Retards, Rebels, & Slackers

by Jaina Bell; Philadelphia, Xlibris Corporation, 2001, 327 pages, $22.99 softcover

Jeffrey L. Geller, M.D., M.P.H.

In the tradition of *Mount Misery* (1) (written from the perspective of a psychiatrist), *Insanity, Inc.* (2) (a registered nurse), *Gentle Asylum* (3) (a social worker), and *One Flew Over the Cuckoo's Nest* (4) (a research subject), Jaina Bell's novel, *Retards, Rebels, & Slackers,* is based on the author's experiences in the greater world of mental health care—in this case as a residential staff person in a community home for individuals with mental retardation. It is clear that the "retards" component of Bell's title refers to the residents who have developmental disabilities and that "slackers" refers to many of the staff. Who the "rebels" are is unclear.

Bell's novel is potentially dangerous in the same way that Kesey's *One Flew Over the Cuckoo's Nest* was. The uninformed were frightened by Kesey's portrayal of electroconvulsive therapy, a portrayal that has had a ripple effect to this very day. Bell paints a picture of the community residential program for individuals with developmental disabilities that would make most people shudder at the thought that one of their relatives or someone they cared about resided in such a facility.

The individuals who live in the various residential programs under the auspices of the provider agency for which Bell works are best characterized as having moderate to severe mental retardation. Some of these individuals are verbal, and some are not. Although a few are docile, many are assaultive and attack other residents and staff. Biting is a frequent means of assault. As much as Bell paints a picture of the clients as misfits, she provides an even more dramatic portrayal of the staff as misfits.

Many of the staff, including Bell, are themselves homeless and sleep at the residential facility whether they are on duty or not. On- and off-duty activities include drinking alcohol, smoking marijuana, using cocaine, making drug deals, and having sexual intercourse. The sexual intercourse is confined to the staff—there is no evidence of sexual abuse of residents.

The staff's interactions with the developmentally disabled residents include affectionately calling them "retards" and intermittently being sadistic—toying with the residents for kicks and administering extra doses of antipsychotic medication, which are hidden in the residents' food. An analogy is made between training "the low functioning D.D's" and training a dog. The staff make statements such as, "Working here is like being trapped in a cartoon." On the other hand, the staff come across as caring and supportive, becoming angry with people in the community who discriminate against their clients.

People who are concerned about whether individuals with developmental disabilities who live outside large institutional settings, such as developmental centers or state schools, receive appropriate medications will get no reassurance from this novel: "I went to McCurdy's room to get her up and give her her Lithium, I got Nerissa up and gave her her Haldol, and I gave Sadie her big handful of drugs, which included Mellaril, Risperdal, Prozac, and Thorazine. Sadie was insane."

There is an interesting subtext of the staff's struggling to balance respect of clients' rights on one hand against protection from the outside world on the other. Unfortunately, sometimes staff resort to what amounts to physical abuse of clients to "get them going." As is portrayed in the novel, it is not always clear that the underpaid, undereducated, and underappreciated staff always have choices. It really is as if they live in a war zone.

The book describes emergency after emergency requiring outside interventions from paramedics and from the police. These "outsiders" frequently inquire about the appropriateness of the residents' living in the kind of facility portrayed in the novel: "Does she really need to be living in a home like this? Don't you think she belongs in the state hospital?" asks one of the paramedics on one of many rescue missions.

The stress and strain on the staff are well portrayed. As Bell says, "My spirit was in limbo, suspended above this drama, waiting anxiously for me to get out, and get on with my life, I couldn't do this indefinitely." Dealing with diapered and intermittently incontinent adults, some of whom have hepatitis and seem unable to learn from experience, is, as portrayed in the novel, simply overwhelming. The behavior of one resident who is being tested for hepatitis is described as follows: "Dennis came down the hall from his room, hands down his pants, he pulled them out, and trailed shit along the walls, his feces-covered hands finally coming to rest on the kitchen table."

