam-era prisoners of war, and nothing on the other engagements of the century, such as Somalia and Haiti. The Navy, with its particular stresses and horrendous losses at sea in both world wars, is not discussed, nor is the Merchant Marine. The Air Force is occasionally added to the discussion (1).

Great Britain and the United States are contrasted, usually in a balanced manner, identifying errors on both sides. Many would find things to disagree with, such as Shephard's statement that in the care of soldiers after World War II, "British post-war policy was very low-key and, by modern standards, tough, whereas American policy was more ambitious, even tender….What especially distinguished the American approach from the British, however, was the lavish psychiatric treatment provided" (pp. 328–329).

The recent legal battles in Great Britain of veterans of the Falklands War have raised the issues of how veterans should be cared for, from diagnosis to treatment. We still struggle with this issue today, particularly as we look for new early interventions after traumatic events, including war and the possibilities of terrorist attacks with weapons of horror (2, 3). Ben Shepherd reminds us of the historical context of such societal events. We might not all agree with his perspectives, but his documentation will fascinate and require thoughtful discussion among all who read this volume. It is worth the time.

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For Better or For Worse: Divorce Reconsidered, *by E. Mavis Hetherington and John Kelly. New York, W.W. Norton & Co., 2002, 307 pp., $26.95.*

Professor Hetherington has studied divorce for more than 30 years. She has evaluated more than 1,400 families and claims her research is "the most comprehensive study of divorce ever conducted." *For Better or For Worse* summarizes her work.

The most well-known long-term studies of divorce have been written by her and by Judith Wallerstein, but, on the basis of their writings, one might think that these contemporaries are unknown to each other. Hetherington never mentions Wallerstein in this book. This, despite the overlap of some of their findings and despite Hetherington's joining issues about which they disagree. (Wallerstein barely mentions Hetherington in her latest book, *The Unexpected Legacy of Divorce* [1].)

Hetherington agrees with the first half of Wallerstein's main thesis in *The Unexpected Legacy,* namely, that divorce is a continuous process, beginning long before the separation and having consequences many years after. But she disagrees with the second half: that disordered development of a child must follow. Hetherington believes that "the vast majority [of chil-

dren of divorce] are adjusting reasonably well six years after divorce" (p. 159).

Hetherington's original research is more rigorous than most divorce studies. She evaluated a large number of families for a long time, and she set up nondivorced comparison subjects. But the book does not present the factual details or discuss the methodology at length. The reader learns mostly about the outcomes and the authors' reaction to them. She and her coauthor, writer John Kelly, present a narrative and even give advice. At this, Hetherington is much less successful than Wallerstein, whose work is a naturalistic, psychodynamically oriented study, and who regularly offers trenchant psychological insights about divorce.

For those psychiatrists clinically involved in custody and divorce, the book provides useful information. The authors suggest, for example, that despite the suffering of divorcees in the first year, most are doing relatively well by the sixth year. Another example is that despite the problems of stepchildren, second marriages with stepfamilies are actually happier in the earlier years of marriage than couples in long-established first marriages—although this does not appear to last. There are some interesting anecdotes too, like the story of the recently divorced man who was so captivated by the shapely woman walking ahead of him that he began following her—only to discover that she was his ex-wife, now 40 lb lighter.

The problem with the book is that Hetherington has tried to serve two masters—to summarize her important research over the years and provide a popular guide for traversing divorce's various stages. She has not laid out her previous work in the careful detail it deserves. Many parts beg for more description, which is missing not only from the text but also from the references, for the reader who wants more. By failing to elaborate the bases of her opinions, she does not promote a dialogue between author and reader.

As for the practical guide that Hetherington and Kelly try to set up, the results are so processed for popular consumption that the reader is often left with platitudes: "Take one day at a time," "Nurture the marital relationship," or, worse, "Competent loners have everything they need to make their life a happy and fulfilling one."

To her credit, Hetherington eschews easy answers to issues of divorce. She notes the difficulty in distinguishing what the specific effect divorce has had on the parents and children. She recognizes that biological and predivorce issues may be crucial in the outcome, and that the problems of adults and children from divorced families may not be much different from those of intact families.

The book introduces the general public to Hetherington's major accomplishments, but the mental health professional will have to read her individual publications to grapple with the substance of her work.

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THE PHYSIOLOGY OF STRESS

Handbook of Physiology: A Critical, Comprehensive Presentation of Physiological Knowledge and Concepts, Section 7: The Endocrine System, vol. IV: Coping With the Environment: Neural and Endocrine Mechanisms, *edited by Bruce S. McEwen; section editor: H. Maurice Goodman. New York, Oxford University Press, 2001, 562 pp., $150.00.*

Coping with the environment is obviously a universally necessary skill for all organisms. How one copes with the environment affects virtually every facet of life, from general well-being and social interactions to pathology. *Coping With the Environment* is a propitious introduction to the discussion of biological responses to environmental challenges. This volume has contributions from leaders in the neuroendocrinology field and is suitable for readers interested in a review of neuroendocrinology as well as readers interested specifically in the issue of coping with the environment. Two points of criticism of this volume of *The Endocrine System* include the relative scarcity of current references and the universally unattractive figures, which are complex and poorly labeled.

This volume is composed of six sections, each addressing a different aspect of coping with the environment. Part 1 reviews the primary mediators of the coping response, including the adrenal medullary hormones, the sympathetic nervous system, catecholamines in the brain and responses to stress, the biochemistry and cell biology of corticotropin, proopiomelanocortin synthesis and cell-specific processing, and regulation and actions of the corticotropin-releasing hormone.

Part 2 contains chapters aimed at discussing fear, stress, and coping. The chapters in this section include discussions of the neural basis of defensive behavior and fearful feelings, the role of the hippocampus in the neurobiology of interpreting and responding to stressful events, the role of the hypothalamic-pituitary-adrenal (HPA) axis in chronic stress and energy balance, and adrenocortical responses to stress and their modulation in free-living vertebrates.

Part 3 is a discussion of differences over the course of life in strategies for coping with stress. Chapters included in this section discuss the development of the HPA axis and the stress response, the role of the postnatal environment in the development of individual differences in behavioral and endocrine responses to stress, and the mechanisms of glucocorticoid actions in stress and brain aging.

Part 4 examines the effect of diurnal rhythms and sleep patterns on the systems involved in coping behavior. Chapter 1 of this section reviews the roles of sleep-wake and dark-light cycles in the control of endocrine, metabolic, cardiovascular, and cognitive function. Chapter 2 scrutinizes the influence of hormones and cytokines on sleep.

