Schizophrenia: Advances in Psychotherapy: Evidence-based Practice Series

by Steven M. Silverstein, William D. Spaulding, and Anthony A. Menditto; Cambridge, Massachusetts, Hogrefe and Huber Publishers, 2006, 84 pages, $24.95 softcover

Jeffrey Stovall, M.D.

I began to read this book with modest expectations. I anticipated another text that fragmented the discussion of the treatment of schizophrenia into different camps and philosophies that grow out of competing understandings of the etiology of the disorder. *Schizophrenia*, written by Drs. Silverstein, Spaulding, and Menditto, accomplishes much more than that.

The volume is part of a series in evidence-based practices in psychotherapy and is succinctly written to provide a workable treatment framework for practitioners. It will provide psychiatry residents and medical students with a clear introduction to psychosocial treatments of schizophrenia. The authors begin with the argument that schizophrenia develops with a combination of biological and environmental factors that interact to alter brain development. They review the role of antipsychotic medications in the management of symptoms of schizophrenia, and then they focus on the psychosocial and rehabilitation treatments that can alter the individual's long-term functioning and the course of the disorder.

Beginning with an introduction and summary of studies about the epidemiology and development of schizophrenia, the authors base their arguments of the concept of rehabilitation outlined by the supportiveness of the individual's environment, the individual's strengths and characteristics, and the community's requirements for adequate functioning. They propose psychosocial treatments that focus on the individual's degree of social disability; unique skills, strengths, and deficits; reactivity to environmental stress; and presence of abnormal cognitions. Using this foundation the authors provide a thorough and clearly written 26-page review of psychosocial treatments for schizophrenia.

Improvements in the text would have been possible. One case example is provided, but additional case studies might have allowed the reader to more clearly understand the areas of assessment and treatment planning. The authors provide only a brief discussion of the role of addiction in schizophrenia. Given the evidence-based models of treatment for patients with dual diagnoses, a broader discussion of this topic was warranted. The book also suffers from an overreliance on references and studies that are up to ten years old. More recent studies with similar findings on the impact of psychosocial treatments would have strengthened the book and helped convince more skeptical readers.

Finally, the discussion of well-defined models of service delivery, such as assertive case management, clubhouses, and supported housing, would have benefited from expansion and would have been consistent with the authors' overall discussion.

Overall, *Schizophrenia* strongly serves the purpose of broadening our understanding of effective treatment for schizophrenia and could easily serve as introductory reading in many training programs. The authors' argument that the most effective treatment is an integrated one that combines symptom-focused treatments with strength- and vulnerability-based rehabilitation efforts is a timely reminder to all of us involved in treating individuals with schizophrenia. ♦

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The Biopsychosocial Formulation Manual: A Guide for Mental Health Professionals

by William H. Campbell and Robert M. Rohrbaugh; New York, Routledge, 2006, 176 pages, $29.95 softcover

Sarah Guzofski, M.D.
Jeffrey Geller, M.D., M.P.H.

In 1977 George Engel (1) said, "To provide a basis for understanding the determinants of disease and arriving at rational treatments and patterns of health care, a medical model must take into account the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of the illness."

This manual was developed by two psychiatry residency program directors, William Campbell and Robert Rohrbaugh, and is based on their experience teaching a structured model for biopsychosocial formulation to residents. They observe that many trainees, despite efforts to gather a thorough history, struggle to organize a patient's history into a complete and meaningful biopsychosocial formulation. They claim that the "predominant mode of instruction in many contemporary training programs (psychiatry, psychology, social work) does a disservice to the biopsychosocial model." To promote full consideration of the biological, psychological, and social realms, the authors propose a "structured paradigm" in the collection and analysis of clinical information. Following Campbell and Rohrbaugh's approach creates a biologic formulation, a psychological for-

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mulation, and a social formulation. It is less apparent that it creates a biopsychosocial formulation.

A brief chapter about biologic contributions reminds the reader to consider how demographic characteristics, medical illness, genetic predispositions, and use of substances fit with a patient's presentation. Here the authors are a little too cute with mnemonic acronyms. The authors find that early training often underemphasizes psychological formulation, so this area is discussed at considerably greater length. The psychological formulation in this manual is organized around four components: the patient's psychological theme, the current psychosocial precipitant, the impact of this stressor on the patient's emotions and cognitions, and the patient's adaptive and maladaptive coping mechanisms. To assist the reader in considering a variety of psychotherapeutic perspectives, brief explanations of relevant concepts from psychodynamic, cognitive, and behavioral therapy—such as common defense mechanisms and cognitive distortions—are included. The chapter about social formulation starts from a social database of ten categories and grafts on cultural and spiritual assessments.

Differential diagnosis should be made by using the three areas—bio, psycho, and social— and sorting presenting symptoms into eight major categories. One then matches these with *DSM-IV* diagnoses. Risk assessment is then done with another database and more mnemonics. When considering risk assessment, the authors suggest separate consideration of static risk factors, dynamic risk factors, protective factors, and a review of the steps that might culminate in violence. A risk reduction plan is developed with interventions planned for each of the dynamic risk factors.