The various plots are basically much less important than the descriptions and the general sense of life the book conveys. Near the end of the novel, the agency for whom the staff works goes bankrupt, and a much more "politically correct" agency takes over. Although this group does things by the book, there are many indications that doing things this way is actually less humane than the care provided by the "slackers." The reader is left wondering whether the individuals living in these residential programs would be better off if most of the time they had no staff present whatsoever—a condition I once encoun-

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tered and described in the book *Psychiatric House Calls* (5).

Who should read *Retards, Rebels, & Slackers*? I have no idea! Certainly not the uninitiated, for they will be frightened and misled; probably not the well initiated, for they may feel that their reading experience is no more than a busman's holiday; and most likely not policy makers and politicians, who, in this climate, could take this information as a basis for defunding adult residences for persons with developmental disabilities. It is unfortunate that it would be better if a large percentage of the potential readership never read the book, because the book is as engaging and entertaining as much of the fiction currently available. Maybe you, the readership of *Psychiatric Services,* could read *Retards, Rebels, & Slackers* and let me know who you think its audience is.

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A Handbook for Correctional Psychologists: Guidance for the Prison Practitioner

by Kevin M. Correia, Ph.D.; Springfield, Illinois, Charles C. Thomas Publisher Ltd., 2001, 179 pages, $44.95

Melissa G. Warren, Ph.D.

The title of this highly readable volume belies its broad appeal. Only one of its eight chapters—the chapter devoted to assessment using the Minnesota Multiphasic Personality Inventory, the Millon Clinical Multiaxial Inventory, and the Rorschach—might be seen as restricted in its utility. Psychiatrists, social workers, psychiatric nurses, and members of any discipline that contributes to mental health services in correctional settings will find much useful information in *A Handbook for Correctional Psychologists: Guidance for the Prison Practitioner,* conveyed in a conversational style. Subject and author indexes, a reference list, and a detailed table of contents that lists sections within chapters render the book easy to use as a quick guide.

The impetus for the book was the author's desire to describe correctional mental health to prospective recruits. His two stated purposes—to counter common misbeliefs about working in prisons and to provide a basic resource for professionals who work in corrections—have been achieved. Correia points out that corrections is a growth industry and that mental health professionals, just like general medical staff, are in demand.

The book's title gives an indication of an important caveat. The descriptions and recommendations are derived from Correia's many years of experience in the Federal Bureau of Prisons—the book might have been titled "One Psychologist's Life in the Bureau of Prisons." The dominance of psychology is one of many significant differences between federal and state correctional systems. Those differences are not made explicit in the book. Readers who are not familiar with the wide range of variability found in corrections run the risk of overgeneralizing to settings in which the book may not apply. (According to the Bureau of Justice Statistics, at the end of 2001 the total number of prisoners in adult correctional facilities was 1,406,031. Only 156,993 were in federal custody, whereas 1,249,038 were in state prisons. Mental health providers are therefore more likely to work in either jails or state prisons [1].)

Most state correctional systems do not organize their mental health services in the same way that the Bureau of Prisons does. Yet some of the recommendations in this book rest on practices that are unique to that setting. The mixed mission of psychology in the Bureau of Prisons, which extends well beyond providing services to inmates, is atypical. Mental health professionals do not usually provide employee assistance programs to custodial staff. Nor are they trained as corrections officers and occasionally deployed in custodial roles, as occurs in the Bureau of Prisons. Furthermore, a section in the book about confidentiality does not comport with widely accepted guidelines, standards, and professional practices.

One excellent recommendation Correia makes is that the best way to learn about a correctional institution is to walk around in it. Not only do the closed perimeters of prisons render them secret societies in the eyes of the outside world; inside, most prisons are worlds within worlds. Even if entry is granted, considerable effort may be required to visit those worlds. Overcoming physical barriers, such as a series of locked gates or large geographic distances, can be costly in terms of time and convenience. Social barriers may be even more formidable. Mental health professionals are accustomed to working in teams located in clinics or offices. Venturing alone down long, locked corridors that lead to cell blocks, dormitories, or yards where hundreds of inmates may be supervised by a handful of officers does not come naturally to many civilians. Being the only mental health professional among scores of uniformed personnel requires that social constraints be broken down

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but is likely to be rewarded by valuable observations and much situational learning.