Part 5 discusses how an organism's ability or inability to cope with stress can affect the immune system. Chapters in this section include "Regional Neural Regulation of Immunity: Anatomy and Functions," "Role of Endogenous Glucocorticoids in Immune System Function: Regulation and Counterregulation," "Interactions Between the Hypothalamic-Pituitary-Adrenal Axis and Immune System During Vi-

ral Infection: Pathways for Environmental Effects on Disease Expression," "Regulation of Inflammatory Autoimmune Diseases," "Immunophysiology: The Interaction of Hormones, Lymphohematopoietic Cytokines and the Neuroimmune Axis," and "Environmental Factors and Disease: Stress and Cancer." Part 6 contains two chapters discussing the physiological and pathophysiological implications of social stress in mammals.

This volume of the *Handbook of Physiology* focuses primarily on the effect of stressors on the endocrine system, with some attention to the role of the endocrine system in regulating normal function. Some chapters begin to address the body's reaction to the environment and how these responses help the organism "cope" with alterations in environment (both physical and psychological).

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Environmental and Chemical Toxins and Psychiatric Illness, *by James S. Brown, Jr., M.D. Washington, D.C., American Psychiatric Publishing, 2002, 320 pp., $45.00 (paper).*

This book fills a needed gap. Although there are texts written for toxicologists and environmental experts, very little is available to psychiatrists on the subjects of toxins. James Brown has assembled an impressive amount of information on known environmental and chemical toxins and presents it in a user-friendly format. For those wanting information on the physical and psychiatric effects of heavy metals such as mercury or lead, pesticides, solvents, and other agents, this book has it all.

Apropos to our post-9/11 world, the book begins with a chapter titled "Military, Terrorists, and Disaster Incidents." Unfortunately, poisoning from these sources has led the world to become an increasingly scary place to live. In order to cope with nearly daily threats, psychiatrists need to have a basic understanding of nerve gas poisoning and other potential threats. Also covered is the so-called Gulf War syndrome, which is handled in a responsible fashion considering all the hysteria that has been attached to the condition. Brown also discusses "sensitivity syndromes," in which I have a substantial interest (1). Although the coverage is brief, it is reasonable and as balanced as something as controversial as this topic can be. This is followed by a discussion of other controversial topics in chapters titled "Food Additives and Child Behavior Disorders" and the "Sick Building Syndrome." Other topics covered in the book include stress reactions, ionizing radiation, toxic gases (including carbon monoxide and hydrogen sulfide), and miscellaneous "elements, chemicals, and syndromes," including such diverse agents as boron, copper, vinyl chloride, and silicon. (Remember the silicon breast implant brouhaha?)

The book also includes useful tables, references, and additional readings. (I guess these are for people who just can't get enough of the topic.) Brown even divides the additional readings by topic. For example, the additional readings on the multiple chemical sensitivity syndrome are divided by those "generally supportive of the physiologic cause" and "those generally not supportive of a physiologic cause." Most of the references predate 2000, and so the only drawback of this book is that, for many of the conditions discussed (e.g., Gulf War syndrome, multiple chemical sensitivity syndrome), useful papers have been published since the author conducted his literature search. This is a minor drawback. The author should be commended for tackling such a difficult area and producing a readable volume.

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MIND, BODY, AND BEHAVIOR

Health and Behavior: The Interplay of Biological, Behavioral, and Societal Influences, *by the Committee on Health and Behavior: Research, Practice, and Policy, Board on Neuroscience and Behavioral Health, Institute of Medicine. Washington, DC, National Academy Press, 2001, 377 pp., $49.95.*

This comprehensive volume updates the 1982 Institute of Medicine's landmark study, "Health and Biobehavioral Frontiers of Biobehavioral Research," which stimulated research and education during the past two decades and contributed to recognition of the role of behavior in HIV and AIDS. The current book presents new findings on the areas covered in 1982 and also discusses evaluations and applications of the newer research findings and the cost-effectiveness of research and intervention programs.

The committee that authored the report was composed of authorities in internal, family, adolescent, and pediatric medicine along with authorities in health policy, epidemiology, social epidemiology, family therapy, clinical and social psychology, law and ethics, health education, neuroendocrinology, immunology, and psychiatry. Its charge was to 1) update scientific findings about the links between biological, psychosocial, and behavioral factors and health, 2) identify factors involved in health and disease for which research on them and on effective behavioral and psychosocial interventions is complete, 3) identify and review applications of newer behavioral and psychosocial interventions, 4) examine the implementation of behavioral and psychosocial interventions, 5) review evidence of cost-effectiveness of programs, and 6) make recommendations for further research, its applications and financing, and psychosocial interventions.

The committee handled that formidable charge by reviewing about 1,700 research reports on health and behavior published since 1982 (there are 99 pages of citations). Committee members focused on developments in those fields and also included psychosocial factors, conceptualized as the individual's interpretations of social relationships, events, or status, inasmuch as they reflect psychological and social variables that, when internalized, affect biological processes.

The overwhelming mass of data, descriptive material, and comments is masterfully organized. The volume begins with

a helpful 18-page executive summary, followed by a 19-page introduction containing many of the definitions that will be used. Part 1, Biological, Behavioral, and Social Factors Affecting Health, consists of three chapters: "Biobehavioral Factors and Health and Disease," "Behavioral Risk Factors," and "Social Risk Factors." Part 2, Health-Related Interventions, also contains three chapters: "Individuals and Families: Models and Interventions," "Organizations, Communities, and Society," and "Evaluating and Disseminating Intervention Research." Part 3, Findings and Recommendations, provides a short, superb summary in 19 pages.

The committee presents their ecological definition of health as "a state of complete physical, mental, and social well-being and not the absence of infirmity." They insist that a comprehensive definition of health requires both an integration of broader concepts of morbidity and mortality than we now consider and also an "outcomes model" focused on patients' outcomes rather than disease pathology. Furthermore, they point out that health is multidimensional and present a concept of positive health that has four constructs: a healthy body, high-quality personal relationships, a sense of purpose in life, and self-regarded mastery of life tasks, along with resilience to stress, trauma, and change.

Behavior is not simply a matter of individual choice but is shaped by the multiple influences of families, social networks, communities, and such organizations as workplaces and schools. Thus, there are multiple targets for change and strategies for interventions at different levels. The committee expresses hope that their report will stimulate researchers, practitioners, program developers, and policy makers to consider multiple levels for assessments.

The organization of *Health and Behavior* deserves special attention. Part 1 describes the status of knowledge about biological, behavioral, and social factors that affect health and their interactions. Part 2 addresses research interventions in health-related behaviors at the individual, family, community, and society levels. The committee points out that the associations between socioeconomic status and health and the influences of social networks, employment status, and personal beliefs have not received sufficient attention. Part 3 presents the committee's principal findings and recommendations.

