

Better but Not Well: Mental Health Policy in the United States Since 1950

by Richard G. Frank and Sherry A. Glied; Baltimore, Johns Hopkins University Press, 2006, 208 pages, \$21.95

William H. Fisher, Ph.D.

As illustrated by Jeffrey Geller's (1) overview of 50 years of discussions regarding psychiatric services, the last half of the 20th century was a time of major upheaval in the delivery of mental health services. From the late 1970s to the early 1990s a number of volumes by historians, sociologists, policy analysts, and psychiatrists provided narrative for these events (2–5). The 1990s—which saw the introduction of managed care, privatization, redoubled efforts to close state hospitals, and the ascendancy of Medicaid as a major driving force in mental health service delivery—were in many ways the culmination of the events of the preceding 40 years. But just as things got really interesting, the pace of narrative production in the form of books diminished. Someone needed to succinctly tie together the policy, organization, financing, clinical, and philosophical threads that constitute the fabric of current mental health policy in a succinct overview that could be read and understood by a wide audience. In *Better but Not Well* Richard Frank and Sherry Glied address that need admirably.

Better but Not Well, a title recycled from a paper written in the 1970s by the late Gerald Klerman (5), begins with an overview of what is known about the prevalence of mental illness from current epidemiological studies. The book then proceeds to describe research regarding the status of contemporary treatment approaches for psychiatric disorders. The next two chapters deal with how that treatment is funded and the changing landscape of systems for delivering that treatment. The sixth chapter suc-

cinctly outlines the status of mental health policy and briefly describes the historical processes that created the current policy environment. Chapter 7 summarizes current data on the well-being of persons with mental illness—a discussion that fits particularly well in the context of the chapters leading up to it. In some ways, this chapter answers the question “What has been the product of the last half century's efforts?”

As the book's title suggests, the authors argue that the status of persons with psychiatric disabilities has improved significantly in the past 50 years in a host of different dimensions but still is not where it could or should be. In the final chapter the authors suggest reforms for further improving the lives of persons with psychiatric disorders. Their observations are responsive to those of Rosalynn Carter, who, in her foreword to the book, argues that progress has been attempted but in some cases thwarted politically and that much reform remains to be accomplished.

The subtitle of this book led me to

expect a dense, massive tome. It is anything but. It provides a wealth of information but contextualizes that information extremely well. As such, it will serve for many years as a useful reference for persons working in this field. The book is also an amazingly good read for one providing so much information and could easily be assigned to advanced undergraduates and graduate students. But *Better but Not Well* should be assigned to every practitioner, mental health clinician, administrator, and advocate—as well as every legislator and policy maker—concerned with the status of Americans with serious mental illness and what might be done to improve it. ♦

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The Dilemma of Federal Mental Health Policy: Radical Reform or Incremental Change?

by Gerald N. Grob and Howard H. Goldman; New Brunswick, New Jersey, Rutgers University Press, 2007, 226 pages, \$44.95

Scott E. Provost, M.M., M.S.W.

An important question in social policy analysis is “what kinds of patterns exist in policymaking activity over time?” (1). It is rare that a publication sufficiently elucidates both the historical forces and policy initiatives impacting the organization and delivery of mental health treatment. Written by historian Gerald Grob and Howard Goldman, a policy researcher and editor of *Psychiatric*

Services, *The Dilemma of Federal Mental Health Policy* is an important contribution to the field.

The authors focus on policy changes since 1942 that affect adults with severe and persistent mental illness and describe the people, events,

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and legislation influencing mental health policy. Notable examples include the Joint Commission on Mental Illness and Mental Health, the Community Mental Health Centers Act of 1963, the President's Commission on Mental Health, the Community Support Program, the Omnibus Budget Reconciliation Act of 1981, the 1999 Surgeon General's report on mental health, and the New Freedom Commission on Mental Health. The book also contains a helpful list of acronyms. The major theme of the book is that mental health policy reform efforts have either been incremental or radical and have often ignored individuals with severe and persistent mental illness.