One of the most intellectually stimulating aspects of working in corrections is the variety of experiences that will be encountered. The primary mission of all correctional facilities is security and control. Each facility achieves its primary mission differently, as well as its secondary missions, such as food distribution, medical care, recreation, and the maintenance of certain minimally acceptable conditions of confinement. Prisons are like schools in that having a common mission does not bring uniformity. Like schools, prisons each have their own personality and favored methods that develop the force of law. Like those in small towns, the networks of personal and social relationships, particularly among the staff, are deep and of a complex weave.

The effectiveness of mental health services is enhanced, specialized knowledge increases, and professional fulfillment becomes more likely when mental health staff join the community outside the clinic. Entire programs, as well as single-episode interventions, may be compromised or negated if they are not both well designed and integrated into the institution as a whole. Skilled clinicians and medical administrators who understand systems are likely to find corrections a fascinating field.

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Machinery of Death: The Reality of America's Death Penalty Regime

edited by David R. Dow and Mark Dow; New York, Rutledge, 2002, 304 pages, $17.95

Margaret M. Chaplin, M.D.

In the spring of 2002, the Supreme Court put an end to the execution of mentally retarded persons, citing "evolving standards of decency" (1). At first brush this phrase is puzzling. How could our sense of decency evolve? Isn't decency an absolute? Don't we all innately know what is decent and what is not? *Machinery of Death: The Reality of America's Death Penalty Regime*, a compilation of testimonial essays brought together by death penalty lawyer David Dow and journalist Mark Dow, builds the case that the death penalty in any form is irrefutably and inexcusably not decent. The editors bring together the voices of lawyers, prison personnel, and relatives of murder victims to bear witness to the reality of the death penalty in America.

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Christopher Hitchens sets the tone in the foreword by reframing the death penalty dilemma. He argues that the issue is not one of whether we execute innocent people (we do) but of when and how we will put an end to the death penalty altogether. He tells us of former Supreme Court justice Harry Blackmun's epiphany that the death penalty, linked as it is to human fallibility, is unworkable. Blackmun, he reports, was a staunch supporter of the death penalty through part of two decades before reversing himself with the memorable phrase, "I shall no longer tinker with the machinery of death." Why? Because "the inevitability of factual, legal, and moral error gives us a system that we know must wrongly kill some defendants."

The next 16 chapters show with shocking, heartrending, factual detail just how true this conclusion is. Each essay is thought-provoking and harrowing, delineating in case after case the inevitability of missteps of justice from the entrenched racial biases to the often abysmal representation available to the poor and disenfranchised.

The final two chapters, written by family members of victims, go one step further, arguing that even when there is no doubt of guilt, the death penalty is wrong. Bud Welch, whose daughter died in the Oklahoma City bombing, writes of the evolution of his own healing from raw anger with its desperate need for retaliation to his conviction that executing those who have wronged us only fuels hate and thwarts healing. Similarly, Renny Cushing, whose father was senselessly and violently murdered, writes, "The idea that I would be healed, that any murder victim would be healed, by inflicting pain upon . . . the family of a murderer is nonsense. Life is not a zero-sum game. My pain does not get eased by inflicting pain on another."

The book is intended as an exposé for a lay (nonlegal) audience. The intense subject matter sets it apart from other books of this genre. It does not make for light reading. Why should mental health professionals read this book? Certainly, far too many of our patients are on death row or at risk of being on death row, victims of their own untreated psychosis (although the book does not address this directly). However, I believe we need to read this book for a more compelling reason. As mental health professionals, we deal with life stories and with helping people survive emotional insults and atrocities; we struggle with the difficult reality that the deepest psychic injuries are those human beings inflict upon one another. Is this an absolute of the human condition, or is there some hope that we may someday outgrow man's inhumanity to man? In the crucible of the machinery of death, our thinking about human decency is challenged to evolve.

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Infanticide: Psychosocial and Legal Perspectives on Mothers Who Kill

edited by Margaret G. Spinelli, M.D.; Washington, D.C., American Psychiatric Publishing, Inc., 2003, 300 pages, $49.95

Phillip J. Resnick, M.D.
Susan Hatters-Friedman, M.D.