The concepts of allostasis and of the allostatic load are introduced in chapter 1 after a brief discussion of stress and homeostasis. Allostasis is defined as the "maintenance of overall stability (homeostasis) through the constant adjustment and balancing of various common components in the process of adapting to challenges"—in a sense, the capacity to adapt. The allostatic load, the wear and tear the body experiences as a result of repeated allostatic responses, affects all bodily systems, especially the hormonal, immunologic, and central nervous systems. The allostatic load is more than chronic stress; it reflects failure to cope efficiently with daily challenges related to such influential life-style factors as diet, physical activity, and alcohol. Adrenal steroids and catecholamines are the main mediators of both the protective and the damaging effects of allostatic responses, and the brain, as the interpreter, regulator, and also target of the allostatic load, is subject to long-term wear and tear.

In chapter 3, "Behavioral Risk Factors," cigarette smoking is indicted as the major cause of preventable morbidity and mortality in the United States, accounting for 400,000 deaths each year. Obesity, now the second leading factor contributing to mortality, influences gall bladder disease, sleep apnea, respiratory diseases, and musculoskeletal problems. Avoiding weight gain as an adult needs to be a high priority because the treatment of obesity has notoriously poor long-term success.

Chapter 4, "Social Risk Factors," presents many new data and emphasizes some from the past as well. For example, not only is the socioeconomic status of the individual and the family inversely associated with illness and mortality, but recent studies of census tract incomes indicate that the socioeconomic status of the community makes an independent contribution to mortality. Also, there is a graded, continuous association between income and mortality that persists well into the middle-class range of incomes. Furthermore, strong correlations are being found between measures of income equality and standardized mortality rates. Even modestly lower relative income is associated with higher rates of infant mortality and deaths from coronary heart disease. Among social risk factors are the reverse causation seen when poor health leads to a lowering of socioeconomic status rather than just lower socioeconomic status leading to poor health.

Research is showing the benefits of social support in managing stress, coping, and improving family relationships. Powerful epidemiologic evidence supports views that social ties, especially intimate ones, along with emotional support, are associated with improved prognosis and survival for patients with cardiovascular disease. For example, significant evidence indicates that marital discord affects general health and immunity adversely. Not all social connections, however, are beneficial. Conflicted, hostile, and/or abusive family environments affect health negatively. Individuals in positive relationships are less likely to show a high allostatic load than the lonely and isolated. The committee also presents data on the adverse effects of racial disparities, discrimination, and lack of social cohesion.

Among other influential social factors are those pertaining to religious belief and practices; participating in religious activities and/or holding religious beliefs are associated with improved health status. In chapter 4, the discussion of social risk factors, including the short 2-page section on social cohesion and social capital, is especially valuable.

Part 2 is devoted to health-related interventions. In accord with their social systems/ecologic perspective, the committee finds that the family provides the social context that has the most immediate effects on disease management and the greatest implications for intervention.

In part 3, the committee concludes with a summary of the following seven major findings and recommendations:

1. Health and disease are determined mainly by interactions over time among biological, psychological, behavioral, and social factors. Recommendation number l, therefore, is that cooperation and collaborations among multiple disciplines are necessary in order to influence health and behavior favorably. Funding agencies need to direct resources toward interdisciplinary research efforts and prevention studies that integrate biological, psychological, behavioral, and social variables. Collaborations across disciplines need further encouragement.

2. A fundamental finding is that psychosocial factors influence health both directly through biological mechanisms and indirectly through behaviors. Recommendation number 2,

therefore, is that research efforts need to bring to the surface the mechanisms by which social and psychological factors influence health, and intervention studies are needed to evaluate the effectiveness of modifying factors that promote health and prevent disease. Such studies need to cover a broad research span, from clinical trials to feasibility and randomized double-blind studies to community-based participatory research.

3. Behavior can be changed; behavioral interventions can successfully teach new behaviors and diminish risky ones. However, maintaining behavior change over time is the challenge. Improved health outcomes often require prolonged interventions and lengthy follow-up protocols. Recommendation number 3, therefore, is that funding for health-related behavioral and psychosocial interventions needs to support long-duration efforts.

4. Individual behavior, family interactions, community and workplace relationships, resources, and public policy all can influence behavioral change and contribute to health. Only interventions at those multiple levels will sustain behavioral change. Recommendation number 4, therefore, is that concurrent interventions at multiple levels and assessments of coordinated efforts across those levels are necessary.

5. Initiating and maintaining behavior change is difficult. It is easier to generalize a newly learned behavior than to change existing behaviors. Recommendation number 5, therefore, is that resources should be allocated to promote long-term health-enhancing behaviors and primary prevention programs that then become public health and health care priorities.

6. The goals of public health and health care are to increase life expectancy and improve health-related quality of life, not just to modify risk factors. Recommendation number 6, therefore, is that intervention research must include all appropriate biological and psychosocial measures to determine whether the strategies being used are producing the desired health effects.

7. Changing unhealthy behavior is not just a matter of willpower because behavior has biological underpinnings and is influenced by its social and psychological contexts. Much can be learned, for example, by studying the effects of higher cigarette taxes, controlled advertising of unhealthful products, communities' increasing or decreasing facilities for healthful recreation, and social and other policy decisions. Recommendation number 7, therefore, is that policy makers and program planners need to consider how to modify social and societal conditions to enable healthy behaviors and enhance social relationships. Also, longitudinal research design, quasi-experimental methods, and community-based participatory research, along with the development of new research methods, can advance knowledge about health and behavior.

Health and Behavior is an important book, an outstanding compilation of the available information on this vital topic. The committee members who authored it extracted the essential data and findings from many references and wove them into a well-organized, coherent, readable volume. They should be both thanked and commended for their successful efforts. Obviously, reading all of it is a somewhat daunting, laborious task, but the importance of the content and quality of the writing make the task interesting.

Inasmuch as this book will be used most often as a reference, it needs to be available in all medical and other scientific libraries for researchers in health and behavior and related fields. Also, many clinicians will find that it has utility in validating their frequently necessary recommendations and admonitions to patients about unhealthful behaviors, for example, about diet and exercise in order to control the burgeoning epidemic of obesity and its consequences. In summary, *Health and Behavior* presents a mass of information that, in whole or in part, will be useful to many clinicians, researchers, other scientists, and policy makers involved with the many challenges to improve health in our society.

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Mind, Body, and Medicine: An Integrative Text, *by Raphael N. Melmed. New York, Oxford University Press, 2001, 424 pp., $49.95.*

Books concerned with the ways in which the mind can hold sway over the workings of the body have become very popular in the last 10 years. Paul Martin's *The Sickening Mind* (1) was a good example of its type, and Melmed's book arrived in the same week that I was asked to review a volume called *Stress and the Heart* for the *British Medical Journal* (2).