Not surprisingly, the book reads like a historical account of mental health policy. Stories of the people who have played integral roles in developing mental health policy are especially intriguing. A major strength of the book is that it highlights how rhetoric and ideology rather than empirical evidence fueled the establishment of community mental health centers. To emphasize important points, the authors include practical pieces of policy insight based on their first-hand experiences. For example, in comparing the President's Commission on Mental Health (PCMH) to the recent New Freedom Commission on Mental Health, the authors note that "both commissions were expected to recommend far-reaching changes, yet the lesson of the PCMH was that fundamental change was elusive, but small sequential steps guided by a specific set of recommendations were more likely to bear fruit."

One weakness is that the authors did not examine the role that the recent Institute of Medicine report (2) on the quality of mental health and substance abuse treatment may have in future mental health policy reform. Surprisingly, the book does not include any tables, graphs, or figures to illustrate trends. At a minimum, a chart showing a timeline of significant events would have been helpful.

Readers of *Psychiatric Services* will find this book relevant and informative. The book will be suitable as a

primary text for courses in mental health policy and services research, as well as a supplemental book for general health policy courses. Readers may want to compare this book with Richard Frank's and Sherry Glied's recent book that examines mental health policy changes from an economic perspective (3) [See the review on page 881]. David Rochefort's text (1) would also be a useful companion to this book for those interested in understanding conceptual frameworks applied to mental health policy analysis. In fact, Rochefort's thesis that mental health policy represents a cyclical model of change is consistent

with Grob and Goldman's narrative. Hopefully future reforms, whether radical, incremental, or cyclical, do not repeat past failures and ignore the needs of individuals with severe and chronic mental illness. ♦

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Evidence-Based Practices in Mental Health: Debate and Dialogue on the Fundamental Questions

edited by John C. Norcross, Larry E. Beutler, and Ronald F. Levant; Washington, D.C., American Psychological Association, 2006, 435 pages, \$49.95

Timothy B. Sullivan, M.D.

As I read a professional text such as *Evidence-Based Practices in Mental Health*, the thought occurs to me that I wish to see a live staging of the material I am reading. Most of what I read for work is a bit dry for that sort of treatment, though there are exceptions: fine clinical narratives, first-person accounts, and the like. But this book is unique, and, although you may wonder at my fancy, I hope my explanation will help you to understand my wish, and more substantively, to appreciate this text and why it is important to mental health practice.

Like me, you may have found yourself wondering why outcomes in your practice don't follow the predicted course charted by the literature or why patients you see don't conform to traditional nosology. And you may have worried whether, with your particular background and training, you are providing the best evidence-based practice or found that insurers or regulators with whom you interact are threatening not to pay for treatment that does not meet an evidence-based practice standard. You may even have read

about controversies within the academic community regarding the validity, or advisability, of translating evidence-based practices into standard clinical settings (1).

If so, you will be intrigued, even fascinated, by this book, which seeks to objectively explore these and other questions. In so doing, the book helps to guide our allied professions toward a future when we may hope to treat patients effectively, consistently, and humanely, with individuality and respect for the uniqueness of each patient, each clinician, and each clinical context.

The editors, who each also contribute a chapter, set as their agenda the examination of "nine fundamental questions" facing the mental health field with regard to the adoption of evidence-based practices in clinical settings. Chapters include "What Qualifies as Evidence of Effective Practice?" "Does Manualiza-

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tion Improve Therapy Outcomes?" "Are Research Patients and Clinical Trials Representative of Clinical Practice?" "What Should Be Validated?" and so forth. Respected practitioners and researchers were recruited to contribute position papers, which form a kind of pro-and-con debate, as many of us have previously seen in journals. What is unique about this format is both the depth of examination, the breadth of perspectives, and the effort at the conclusion of each chapter to have the contributors critique their own arguments, and the others within that segment, and attempt to find consensus, or at least rational convergence.