The stated goals of this edited volume are to provide background for future research endeavors in identifying women who are at risk of committing infanticide and to help attorneys and mental health experts who participate in infanticide criminal cases. *Infanticide: Psychosocial and Legal Perspectives on Mothers Who Kill* gives very good coverage to a variety of topics, including postpartum mental illnesses, denial of pregnancy, epidemiology of infanticide, and legal issues related to infanticide. Most chapter authors are nationally known experts. Laura J. Miller, M.D., provides an excellent discussion of pregnancy denial, and the chapters by Katherine L. Wisner, M.D., M.S., and coauthors and by Debra Sichel, M.D., present useful information about postpartum disorders in an easily understood manner.

Spinelli's chapter on neonaticide—murder of the newborn during the first 24 hours of life—is one of the less scientifically based chapters, making broad generalizations that are not supported by the author's evidence. Spinelli reports on forensic interviews, largely requested by the defense, of 16 women charged with neonaticide and one charged with attempted neonaticide. A majority of the defendants' scores on the Dissociative Experiences Scale (DES) suggested dissociative disorders. However, the DES is easy to fake in the absence of measures for malingering. Mendlowicz and associates (1) observed that the accused women were given "an extensive checklist of mental symptoms [that] may inadvertently educate them about psychiatric symptoms" in order to provide a defense for their actions. Spinelli suggests that when these women went into labor, they often did not realize it was labor. She adds, "Because the reality was intolerable, a brief dissociative psychosis occurred. On reintegration, they could not account for the dead infant."

In contrast, authors in multiple countries (2–4) have reported that neonaticide is primarily a phenomenon of nonpsychiatrically ill young mothers who kill their unwanted infants in desperation. Spinelli's work is useful in that it offers an alternative way to view neonaticide in specific cases. However, her suggestion that dissociation predominates in neonaticides is not consistent with other studies and may be due to referral bias.

The book includes a thorough analysis of legal defenses presented in infanticide cases. In several chapters, authors search for ways to relieve young women of responsibility when they may or may not have a valid defense. One chapter author, Judith Macfarlane, J.D., suggests the "involuntary act defense" as well as the insanity defense, stating that "in many cases the mother fails to rescue her baby from a toilet or is unable to move subsequent to delivery and thus leaves the child to die. . . . Depersonalization disorder may be a good defense . . . since this dissociative state leaves the mother with the sensation that she is unable to control her own movements."

Macfarlane also argues for the unsubstantiated "neonaticide syndrome," which thus far the courts have wisely rejected (5). No act alone should be allowed to define an illness. For example, "homicidal insanity," a form of "moral insanity," was a defense in the 1800s. It was ultimately rejected as having no valid scientific basis.

We do recommend this book to clinicians treating women of childbearing age and to attorneys seeking to increase their knowledge about perinatal mental illnesses. Hopefully, the contributions of various authors can lead to earlier identification of women at risk of harming their children to avoid these tragedies. "The murder of one single child is made negligible by nothing, not even Hiroshima" (6).

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Interviews With Brief Therapy Experts

by Michael F. Hoyt, Ph.D.; Philadelphia, Brunner-Routledge, 2001, 307 pages, $34.95

Kate Eisenmenger, M.D.

Michael F. Hoyt, the author of *Interviews With Brief Therapy Experts*, is a family therapist and senior psychologist with Kaiser Permanente in California who writes and teaches about brief therapy and its relationship to managed care. The text contains 11 interviews that Hoyt conducted between 1992 and 1998 with individuals who helped develop the brief therapies he terms "constructive therapies." Hoyt assumes that the reader is familiar with social

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constructionist principles and Milton Erickson's work—both are referred to frequently but not explained. Even the individuals interviewed are given scant introduction beyond a list of their publications. A description of their contributions to the field might have made this book more coherent.