This interest may reflect an increased awareness of mind-body interactions in medicine, although my attempts to acquire a copy of the journal *Advances in Mind-Body Medicine* have so far failed. In our hospital library (a large university teaching establishment), copies of *Time* and *The Economist* are easier to come by than *Advances in Mind-Body Medicine*.

In *Mind, Body, and Medicine,* Melmed describes the ways in which stressors challenge the physical and psychological health of the individual. There are additional chapters on chronic fatigue and chronic pain as well as visceral pain syndromes and panic disorder and pragmatic advice about management of these disorders.

The strengths of this book lie in Melmed's accounts of mind-body interactions from a physiological viewpoint, and the most interesting chapters are those in which he describes the pathophysiological mechanisms involved in psychosomatic illnesses. Melmed is not only a practicing clinician but also the head of a unit for behavioral medicine, and so he is uniquely suited to write about mind-body interactions of this sort. He is also aware of the importance of the doctor-patient interaction and how this may affect the outcome of a variety of medical disorders. Of course he is right in emphasizing that the assessment can influence the ways in which an illness evolves: he cites Engel's statement in 1986 that the lack of adequate knowledge of human behavior among physicians compromises their effectiveness as clinicians.

The book is well written and well referenced and includes useful chapters on behavioral management of diverse disorders, with practical accounts of relaxation procedures in stressed states; Melmed is well aware of (and endorses) the use of cognitive behavior therapy as a powerful therapeutic tool in the medical context. He is right to do this because recent reviews carried out in the United States and the United Kingdom have emphasized the importance of cognitive behavior therapy in such disorders as chronic fatigue syndrome and chronic widespread pain (fibromyalgia).

Melmed is also concerned with restoring to patients a sense of control in an attempt to help diminish the intensity and frequency of distressing symptoms. This is in keeping with the current articles on patient empowerment, although most U.K. clinicians prefer the term "self-management." Melmed cites the growing popularity of alternative medicine in the West as an expression of the need for patients to exert some control over particular treatment options, even if these treatments are demonstrably ineffective (as is the case for many alternative treatments used in patients with cancer). The patients who use these treatments seem less bothered that these treatments lack an evidence base than those who prescribe them. This is a major challenge for modern "evidence-based" medicine.

Because psychosomatic problems in clinical practice fall squarely in the arena of general medicine and its subspecialties, this book should be read primarily by general physicians, but it will also be of interest to psychiatrists and primary care physicians. Melmed rightly bemoans the "stilted, uneasy, inhibited relationship that characterizes the interaction of psychiatry with the rest of the medical profession" but sensibly declines to explore the historical origins of this unfortunate development. Surely radical changes must take place in the training of our physicians (or lack of it) before we can become as adept at understanding and managing the psychological aspects of medical practice outlined by Melmed in this humane and stimulating book.

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Somatoform and Factitious Disorders, *edited by Katherine A. Phillips, M.D. Washington, D.C., American Psychiatric Publishing, 2001, 181 pp., $31.95 (paper).*

On any given day in the United States (and probably elsewhere), hundreds of thousands of individuals make visits to physicians with complaints unexplained by physical disease. The history of attempts to understand, classify, and minister to patients with poorly understood physical complaints ranges over a period of at least 2,000 years. There is perhaps no more controversial, ever-shifting classification of psychiatric disorders than that of the somatoform group (to which the editors of this book have added factitious disorders because, as they argue, all medically unexplained symptoms occupy points on a continuum not readily differentiated). At times, classification may appear more a matter of convenience than based on good clinical rationale. Do they belong with adjustment disorders, dissociative disorders, obsessive-compulsive disorder, depression, or other disorders?

This defiance of categorization reminds us that the truth most likely lies in the whole human being and his or her life experience; psychiatry does not live by DSM alone. Patients with somatoform disorders probably most closely resemble the human condition, with its attention to bodily or somatic perturbations. We are all imbued to some extent with some aspect of these syndromes; we are all somatizers to one degree or another. Developmentally, as proclaimed by Freud, the ego is first and foremost a body ego. Perhaps, in some measure, it is this closeness to our own experience which contributes to the difficulty in clearly medicalizing these conditions as disorders.

The editors and authors of this brief compendium are to be congratulated for their balanced, intelligent synopsis of current knowledge about this troublesome rubric of somatoform disorders. To even attempt a concise review of the history and clinical differentiation of somatoform disorders deserves an A for effort. As volume 20 of the Review of Psychiatry series of American Psychiatric Publishing, it does, as the editors advise, "the best job that can be done at this point." Better planning of the series might more appropriately have included pain disorder in the current volume rather than in a previous one, but except for this minor caveat, the contributors to and editor of this stellar work have admirably achieved their objective.

Woefully, we must admit that our armamentarium of treatment methods for these ailments remains impoverished and rudimentary. Or, as the series editors of this book state in the introduction, "certain conditions, such as the somatoform and factitious disorders, can baffle even our most experienced clinicians." Therapeutic issues realistically command less than one-fifth of the book and may thwart the expectations of those seeking a true how-to manual of treatment approaches. The most extensive coverage of treatment is in the chapter on hypochondriasis by Fallon and Feinstein, not surprising in view of the new perspectives on this ancient malady (1). Because some of the principles of management and treatment are common to almost all the somatoform disorders, a next edition might consider the value of including a separate chapter on management techniques, emphasizing important aspects of the patient-physician relationship across the continuum.

Some redundancy is a virtual staple of multiauthored works, but the minimal degree of repetition in this book permits each chapter to stand on its own as well as to be an integral part of the total. Each chapter is a gem of pristine prose and lucid organization, reflecting, without overstatement, what is known and what remains speculative about these disorders. In spite of omitting chapters on pain disorder and undifferentiated somatoform disorders, this little volume presents what is mostly known (and unknown) about the various so-called somatoform disorders in a highly readable, reassuring manner that helps to blunt some of the many uncertainties that surround this generally orphaned group of psychiatric disorders.

Five succinct chapters expertly describe somatization disorder, hypochondriasis, body dysmorphic disorder, conversion disorder, and factitious disorder. Even in its brevity, there is a hint of the rich, colorful, and largely anecdotal history of the many conditions alluded to as "hysterical" or "hypochondriacal" in the psychiatric literature of the past. Fortunately, the precision of this well-written, well-edited review has not completely DSM-cleansed the intriguing developmental nuances of those conditions Freud alluded to as the "mysterious leap from the mind to the body." The

chapter on conversion disorder by Maldonado and Spiegel has a particularly good section on history that reminds us of the creative ideas of Freud, Charcot, Briquet, and others who have provided such seminal insights into the somatizing process.