The aim of this book is not to settle issues, and I left my reading of some chapters with much uncertainty, even impatience. But that was what was most exciting about reading this work, an exciting debate that the contributors and editors have achieved with singular success. As a result, I hungered for more discussion and an opportunity to interact with these distinguished colleagues, because these issues matter a great deal, and I want to understand even more. ♦

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Restraint and Seclusion: The Model for Eliminating Use in Health Care

by Tim Murphy, M.D., and Maggie Bennington-Davis, M.D.; Arlington, Virginia, American Psychiatric Publishing, Inc., 2005, 119 pages, \$99

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

The reduction and even the elimination of restraint and seclusion did not begin in 1999 with *Guiding Principles on Restraint and Seclusion for Behavioral Health Systems* (1), in 2003 with the American Psychiatric Association's material on the subject (2), in the Substance Abuse and Mental Health Services Administration's publication of the *National Action Plan on Seclusion and Restraint* (3), nor in 2001 with Centers for Medicare and Medicaid Services' interim final rule (4). Rather, efforts aimed at the reduction, and preferably the elimination, of mechanical restraint is an idea well rooted in the 19th century, and in fact, zero restraint was reported by some 19th century asylums (5).

In discussing the subject of restraint and seclusion it is important to note that when the term "restraint and seclusion" is used, one is actually referring to using either re-

straint or using seclusion. There should be no doubt that the combined use of restraint and seclusion is not permitted.

Murphy and Bennington-Davis take on the task of creating a manual with a contemporary approach to eliminating the use of restraint and the use of seclusion. Their venue is a 280-bed general hospital in Oregon with a freestanding psychiatric inpatient unit three blocks from the main hospital. That unit is secure with 24 beds and an average eight-day length of stay. Approximately one-third of persons admitted are having their first psychiatric hospitalization. To what degree one can generalize the authors' approach to psychiatric inpatient settings that are quite different from Salem Hospital is at this point an unanswered question.

The authors draw upon the ideas of Sandra Bloom and her approach of "trauma informed care," Xavier Amador and his thoughts as articulated *I'm Not Sick, I Don't Need Help*; Prochaska and DiClemente's stages of change, Japanese indus-

tries' unacknowledged models for organizational change, the recovery model, the Hawthorne effect, and the Joint Commission on Accreditation of Healthcare Organizations. The authors do a fine job of weaving these quite discrepant sources into an interesting approach that they refer to as the "Engagement Model."

There is much that no one would dispute in this book. The authors contend that in order for treatment to be effective it must be "delivered safely, respectfully, and humanely." The authors explain that a hospital "is a social system that strongly influences employees and physicians through its culture," and that trauma-informed treatment plans incorporate a scheme for safety while the patient is in the treatment environment. They also state that a treatment plan should be unique and individualized and should contain hope and assume recovery. They say that all should work to create an environment "where the healed and the healers work together to find paths to recovery" and that the environment created should be "a place of absolute safety and respect for the staff and for the people served."

Where one might dispute the authors' approach is the emphasis they place on trauma theory. As Sandra Bloom opines in the foreword, "We talk a great deal about the issue of trauma because it is a profound problem that lurks behind most psychiatric and social dysfunction that results in hospitalization." And if that is the case, should we focus only on the trauma inflicted upon staff and patients when restraint or seclusion is used? Some would argue that we also need to focus on the trauma inflicted upon staff when they are in an environment that reprimands them or perhaps punishes them if they use restraint or seclusion or when they are asked to work in an environment in which they fear for their own safety because of the acuity of the ward or the dangerousness of the patients to whom they deliver care and treatment. An argument could also be made that patient-to-patient as-

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saults are frequent and can be seen as a cost of refraining from using “too much” restraint or seclusion.