Despite the author's avowed goal to explore technical, theoretical, and ethical aspects of the theory and practice of brief therapy, one suspects that this was not necessarily the defined goal at the time each of these interviews was conducted. This is not to say that the interviews aren't interesting. This is an eclectic collection. Some interviews are structured and focused, some conversational and meandering. In one of the best interviews, Donald Meichenbaum articulately describes his rationale for combining a narrative constructionist approach with a cognitive-behavioral model in the treatment of posttraumatic stress disorder. In another chapter, Bill O'Hanlon thoughtfully discusses how he has used the techniques of Carl Rogers, hearing and acknowledging the felt experiences to modify a solution-oriented approach in working with sexual abuse. With the exception of these interviews, the treatment of significant psychiatric illness is not addressed. One interview contains a very personal account of how life events shaped a therapist's approach to clinical work. Other interviews contain esoteric discussions of theory, hermeneutics, and whether it is possible to "know reality."

The unifying themes of these conversations are a concern with the potential of psychotherapy to dehumanize and demoralize through the use of pathologically based language and an awareness of how the intrinsic power imbalance in the therapeutic relationship may lead to the imposition of agendas that are inconsistent with a client's goals.

These therapies attempt to address these issues through the use of both language and the conduct of the therapeutic interaction to promote empowerment and self-respect. They focus on identifying strengths, collaboratively defining goals, and devising solutions. The fundamental structure and techniques of this work are cognitive-behavioral in orientation: defining a specific problem and monitoring progress toward a goal in behavioral terms, with clearly defined responsibilities of both the client and the therapist. The emphasis is on experiential learning that leads to change, as opposed to understanding or insight.

In sum, *Interviews With Brief Therapy Experts* is not an introduction to this therapeutic approach and will be most appreciated by those who are already familiar with the work and the theoretical orientation of those interviewed. However, the structure of the book—a set of self-contained interviews that can be read in any order and a readable, nonpedantic text—has its appeal. The collection, although perhaps lacking in depth, may cover enough ground to be thought-provoking to those who are interested in the puzzle of how to help suffering people grow.

Beginnings: The Art and Science of Planning Psychotherapy

by Mary Jo Peebles-Kleiger; Hillsdale, New Jersey, Analytic Press, 2002, 344 pages, $49.95

E. James Lieberman, M.D., M.P.H.

The title of this important book seems to understate the book's importance to all therapists—it is not just for beginners, but for anyone who wants a broad and deep survey of what we do to help patients and how to do it better. The author writes clearly, with a broad foundation, giving case illustrations that reveal her humanity as well as her authority, and provides some precious pearls—for example, "Allowing the unpredictable to emerge is the art; learning from the unpredictable is the science."

Mary Jo Peebles-Kleiger, Ph.D., is a psychoanalyst in Bethesda, Maryland, who spent nearly 20 years at the Menninger Clinic. She is board certified in clinical psychology and hypnosis. *Beginnings: The Art and Science of Planning Psychotherapy* is divided into 22 chapters, some with summary tables and charts. Starting with diagnosis and history taking, the author devotes the middle section to two main issues—the concept of underlying disturbance, and enhancing the ability to form an alliance. The former comprises deficit, characterologic dysfunction, conflict, and trauma; the latter includes reality testing, reasoning, emotional regulation, relatedness, and conscience. A chapter is devoted to each of these elements. The book closes with chapters on the psychological costs of change, the patient's learning style, expectations, and priorities and modalities.

The author balances structure with openness, control with spontaneity, and clinical observation with genuine openness to the patient's point of view. Transference exists, but so does focus: "Gone is the notion of a pure transference uncontaminated by the therapist's influence. Instead, interaction between patient and therapist is now considered to be a co-creation of the patient's inner world resonating with the analyst's inner world" (29). The author's understanding of and respect for a variety of theories and modalities finds expression in a summary table of theoretical schools, an acceptance of multiple hypotheses, and a commitment to "disciplined subjectivity."

Evidently the author's experience with family therapy is limited. Although she gives an example of its use as an adjunct, she does not see it as a major modality. And the simple (uninterpreted) family genogram as an

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aid in selective history taking is not mentioned. It is useful in teaching residents and medical students; it provides graphic help in recalling family data and in making concise case presentations.