The authors and editors recognize that controversy and confusion continue to surround these interesting clinical conditions. After all, even in our DSM-ness, do we really know all that much more than Freud and his followers when they pursued the mystery of "somatic compliance" in their psychological explorations? Our treatment techniques may have changed, but descriptions of these curious disorders have shown remarkable endurance.

This book is a delight to read. Blaise Pascal is thought to have said, "I have written a long letter because I did not have time to write a short one." The art of abridgment is well exercised in this useful book, helping the "consumer differentiate between sound advice and insubstantial opinion." For the well-informed, it will momentarily clear the field; the novitiate, one hopes, will be enticed to delve more deeply. Readers whose curiosity is piqued will find a rich bibliography appended to each chapter.

Here, then, in a mere 181 pages, is a book intended to "help identify the presence of the somatoform and factitious disorders, as well as [to provide] recommendations about their treatment." How well it does that can only be judged by the efficacy with which physicians can absorb and apply this knowledge and the extent to which patients' ailments might benefit from that application. The pity is that this book will be read mostly by psychiatrists, not the primary care physicians who are most likely to see (and probably misdiagnose) these patients in their offices, making application of its abundant wisdom even more remote.

The book's introduction, exclaiming that "the somatoform and factitious disorders are fascinating syndromes that are beset with contradictions," calls to mind for me a sobering reminder of one difference between psychiatrists and other physicians. I have always kept in mind one of my earliest encounters with a frustrated physician treating the multiple factitious presentations of a patient with systemic infections when, after consultation, I said, "This is a fascinating situation." His reply, "To you, maybe; to me, he's a pain in the ass." It is uncertain how much help even this fine concise volume will be to such physicians. Yet that is a large part of our challenge since most of the conditions described here are seen on the front line of medicine, not in psychiatrists' offices. But if all psychiatrists can ingest and translate the content of this superb small volume to their nonpsychiatrist colleagues, the educational impact may be substantial and all (not least, the patient) will be richly rewarded.

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HISTORICAL, PHILOSOPHICAL, AND RELIGIOUS PERSPECTIVES

The Transformation of Psychology: Influences of 19th-Century Philosophy, Technology, and Natural Science, *edited by Christopher D. Green, Ph.D., Marlene Shore, Ph.D., and Thomas Teo, Ph.D. Washington, D.C., American Psychological Association, 2001, 280 pp., $39.95.*

What began as a seminar at York University in Toronto supported by a grant from the Gersten Foundation was transformed into a marvelous collection of essays focusing on the more complex psychohistorical social forces that led to the foundations for the science of psychology. Looking beyond the simplistic version of most psychological textbooks on the history of the science of psychology, the authors take us on a historical journey from the beginning of the 19th century, when Kant expressed his skepticism that psychology would ever become a true natural science, to the 20th century, in which the foundations of the science of psychology were well established. "How was it possible," the authors ask, "that the transformation took place so rapidly?"

In 11 chapters we are provided with a narrative that takes us into the complex world of the development of psychology as a science, including 1) Darwin's theory of evolution, 2) phrenology, 3) theories of memory, 4) psychological technology and the World Colombian Exposition in 1893 in Chicago, 5) mathematical psychology and empiricism, including Fechner's "golden section" as a mathematical proportion of visual beauty, 6) Ernest Mach's replacement of the concept of causation with the concept of function, 7) the invention by Charles Babbage of the analytical engine as a precursor to robotics and information systems, 8) the technology of the "tempest prognosticator" in 1851 presented at the Great Exhibition in London as a "device intended to predict the weather by using the presumed instinct of leaches," 9) an examination of the influence of the philosophies of Hegel and Kant on modern psychology, 10) an exploration of Marx and Dilthey's theories and the concept of cogitamus or "we-think," which deals with the relevance of a social context in history and human thinking as opposed to Descartes's "Cogito ergo sum" and the development of a natural science of human beings and empathy, and, finally, 11) an examination of the impact of genetic and embryological influences on early development (focusing on the prenatal environment and the so-called critical period) and the biological underpinnings of modern psychology. What a journey!

Throughout the first part of the book, we are taken on a political journey in which religion and philosophy are set up as a gauntlet for the psychological "secularists" and the concept of the natural world is seen as superseding metaphysics. One example is worth noting as we hear about it in today's parlance. The authors introduce us to Tyndal's writings on the efficacy of prayer and Gaulton's reactions by writing a text on the "statistical inquiries into the efficacy of prayer" in 1872. These controversies set the stage for looking at history as a basis for many of our current dilemmas in psychology on how to measure ideas and behavior in real life.

For most of us, the origins of the science of psychology are grounded in Wundt's theory of memory and the recognition of the importance of experimental design, Fechner's introduction to psychophysics, Ebbinghaus's laboratory for the study of memory, and Gaulton's introduction to statistics and measurement of mental abilities. The authors take us deep into the historical, religious, secular, mathematical, materialistic, anthropological, and physiological foundations of psychology. Unfortunately, the current divorce of psychology and philosophy has left the mental health profession with a theoretical void as new technologies, best practices, and standards of care are mistaken for a theory and philosophy of psychology. Without appeal to the history of psychology, and lacking a grounding in philosophy, the field of psychology seems doomed to a new technological reductionism and confined to a fate of never fully knowing what it is all about as a science.

At times this book was difficult to read. There are aspects of the prose that are tedious and cumbersome. Some of the pictures, however, are superb, and, as the philosopher Spinoza reminded us, all things worth knowing are as difficult as they are rare. The ideas presented in this book are well worth knowing.

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The Rise and Fall of Modern Medicine, *by James Le Fanu, M.D. New York, Carroll & Graf, 1999, 426 pp., $26.00.*

Cicero, before his head and hands were unceremoniously dismembered from his body and displayed before the Roman Senate, said that gratitude is the greatest of all virtues and that, in fact, it is the father of all virtues, upon which all virtues are based. As I enter the third decade of my private practice of medicine, I realize how Plutarch's *Moralia* (or *Lives and Essays*) and George Santayana's admonitions to study history can indeed suffuse my sometimes disaffected heart with gratitude as I listen to Longfellow's call to virtue:

> Lives of great men all remind us we can make our lives sublime, and despairing, leave behind us footprints on the sands of time.
>
> Footprints, that perhaps another, sailing o'er life's solemn main, a forlorn & shipwrecked brother, seeing, shall take heart again.

The biggest hindrance for psychiatrists in private practice is not only the fear of what Pascal referred to as "the eternal silence of these infinite spaces" but an epidemic disease that has insidiously infected us all in these litigious times: eisoptrophobia, a morbid fear of mirrors.