Restraint and Seclusion is a wonderful starting point for a discussion on any unit in any type of facility for creating an environment of more humane care. The writing is clear, concise, thoughtful, and compassionate. The same can be said of the message.

The risks, however, are that those who work in these environments will feel somehow that their efforts were ill informed or less than they ought to have been. They may never achieve what Murphy and Bennington-Davis seem to be suggesting are not only goals but perhaps standards. In those environments, as in any others, examination of the use of restraint and seclusion needs to be done while simultaneously looking at other variables, such as patient-on-patient assaults, patient-on-staff assaults, the use of polypharmacy, and the use of PRN psychotropic medication, as well as what population is served, for what length of time, with what resources, and under what legal sanc-

tions. It may well be that the population in Oregon State Hospital and the population in Salem Hospital are two inpatient cohorts that are hospitalized in the same city but come from very different places. ♦

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Complementary and Alternative Treatments in Mental Health Care

edited by James H. Lake, M.D., and David Spiegel, M.D.; Arlington, Virginia, American Psychiatric Publishing, Inc., 2006, 504 pages, \$56

Lillian Mezey, M.D.

Interest in complementary and alternative medicine approaches to mental health treatment is growing in Western countries, even as many conventional mental health practitioners have little knowledge of these practices. The appeal of non-conventional treatment approaches includes the holistic approach to health, the emphasis on self-healing and the “development of latent human capacities,” and the focus on wellness and balance rather than

pathology.

It is important for psychiatrists and primary care physicians to gain a better understanding of these alternative treatments, in part because many people already engage in non-conventional therapies in combination with their prescribed conventional treatments but without alerting their physician. Clearly there are significant risks to uncoordinated concurrent therapies, including drug and herb toxicities and unexplained poor outcomes because of incompatible treatments.

Also, as people seek out information about complementary and alternative medicine, it is helpful for the physician to be able to offer an in-

formed response. A physician who is unfamiliar with alternative treatment approaches might unnecessarily dismiss potentially beneficial therapies and practices. Treatment efficacy can be greatly enhanced if the physician is able to establish a collaborative treatment relationship by being open, in a knowledgeable way, to a patient's interest in complementary and alternative therapies.

This book is an excellent review of the most widely practiced complementary and alternative treatments. The book is organized into two parts, with Part 1 discussing background issues, such as ethical, regulatory, and safety considerations involved with the use of these approaches. In Part 2, each chapter covers a particular treatment approach, discussing the philosophy behind it, evidence of effectiveness, safety issues, and clinical guidelines for use. I found some chapters very useful as thorough reviews of the most current evidence base for practices with which I am more familiar, such as nutrition and nutritional supplements, exercise, mindfulness, and spirituality. Other chapters were, for me, a good introduction to ancient Eastern treatments—Ayurveda, Chinese herbal remedies, qigong, yoga, and homeopathy, for example. The work is well written, well organized, and balanced in its presentation of the currently available evidence, or lack thereof, supporting the different treatment approaches.

The authors discuss the paucity of controlled studies evaluating the effectiveness of many nonconventional approaches to treating mental illness. This is largely because of the difficulties in applying Western research models and methods to Eastern approaches with very different conceptual frameworks and philosophical assumptions. For example, Chinese treatments such as acupuncture are focused on correcting imbalances of energy.

In the introduction, James Lake states that this book “is intended to be a resource that provides mental health practitioners and patients with current information about ef-

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fective treatments of mental illness that are not yet fully examined or endorsed by the institutions of conventional biomedicine.” The editors succeed in this goal; this book would be a very helpful reference book to have at hand in the office because it contains charts describing the evidence base for the different complementary and alternative medicine treat-

ments organized by disorder or symptom treated. Reference charts for drug-herb and drug-supplement interactions are also provided, as well as charts listing the possible adverse effects of nutritional supplements. In addition, each chapter contains a summary of practical clinical guidelines summarizing the information presented. ♦

stories to help with our thinking and planning about recovery. The editors hoped to appeal to a wide audience: mental health colleagues of all types, caregivers, and service users. They succeed. I will keep this collection in my office as a resource as I work to build recovery-oriented community mental health services. This book does what psychiatric rehabilitation does; as explained in the preface, it “offers a positive response to the problems, needs, and aspirations of people with long-term, complex and life-limiting mental health problems.” ♦