This is a volume full of ideas, clinical examples, splendid organization, integration of theory, citation of relevant research, and wisdom. For example, "provocation is a sign that the other person is threatened." And, to a dithering patient, "I can see that you're having trouble responding to me right now. Can you tell me more about what is happening?" The bibliography contains some 450 references, and the name index runs to seven pages, whereas the subject index seems a little thin at five pages. In all, the book's organic integrity and its combination of humility and optimism that come with mature experience make it an exemplary companion for therapists of any background in any stage of their career.

Polypharmacy in Psychiatry

edited by S. Nassir Ghaemi; New York, Marcel Dekker, 2002, 346 pages, $135

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In general medicine, polypharmacy is a well-known and generally accepted practice that is often required in order to treat the complications of many disease states. Persons with asthma, for example, often require two or more inhalers as well as medication in tablet or capsule form for control of symptoms. In psychiatry, however, the practice of polypharmacy is generally considered to be taboo, and we are taught to avoid it or to use it only as a last resort in a patient's care. But just as asthma has many different causes, complications, and symptoms that need to be treated, so do psychiatric illnesses—maybe more so.

Polypharmacy in Psychiatry is firmly grounded, thoughtfully written, and well balanced in its presentation and identification of the role of rational polypharmacy in psychiatry. S. Nassir Ghaemi, the book's editor, addresses many of the issues we struggle with on a daily basis and provides a comprehensive, well-rounded picture of the pros and cons of polypsychopharmacology.

The book begins by addressing the origin of polypharmacy in psychiatry, dating back to the mid–19th century. The history of this "taboo" is explained in exquisite depth in the first chapter, whose authors set forth to review the practice of polypharmacy from its historical roots through the psychopharmacological revolution and to the present day. The book includes major reviews and offers much needed interdisciplinary insight into polypsychopharmacological issues pertaining to many of the major *DSM* diagnoses, such as schizophrenia, bipolar disorder, and posttraumatic stress disorder. Approaches to polypharmacy are discussed from the perspective of the disease, the type of drug, and the population—for example, high-risk populations, children, and medically compromised individuals. Issues surrounding "rational" as well as "irrational" polypharmacy are addressed in each of these contexts.

Polypharmacy in Psychiatry is a well-referenced and unbiased presentation of much of today's issues of psychopharmacological care. Psychiatrists, pharmacists, nurses, social workers—anyone who works with psychotropic drugs—will benefit from this book. It gives a skillful overview of major controversies in psychopharmacological polypharmacy and summarizes much of the literature on current polypharmacy prescribing trends in psychiatry. Such a complete, detailed, and well-researched reference was long overdue in psychiatry.

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The Illusion of Conscious Will

by Daniel M. Wegner; Cambridge, Massachusetts, Bradford Books, 2002, 405 pages, $34.95

David Brizer, M.D.

André Breton, psychiatrist-manque and founder of the surrealist movement, defined surrealism as "the chance meeting on an operating table of an umbrella and a sewing machine." Of automatic writing—the practice of emptying the mind so that its covert contents can erupt untrammeled upon the page (the preceding definition being a prime example of same)—Breton wrote, "We shall not weary of repeating that a few lines of genuine automatic writing . . . which succeeds in freeing itself from utilitarian, rational, aesthetic, and moral imperatives . . . still contain too many gleams of the philosopher's stone for us not to repudiate the mean and miserable world that is inflicted on us" (1).

Daniel Wegner's *The Illusion of Conscious Will* is a marvelous and learned excursion, a Baedeker's—or Fodor's, if you prefer—into the pellucid hinterland between will, consciousness, preconsciousness, subconsciousness, and, as Wegner terms it, "surconciousness." Automatic writing is but one of the many pyrotechnic feats the brain may be capable of without conscious direction. Wegner, a professor of psychology at Harvard, delights his audience with the breadth and depth of his familiarity with his subject.

The book, a distillate of the best and wisest observations from behavioral research, philosophy, epistemology, and circus sideshow acts, challenges readers to reconsider the universal belief in free will. Through ample humorous and learned examples culled from psychopathological arcana of everyday life as well as from numerous relevant scientific studies, Wegner succeeds in demonstrating what turns out to be a vast behavioral "dead zone" that never sees the light

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of conscious intent, of "will."