As with Plutarch's desire to jump-start the flagging spirits of his fellow Romans, Dr. Le Fanu, an evocative raconteur, weaves a riveting tapestry of stories spanning the years 1935 to 1998 and highlights in bold, colorful—sometimes brash—brush-strokes 10 of 46 definitive moments of modern medicine. Le Fanu succeeds in keeping the reader's interest throughout with an uncanny fiction-author-like manipulation of story, character, plot, and action. He "shows" rather than "tells." He dexterously uses "hooks" and "leads" that leave those among us old enough to have met or known the many protagonists of his play walking away shaking our heads saying, "I'll be damned if I saw that one coming!" and marveling at some description or insight.

Le Fanu, a Londoner, is a medical columnist for both *The Daily Telegraph* and *The Sunday Telegraph* and a writer for the *Times, The Spectator,* and *GQ* magazine. His writing is bold and his wit biting. For example, he says,

> The only sound verdict, hard as it might be to accept, is that The Social Theory [regarding dietary control of diseases, water and air pollution as causing diseases] is in error *in its entirety*. It is possible to assess this without qualification because each of its four components either ignore or are contradicted by the inescapable laws of biology. The dietary theory of heart disease and strokes is invalidated by the biological superlative of maintaining the milieu interieur so the important physiological functions such as the levels of cholesterol and blood pressure are kept in a steady state! The dietary theory of cancer is invalidated by the contribution of biologically inevitable aging to this age-determined disease. The environmentalist theory is invalidated by the biological necessity that the human organism be resilient and not readily injured by miniscule levels of pollutants in air and water!
>
> An analysis in 1997 of nine MRFIT-type studies involving over 125,000 participants confirmed that admonishing people to adopt a healthy lifestyle—no matter how desirable and whatever benefits it might confer from promoting exercise and stopping smoking—had *absolutely no effect* on stopping them from dying from heart disease!

He calls the cholesterol studies of Ancel Keys and Jeremiah Stamler "the great cholesterol deception." I asked my cardiologists their reactions to Le Fanu's ideas. Their responses are not fit to be printed in this publication.

In 1928 Alexander Fleming did not take the matter of discovering penicillin farther because he did not think it worth pursuing, a good example of how preconceived ideas in medicine can stifle the imagination and impede progress. It was not until February 12, 1941, that a 43-year-old British policeman (Albert Alexander) became the first person treated with penicillin, thanks to the combined efforts of Florey and Chain in Oxford (1935).

The same thing seems to have happened in psychiatry. Although Freud died in 1939 at age 82, his oppressive, phantasmagorical influence on the therapeutic nihilism of psychiatrists worldwide was still felt in 1960–1972, when I was in medical school and postgraduate training for adult and child psychiatry. Psychiatric psychoanalysts still ruled over academia and specialty boards. So it was no small miracle that, according to Le Fanu, a French naval surgeon named Henri Laborit, while laboring in a maritime hospital in Tunisia in 1949, by sheer inquisitiveness

> claimed in an article published that year—remarkable for its complete absence of any data—that with this combination [the antihistamine promethazine, among others] we have been able to distinctly influence the development of post-operative problems.

Laborit noted that promethazine produced a "euphoric quietude"—a "calm, with a restful and relaxed face." In 1950, the drug company Rhone-Poulenc, picking up on the hunch that it might be useful for psychiatric patients, initiated a major research into phenothiazines, the group of drugs promethazine belongs to. In 1952, when health maintenance organizations and pharmacopoeia oversight boards, which would have vetoed such an "unproven venture," were unheard of, two Parisian psychiatrists, Jean Delay and Pierre Deniker, treated a 57-year-old laborer, Giovanni A., who was diagnosed as having schizophrenia. After 3 weeks of treatment with chlorpromazine, a phenothiazine, Giovanni was discharged "able to have a normal conversation."

It was not until 1963 that chlorpromazine was shown to interfere with the action of the neurotransmitter dopamine. Le Fanu says, "This goes to show that to treat a problem does not necessarily require absolute knowledge of the causation or the mechanism or the explanation of what is wrong in a particular illness."

And so, on and on, Le Fanu goes in a pace that never lets your interest wane or wander, recounting how 10 definitive moments in medicine—including the discovery of penicillin, open-heart surgery, in vitro fertilization, kidney transplantation, the cure of childhood cancer, the discovery of *Helicobacter pylori* by Barry Marshall—brought on watershed, sometimes tsunami-like changes in the way medicine began to conceptualize and deliver its services. As in the dispirited days of Rome, when Plutarch's *Moralia* fanned the hopes of the spent Romans by reintroducing them to the unheeded advice on gratitude by the beheaded Cicero, Le Fanu fans the dying embers of growing disillusionment among medical professionals.

In *The 1001 Arabian Nights of Scheherazade,* there is a story of three princes from Serendip who were so learned, astute, and intrepid that when ordinary people saw an accidental occurrence or an event of no significance, these three found opportunity and fortune. It is no coincidence that the Chinese words for "crisis" are "way" (risk or danger) and "gee" (opportunity). The medical pioneers whom Le Fanu describes follow a consistent pattern, which mirrors the studies on resiliency and "Emotional Intelligence" by Daniel Goleman (1): zeal, impulse control, persistence, perseverance, self-awareness, self-motivation, empathy, and social deftness.

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Sanity and Sanctity: Mental Health Work Among the Ultra-Orthodox in Jerusalem, *by David Greenberg, M.D., and Eliezer Witztum, M.D. New Haven, Conn., Yale University Press, 2001, 389 pp., $40.00.*

Like other fundamentalist groups, for whom the sacred is a phenomenological constant, ultra-orthodox (*haredi*) Jews seek to insulate themselves from the polluting effects of the secular society in which they are uncomfortably situated. Since they tend to view mental health care as a potential source of such effects, they use psychiatric services reluctantly and parsimoniously, often as a last resort. This attitude charges the cultural gap between Western-trained psychiatrists and Jewish ultra-orthodox patients with moral overtones, which makes it all the more difficult to bridge. In *Sanity and Sanctity*, psychiatrists David Greenberg and Eliezer Witztum, who have been working for more than two decades in the community mental health clinic that serves the ultra-orthodox communities of northern Jerusalem, rise to the challenge of bridging the gap between medical and sacred realities. Combining clinical case studies, ethnographic vignettes, and group data analyses tinged with Talmudic exegeses and Hasidic tales, they portray the peculiar ways in which clinical manifestations prevalent among the ultra-orthodox are shaped by their religious and mystical beliefs and practices and the culture-sensitive interventions designed to combat these problems.