Enabling Recovery: The Principles and Practice of Rehabilitation Psychiatry

edited by Glenn Roberts, Sarah Davenport, Frank Holloway, and Theresa Tattan; London, Royal College of Psychiatrists, 2006, 405 pages, \$25 softcover

Maggie Bennington-Davis, M.D.

The opportunity to review this book was my good fortune. I know little of the mental health system in the United Kingdom, but within the first chapter I found myself in familiar territory and privy to an excellent synopsis of where recovery and rehabilitation in mental health treatment have come thus far, including in the United States. This book is a collection of stories; a comprehensive review of recovery principles, therapeutic techniques, and systems of care; and an analysis of what we know and what we think.

The editors begin with a preface containing a warning that the book is more a collection of narratives from many people than it is a rigorously organized academic tome. The book models the essence of recovery, and the warning is actually more of a heralding. All of the contributors are from the United Kingdom, many at organizations in London. Julian Leff's chapter, “The Social Context of Mental Illness,” as is true for most of the material, could easily be written about the American experience with mental illness. As such, this book is as excellent a resource and as provocative a collection as any I know regarding recovery.

The book is divided into five ma-

jor sections. Part 1 marks where we are currently in our thinking about values and principles of recovery or rehabilitation psychiatry. It offers a history, pertinent to both the United Kingdom and the United States. Part 2 reviews current therapeutic practices, familiar to any reader acquainted with recovery-oriented thinking. Part 3 offers an organizational approach to thinking about these practices and how to deliver them. Here we may learn from the British experience; the chapter by Frank Holloway about the Care Program Approach has particular wisdom for components of community services. Part 4 includes three contributions regarding unique populations—those with brain injury, with learning disability, and in forensic programs. Part 5 is written by the editors, who brainstorm about where to go from here. The sections seem particularly fortuitous; the contributors apparently wrote their contributions independent of each other, which puts the book at risk of being choppy. Instead the flow is excellent, and one contribution is as good as the next. The book's appendices are worth mentioning: there is an excellent list of rating scales, a good reference list of Web sites, and a recommended reading list.

There is no happy ending with a clear roadmap or how-to guide, but the book provides a tidy collection of

Generation Rx: How Prescription Drugs are Altering American Lives, Minds, and Bodies

by Greg Critser; New York, Houghton Mifflin, 2005, 320 pages, \$24.95

Bruce Hurter, M.D.

In *Generation Rx*, Greg Critser reviews changes in the pharmaceutical industry, changes in Americans' relationship to their medicines, and even changes in the concept of illness—defining illnesses by the medicines that treat them.

Critser reviews changes in the drug industry that have had both benefits and significant costs for consumers. He suggests that congressional acts by Evan Bayh and Elizabeth Dole and Orrin Hatch and Henry Waxman, as well as changes in Food and Drug Association funding and mission, have allowed for much greater numbers of drug approvals and shorter renewal times. He asserts that although many of these newly approved medications were important for treatment of AIDS, cancer, and heart disease, most of the approved medications are for treatment of less serious chronic illnesses. He states that pharmaceutical companies have created a paradigm change from “treating disease to

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creating a state of health.” A marked increase in marketing, particularly direct-to-consumer advertising, has expanded the use of medications—often to off-label uses. Medications are simply “marketed as if they were any other consumer product.”