Ranging from discussions of ideomotor behaviors to hypnotic suggestibility to dissociative episodes to voodoo death, *The Illusion of Conscious Will* attacks with gusto the notion that conscious intent always precedes voluntary-seeming behavior. Rather, Wegner argues, "will," the subjective experience of volition, is a feeling, an epiphenomenon, that usually but not always accompanies "intentional" acts.

The discussions and illustrations of table turning, of Ouija board readings, and of mesmerism and 19th-century spiritualism in general are terrific fun and really promote the thesis that ordinary waking consciousness—in which we usually include willed, voluntary action—is but a tiny Plato's cave. Beyond the cave are galaxies of neural connections and social triggers as old as the limbic system itself. Untampered with, these work on their own to promote the organism's tropisms, preferences, appetites, and, I suppose, propagation. Conscious will serves as a timekeeper, an identity marker, a feeling that we have somehow originated or participated in an action. Without the personal stamp of memory, without the feeling that "I" did this or that, the world becomes a sump, stripped of milestones, of cognitive benchmarks, and as participants we become identity-less, unanchored, essentially demented.

Wegner is not arguing a mechanistic, fatalistic universe. It's not that we are robots, programmed from conception to a slate of irreversible decisions. Conscious will is a tool, icing on the cake as it were, that facilitates motivation, drive, and awareness.

Why is this important? The subject is searingly relevant to anyone who would better understand behavior, and to everyone who has a theoretical basis for the practice of altering patients' behavior. It is burningly relevant to practitioners of cognitive therapy, to those who give their patients pep talks, and especially to those of us who believe that conscious intent somehow refracts into neural subprograms ("unconsciousness" and "subconsciousness") that end up having all kinds of ripple effects in turn on health, immune function, self-regard, and self-navigation through the choppy seas of the world.

The book jacket depicts a baby automaton making its way thanks to the merry engagement of well-oiled sprockets and gears. Is that all there is? The beauty and brilliance of this volume is that the question, itself an intricate clockworks, is opened and examined from almost every perspective. Wegner is a terrific writer, sharing his encyclopedic purchase on the material in amusing, entertaining, and masterful ways. A kind of psychologic Ricky Jay, he opens the Pandora's box of mind and joyfully debunks the reflex assumptions of several millenia. (I know I consciously chose to read the volume!)

This was a book I could not skim. Treat yourself to a frontal cut today.

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Asian American Mental Health: Assessment Theories and Methods

edited by Karen S. Kurasaki, Sumie Okazaki, and Stanley Sue; New York, Kluwer Academic/Plenum Publishers, 2002, 345 pages, $95

Russell Lim, M.D.

This book offers a comprehensive look at the assessment of the mental health of Asian Americans. *Asian American Mental Health: Assessment Theories and Methods* contains 21 chapters, written by experts in the field of assessment in Asian American mental health and organized into five sections: cultural relevance of diagnostic categories, sociocultural variables, psychometric equivalence across cultures, culturally informed assessment, and conclusions. The book will be most useful to researchers in psychology and psychiatry who wish to use psychometric measures with patients, but it will also be useful to trainees and training directors who need to review the literature on the assessment of Asian Americans as well as to graduate students learning about multicultural issues in assessment.

Asian American Mental Health is a critical review of the literature and arose from a conference held in 1998 that explored the state of the art of the assessment of the mental health of Asian Americans. For the most part, the individual chapters are very good, although a few are uneven and difficult to read. The book assumes a certain degree of familiarity with psychological terms, constructs, and measures. I particularly liked the chapters on *DSM-IV*—one by Richard H. Dana and another by Keh-Ming Lin and Margaret Lin—which discuss the role of *DSM-IV* in diagnosis and how the manual is not appropriate for diagnosing psychiatric illnesses among Asian American patients. Also good is a chapter by Nolan Zane and May Yeh on the importance of considering "loss of face."