For me, the most impressive aspect of this fascinating report is the authors' attempt to use the unique setting of the clinic for exploring theoretical issues regarding the interface of religion and psychopathology. In the domain of religious ideation, for example, they seek to discern messianic beliefs from psychotic delusions, generalizing from their clinical cases that unlike the former, the latter are secretive, assigning a grandiose personal role to the individual, and are out of step with current religious thinking. Yet they concede that these criteria may become blurred in times of crisis. In the realm of religious rituals, they ask whether the code of Jewish law, with its meticulous emphasis on separation, repetition, and avoidance, is the natural habitat of obsessive-compulsive disorder (OCD) or perfect medicine. Their conclusion, supported by a review of the syndrome in a variety of cultural settings, does not implicate religious background as a causative factor. Rather, religious symptoms of OCD are merely the form OCD typically takes in patients for whom religious beliefs and practices predominate. In the area of religious change, they show that, although mental illness is significantly more common among *baalei teshuva* (religious penitents or returnees), religious change per se should not be viewed as the cause or precipitating factor underlying mental illness. The fact that the majority of the returnees had a previous history of serious psychiatric disturbances and they came for help an average of 5 years after their religious change indicates that the uplifting transformation and the structured life regimen that followed had an assuaging effect, albeit short-lived, on their problems. Regarding the complex relations of mental illness and mysticism, to which many of the penitents are attracted, the authors again note that mystical pursuits, often motivated by unresolved losses, may reflect a new avenue for a person suffering from a long-standing psychopathological process.

The conclusions regarding these and other culturally informed symptoms among the ultra-orthodox (e.g., nocturnal hallucinations, "the Jerusalem syndrome") are compatible with the common psychiatric wisdom that makes analytic distinction between culturally molded (particular) surface manifestations and preexisting pancultural (universal) structures of psychopathology. Although most of the work in cultural psychiatry subscribes to this "stratification model," the authors should be commended for the rich and nuanced portrayal of the religious and mystical idioms of distress that shape psychopathology in the community under study. No less interesting is their discussion of the culture-sensitive

guidelines for working with ultra-orthodox patients they distilled from their rich clinical data.

Far removed from a standard psychiatric text, this book is written in a friendly, jargon-lean style, which sometimes surprisingly resonates with Jewish traditional discourse. I liked the authors' modest, disillusioned, sometimes even self-deprecatory stance regarding the limits of their interventions, their frankness in discussing their failures and misunderstandings (sometimes turned into insights in an arduous trial and error process), and, above all, their genuine respect and empathy for their reluctant patients. At a time when multicultural encounters in the psychiatric clinic become the rule rather than the exception, *Sanity and Sanctity* has much to offer.

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BORDERLINE PERSONALITY

Borderline Personality Disorder: A Clinical Guide, *by John G. Gunderson, M.D. Washington, D.C., American Psychiatric Publishing, 2001, 329 pp., $57.00.*

If this book were a new opera composed by John Gunderson and conducted by him at a worldwide premiere performance at one of the famed houses in Milan, Paris, London, or New York, everyone in the audience, including this critic, would stand up impulsively and cheer. Indeed, stand up and cheer we must.

John Gunderson became interested in borderline patients during his psychiatric residency at the Massachusetts Mental Health Center in Boston. In 1971 he went to the National Institute of Mental Health and, together with William Carpenter and John Strauss within the framework of the International Pilot Study of Schizophrenia, compared a sample of 29 patients with schizophrenia and a group of 24 borderline patients who had all recently been admitted for hospitalization on the severity of 27 psychopathological dimensions ranging from anxiety to withdrawal (1). They demonstrated that in regard to symptoms, these severely ill borderline people, until then often diagnosed and lumped together with patients with schizophrenia, were clearly distinct from the group with schizophrenia.

In the course of this work, Gunderson also reviewed the then existing descriptive accounts, theories, psychodynamic formulations, psychological testing results, and treatment recommendations of borderline patients, some 25–50 papers in all, including important and seminal contributions by Adolph Stern (2), Roy Grinker (3), Otto Kernberg (4), James Masterson (5), and Gerald Adler (6). Some of the publications were semantically confusing, discrepant, or simply a jumble of words describing behavior, dynamic formulations, or symptoms. In an audacious, vigorous, youthful, and memorable article, Gunderson and Singer (7) distilled this material and identified six coherent factors they judged characteristic of most borderline patients according to most of the publications. I well remember reading that article with astonishment and saying to myself that this essay would change the world of borderline patients. It did.

Gunderson's work, together with the brilliant contributions of Grinker (3), Kernberg (4), Masterson (5), and Michael Stone (8) on the one hand and Kety, Rosenthal, and Wender (9) on the other, enabled Spitzer, Endicott, and Gibbon to develop a 22-item set that they mailed to 4,000 members of the American Psychiatric Association in January 1977. There were 808 usable responses, and these ultimately resulted in the first formulation of criteria for borderline personality disorder and schizotypal personality disorder (10). Thus, to a very large extent, not only Gunderson's conception but also his delivery led to the birth of borderline personality disorder in DSM-III for the first time in 1980. This in turn brought this large group of very ill and difficult patients, once the subject mostly of theorizing and treatment in the psychoanalytic community, into mainstream general psychiatric thought and investigation.

And a large group of patients it is. As Michael Stone (11) has pointed out, estimates of the prevalence of borderline personality disorder in the United States are in the range of 2.5%–3.0%—about the size of the population of Denmark or Sweden. To be sure, the specific diagnosis of borderline personality disorder defines a significantly more selective universe of patients than Kernberg's very creative and valuable category of borderline personality organization, a structural diagnostic qualifier encompassing several specific diagnoses that includes approximately "10% or more of the entire population, or, in the case of the United States, a separate 'nation' of patients with borderline disorder as populous as Canada" (11) or Argentina.

Since Gunderson and Singer's 1975 article, thousands of books, clinical reports, and research studies have been published on borderline personality disorder in the United States alone, not counting the entirely independent French work on *les états limites* or *les psychoses blanches* and the influence of U.S. work on German publications on *das Borderline-Syndrom* and *die Borderline-Persönlichkeitsstörung*. Gunderson's innovative persistence and his findings, together with Zanarini and Frankenburg (12), first hinted at in 1975 (1), that brief, transient, and reversible psychotic ("quasi-psychotic") experiences are a characteristic of the lives of many patients with borderline disorder led to the inclusion of transient paranoid ideation and severe dissociative symptoms among the nine criteria for borderline personality disorder in DSM-IV.

Borderline Personality Disorder: A Clinical Guide is an utterly distinguished and unerringly honest book, a meticulously crafted state-of-the-art summary of our knowledge about the diagnosis, the levels of treatment, and modalities of psychotherapy for this illness. This volume gives the reader Gunderson's expert views as refracted through the prism of his 30-year-long experience in research on borderline disorders as well as teaching, consulting, and treating borderline patients.