He asserts that pharmaceutical marketing has dramatically expanded medication sales by aiming at three “tribes.” One tribe is that of “high performance youth.” He argues that medication treatments for attention-deficit hyperactivity disorder (ADHD) of youths are overprescribed in part because of marketing. In fact, he argues that a response to stimulants essentially defines the diagnosis of ADHD. He states that another tribe, of people in their midlife, dodges the body blows of increased cholesterol, high blood pressure, diabetes, and depression. However, he asserts the tribe’s focus is to continue to manage the demands of performance and productivity with the help of, for example, sleep and wakefulness medications. Last, the tribe of super seniors focuses on a number of diseases associated with aging, such as Alzheimer’s disease, diabetes, and depression. Notably, 75% of those over 65 are on daily medications, and polypharmacy is the norm.

Critser emphasizes that it is important to look at the full cost of medications, including economic factors, the risks to our bodies, and the price of the strain on patient-physician independence. He asserts that we are treating chronic conditions with medications for which we usually don’t know the long-term consequences, as has been evident in the problems with Vioxx and Zyprexa. Perhaps the greatest cost to physicians is that if we accept these paradigm changes, we risk damage to the traditional patient-physician relationship.

Recently there have been a number of excellent books criticizing changes in health care’s relationship to the pharmaceutical industry, but Crister presents an additional perspective. He states that pharmaceutical companies use “new media freedoms to create chronic disease awareness, use political and regulatory power to

speed the approval process, use technology to stimulate demand by stimulating patients and doctors, and then use patient information and marketing to make the patient a partner in a lifelong relationship.” The explanation of this paradigm shift is well drawn, as are his questions about the costs of long-term treatments. He appropriately shows that the treatment of chronic illness serves the need of

pharmaceutical companies; however, it is not yet clear that the benefits outweigh the long-term risks. His review of the cost of advertising, particularly direct-to-consumer advertising, raises particularly disturbing questions about patient-physician relationships. The questions raised are important. I recommend this book for consumers as well as physicians and health professionals. ♦

The Body Never Lies: The Lingering Effects of Cruel Parenting

by Alice Miller; New York, W. W. Norton and Company, 2005, 214 pages, \$23.95

Caroline Fisher, M.D., Ph.D.

In this book, Alice Miller presents the idea that childhood abuse manifests as adult physical illness. She holds that the Fourth Commandment—honor your father and mother—keeps both patients and therapists from addressing the parents’ role in, and responsibility for, the abuse. Instead of validating the child’s fury at her parents, the unwitting therapist may collude with the child in excusing her parents or demanding forgiveness for their inadequacy. Miller states that by doing this, the patient’s anger is repressed and is expressed instead by physical ailments. A wise therapist will allow the patient to express anger at her parents directly during therapy and validate those feelings, allowing the patient to release her dysfunctional attachment to her abusers.

That said, you needn’t read the book at all, because it does not offer much else. Miller is a smart woman with valuable ideas, but this book falls short. There are three sections, a preface, an introduction to each section, and a postscript. The meat of the book is in the postscript, wherein Miller states her argument most cogently and sets forth her recommendations for effective treatment tech-

niques. If you insist on reading the book, start there. The first section goes through a series of brief vignettes about famous people who died young and also had been abused as children. In this section I found myself wishing she had coauthored the book with Paul Harvey, because I, for one, need “the rest of the story.” There is little detail in each vignette, sometimes to the point of leaving the reader hanging, and the argument is poorly supported by the data presented. The second section goes into more direct discussion of the ways in which the body harbors the effects of abuse, as well as a fair amount of autobiographical material. The final section, written as the diary of an adolescent girl, is a case study of anorexia. The girl is fictional, and the diary reads like, well, a fictional diary written by someone with an agenda.

In her books, Alice Miller repeatedly asks that society consider the ill effects of parenting that is coercive, abusive, and humiliating. She asks that we consider the everyday, commonplace humiliations as well as the cases of gross abuse. She has been a champion for children and people who were abused as children. In this book, she puts forth a reasonable hypothesis, the truth of which many people will intuitively recognize from their own practices. However, the expansion of that hypothesis falls short. ♦

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