Other chapters discuss important concepts such as acculturation, self-construal, and cultural orientation. Sections 3 and 4 are useful for understanding how measures that were developed for Western patients need to be adapted for use with Asian Americans, such as personality inventories, concepts of depression, measures of parenting, educational assessment, and cognitive testing, as well as developing new methodologies for use in epidemiologic studies with Asian Americans, using ethnologies with Asian Americans, and developing new measures of cultural competence in counseling and in mental health delivery systems.

Also included are some very practi-

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cal chapters, such as one describing methods of evaluating Asian American children and another about career counseling with Asian Americans. All the chapters emphasize the need for adapting known methods or developing new ones to accurately assess Asian Americans from many different ethnic backgrounds and levels of acculturation.

I enjoyed *Asian American Mental Health* very much, as the overall tone is to explain the research that has already been conducted on many topics, to explore the limitations of this research, and to suggest directions for further research. The book's primary usefulness will be as an important reference text for researchers in Asian American mental health and graduate students in counseling and psychology. For a good clinical reference, I would suggest *Working With Asian Americans,* edited by Evelyn Lee (1).

Reference

1. Lee E (ed): Working With Asian Americans. New York, Guilford, 1997

Multiculturalism and the Therapeutic Process

by Judith Mishne; New York, Guilford Press, 2002, 259 pages, $35

Giovanni Caracci, M.D.

The changing demographic pattern of the United States, with its increasingly multiethnic and multicultural population, is having a profound impact on clinical practice and training. In this context, Judith Mishne's book—*Multiculturalism and the Therapeutic Process*—represents a comprehensive effort to deliver culturally competent care to immigrants and patients from diverse cultural and ethnic backgrounds.

Dr. Mishne, a professor at the Shirley M. Ehrenkranz School of Social Work of New York University, is an experienced psychotherapist who draws from traditional psychoanalytic concepts, self-psychology, and object relation theories to demonstrate how culturally informed psychotherapy can be successfully applied in cross-cultural practice. She says, "The book aims to provide a clear and comprehensive presentation of the fundamentals of cross-cultural psychotherapy," and "at the conclusion of the book I hope the reader will be able to see and feel the impact of culture and ethnicity on the treatment process and in the patients' life."

Multiculturalism and the Therapeutic Process is divided into four parts. Part 1 is an overview of cross-cultural treatment considerations. Starting from the 1950s, the author traces a historical outline of how conceptions of culturally responsive clinical practice have shifted through the decades, reflecting changing paradigms in psychotherapy as well as patterns of immigration. Part 2 deals with the beginning phase of the treatment process. The essential principles of assessment and diagnosis of culturally diverse individuals and the crucially important phase of engagement and therapeutic alliance are skillfully articulated with a detailed discussion of case examples from the authors' experience. In part 3, which covers the middle phase and the treatment process, the author discusses, among other things, transference, countertransference, resistance, and defenses within a culturally competent therapeutic framework, again citing case examples. Part 4, which deals with the end phase of the treatment process, offers insightful suggestions for working through the termination phase.

Overall, the book has several strengths. It is well structured and strikes a good balance between the discussion of theoretical constructs and their application in clinical practice. Dr. Mishne is able to make a carefully crafted and powerful argument for using a psychoanalytic perspective both in the understanding of our patients' ethnocultural intricacies and in the application of specific techniques of psychodynamic therapy within the cross-cultural dyad. Moreover, the wealth of case examples to illustrate the author's model is rarely seen in today's books about cultural mental health. These examples help the reader recognize the clinician's struggle to hear the patient's issues as well as the patient's own struggle to be understood within his or her own unique cultural and ethnic context.

The book is written in a clear, concise, and practical style, an important element that transforms complex and sensitive material into enjoyable reading. In addition, I found all of its chapters to be well referenced. In my view this effort deals a major blow to the myth that psychoanalytic approaches are poorly effective in cross-cultural work.

In sum, *Multiculturalism and the Therapeutic Process* more than surpasses its stated goals. It will be very useful for clinicians, students, and educators. I intend to use this scholarly and well-written volume in the supervision of my psychiatric residents. In addition, the book will prove to be a valuable text for training sessions and research we conduct at our cultural competence center.

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