Unfortunately, at present, a disquieting and unbridgeable moat separates the estimated 7–8 million people in our nation with borderline personality disorder from the resources necessary for its successful treatment, so graphically illustrated—with evidence from about 700 publications—in this work. While reflecting on Gunderson's timetable for changes in these patients in the course of at least 5 years of psychotherapy (Figure 3-2, p. 73), I recalled my last conversation with

a utilization manager of a company "managing" psychiatric benefits for health insurance firms and their authorization of seven psychotherapy appointments for one of my patients! Our society has made the anachronistic decisions to provide vigorous financial support for research on neuroscience and mental illnesses but to withhold the funds necessary for the implementation of the practical conclusions of these projects for the benefit and treatment of mentally ill people—thus abandoning them.

Two early chapters of the book provide background on diagnosis and differential diagnosis. Gunderson goes over in great detail the provenance of the diagnostic criteria for borderline personality disorder from the research of the major contributors to the field and the subjective suffering patients experience living life with borderline disorder. He makes the point that borderline personality disorder, by far the most important type of personality disorder, is such a major disorder of the self that it requires priority in planning meaningful rehabilitative treatments and therefore deserves categorical status of equal weight with axis I disorders. This then leads to dilemmas in differential diagnosis thoughtful psychiatrists can encounter in having to decide on a primary diagnosis of borderline personality disorder versus one of bipolar disorder, major depression, posttraumatic stress disorder, narcissistic personality disorder, or antisocial personality disorder.

The ensuing three chapters provide an overview for the treatment of borderline patients. These include therapeutic processes and the functions they serve; a potential sequence and timetable of expectable changes in behavior, affect, social functioning, and object relations; three sequential levels of alliance; case management and the responsibilities of the primary clinician; assessing and responding to recurrent suicidality; boundary violations; and various modalities of care, i.e., hospitalization, residential treatment, partial hospitalization, and outpatient psychotherapy. Here Gunderson distinguishes between treatment that is prescribed to patients, e.g., hospitalization or medications, who receive them with acceptance or resistance, and psychotherapy that to be successful requires assertive collaboration, inquisitiveness, and sharing of goals on the part of the patient.

There are valuable nuggets to be harvested in these chapters: initial "no-therapy" therapy (p. 90); "contracting for safety" (p. 93); responding to chronic suicidality with "false submission" (p. 97); sequential responses to boundary transgressions (p. 102); and the concept that the splits of patients with borderline disorder are not solely the product of their projections (p. 103). However, the language of Sidebar 3-2 (p. 80) is confusing. Patients with borderline disorder are certainly able to contract for therapy and to sometimes experience their therapists as caring and likable (Table 3-4, p. 79), but their internalized representations of others and of themselves are partial and polarized, typically leading to split-off, alternating idealized or persecutory perceptions of their therapists. As a result, they cannot establish a *reliable* collaborative working alliance until well into treatment, hence, the "myth of the alliance" described by Gerald Adler (13).

Along the way, Gunderson introduces pharmacotherapy; cognitive behavior therapies, including dialectical-behavior therapy and psychoeducation; family therapies, including suggestions for psychoeducational materials; and interpersonal group therapy. The detailed discussion of working with families of patients with borderline disorder as potential supports for their treatment, beginning with initial meetings and then establishing an alliance and on through psychoeducation to possible selectively used psychodynamic family therapy, is immensely helpful.

Gunderson is straightforward in regard to dynamic psychotherapy: appropriate patients need to be able to control their impulses and be introspective, psychologically minded, and motivated to change. Even so, the dropout rate is very high. Many psychiatrists, psychologists, social workers, and advance practice nurses are not interested in the issues borderline patients struggle with and are not competent to do psychotherapy with them. Those who are competent have their own lives together, are capable of "holding" patients, believe the patient is suffering and can change, are convinced they can help with issues of dependency and anger, and are themselves nothing less than attentive, authoritative, challenging, clear, confident, conscientious, durable, engaged, and responsive. Competence, not gender of the therapist, is the issue. Table 11-5 (p. 254) helps patients choose such a paragon of virtue as a therapist, and Table 12-5 (p. 272) lists the expectable ultimate results of intensive, long-term psychodynamic therapy.

According to Gunderson, patients move in therapy from engagement to a relational alliance, then through acceptance of a positive dependency on their therapists to secure attachment and a true working alliance, and, finally, to consolidation and integration of their selves. In the course of these phases of therapy, they need, at different junctures, both Gerald Adler's deficit-oriented Kohutian validating corrective relationship and Otto Kernberg's conflict-model interpretive transference analysis. These theoretical perambulations are judiciously sprinkled with examples of inquisitive, gentle, and nonauthoritarian interventions, Gunderson's style in conducting psychotherapy.

Throughout, Gunderson champions split treatment, i.e., treatment that involves "two treaters, two modalities, or any two components…e.g., hospital and psychotherapist, psychopharmacologist and family therapist, a primary clinician and self-assessment group" (p. 104) to safeguard the psychotherapist from becoming a "bad object" from which the patient must flee. I applaud the principle and goal of these suggestions. Unfortunately, such multiple modalities, other than two treaters, are not readily available in a noninstitutional, office-based practice where the vast majority of patients with borderline disorder are seen as outpatients. If it is difficult to find one competent psychiatrist for dynamic psychotherapy, as the author avers, what are the chances of finding two competent, independent professionals, in agreement on goals and methodology, to take care of a single borderline patient? Split treatment by two independent treaters, in a noninstitutional setting, is fraught with great dangers and difficulties for a person with borderline personality disorder. No one knows that better than Gunderson, who, together with Sara Bolton (14), has eloquently described the tragic result such split treatment had for a female physician with borderline personality disorder.

That said, this volume is a first-rate work of scholarship that I highly recommend to all those interested and involved in the treatment of persons with borderline personality disorder, including and especially psychiatric residents. Gunder-

son writes affectingly and gives an attuned, resonant account of the conflicted lives and deficits of these uncommitted people and the dilemmas their physicians face. The writing tempers rigor with compassion, is minutely detailed, and puts these dislocated people and our growing understanding of them into context. Gunderson's work and this book are admirable and immensely valuable achievements.

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Correction

The article "Topiramate in the Treatment of Binge Eating Disorder Associated With Obesity: A Randomized, Placebo-Controlled Trial" by Susan L. McElroy, M.D., et al. (February 2003; 160:255–261) contained an error in Table 1. The mean value for the body mass index of the placebo group should have been 42.0.