Final chapters delineate a similarly structured approach to creating a treatment plan, which is divided into biologic, psychological, and social areas in need of assessment and intervention. Examples of assessment strategies for each area—such as laboratory and imaging studies, psychological testing, and functional evaluations—are provided. Potential treatment approaches are listed in easy-to-use tables. But again, everything is compartmentalized. Finally, the authors instruct the reader on how to write a prognosis.

Templates for recording and organizing interview data, as well as tables summarizing relevant concepts, are included throughout the manual and on the accompanying CD. A case example is provided to illustrate the approach.

Could any resident or attending at any hospital follow this manual, documenting so much material after the mental status exam and before and after the differential diagnosis as the authors illustrate, and ever be able to go home at the end of a work day? We tend to think not.

The best uses for this text are for first-year residents just getting started in doing work-ups and to study for the American Board of Psychiatry and Neurology oral exam. Get your library to purchase a copy. ♦

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Mental Health Systems Compared: Great Britain, Norway, Canada, and the United States

edited by R. Paul Olson; Springfield, Illinois, Charles C Thomas Publisher, 2006, 381 pages, $89.95

David L. Cutler, M.D.

This ambitious work covers a topic that has been neglected but that sorely needs attention in the field of mental health. How are we to know if we are on the right track for sorting out the complexities of issues related to mental health systems and mental illness service provision? Without some comparative studies on ideal international models it will be difficult to shed some light on the best ways to care for populations of persons who have or who are at risk of having mental illnesses. Certainly for the most severe mental illnesses in developed countries the morbidity and mortality are similar, and the loss to society is obvious.

Yet the authors note that there are significant treatment gaps among the selected developed countries, and they identify three systems factors underlying these differences. They are a lack of policy on mental health and neurological health, the failure of professionals in the fields of mental health and neurology to engage in the economic aspects of the health and social policy, and the lack of preparation and training for leadership in policy development and dialogue.

The authors also correctly point out the lack of comparative literature regarding international systems. To remedy this lack of a comparison condition they chose four countries to write about. They set out to describe each within a consistent framework, then finish with two chapters discussing the similarities and differences among them, look at unmet needs in the various countries, and finally make recommendations for reforming the American system.

All of this is exemplary given the reluctance of these various counties to compare themselves to one another for fear of not looking good.

Many failures in this volume keep the editors from accomplishing what they have set out to do. To begin with, the complexity of the task without real comparative data is enormous. It would be nice if there were some international quality standards to use as a measuring device to overlay on each system. The editors don't even attempt such a thing. Second, the descriptions of the countries often do not follow the consistent format they

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seem to have adopted, so the reader is left wondering what is actually being compared. The editors start with giving a three-part structure to the chapters, but each author seems to decide independently whether to use the categories. Part 1 is supposed to be description, Part 2 is evaluation, and Part 3 is recommendations. Only two of the chapters adhere to this format.

Also why did the editors choose to focus on these particular countries? They are all in northern Europe or North America, and, except for Norway, whenever the authors make comparisons to the United States, they usually use Canada and the United Kingdom. Unfortunately, pat arguments already discount these systems, which may not be accurate but are widely accepted as justification to avoid socialized medicine. Norway is a lovely country, but it is not on the minds of Americans. Why not pick Italy, Germany, and France, for example, which are all in Europe, all quite different from the United States, and none of which are commonly compared to the United States? Or the editors could have looked at other Western-style countries such as Japan or Australia. Perhaps the mental health community would be more likely to pay attention.

In all four countries the book considers, most people who need services for a mental illness don't get them. That amounts to 60%–75% of those thought to suffer from some sort of psychological distress. This finding is consistent despite the enormous differences among the four in health care system financing. In fact here the United States looks pretty good at 60% versus 75% for Norway. However, what this really means is unclear, because the figures used are based on different methods of estimating prevalence in the various countries. It leaves one wondering if there is much use in even bothering to make the comparisons.

I did appreciate the section in chapter 6 comparing fair financing mechanisms in the four countries. The authors' rankings put Britain and Norway at the top of the list, then Canada. (The United States is way down the list.) All have single-payer systems—paid for by payroll taxes in Norway and Canada and general taxation in the United Kingdom. The United States has a hodgepodge of revenue schemes, predominantly private sector but also public and private copays and deductibles that place a significant burden on the individual. The World Health Organization ranked 53 countries, which include nearly the entire developed world, higher than the United States in fairness. This is a sad commentary on the state of heath care financing in America.

At the turn of the last century, Upton Sinclair wrote *The Jungle*, which is about the meatpacking industry in Chicago, and it changed the course of history. Perhaps this volume will influence someone in high places to remedy the situation in mental health care financing and systems organization in this country or others. But I doubt if we have another *The Jungle* here, unless one considers having to navigate through one of these "jungle-like systems" that contain more barriers than pathways on the quest for some treatment. The authors do deserve much credit for taking on such a task. ♦

Dimensional Models of Personality Disorders: Refining the Research Agenda for *DSM-V*

edited by Thomas A. Widiger, Ph.D., Erik Simonsen, M.D., Paul J. Sirovatka, M.S., and Darrel A. Regier, M.D., M.P.H.; Arlington, Virginia, American Psychiatric Publishing, Inc., 2007, 315 pages, $55

Roger Peele, M.D.
Sheela Kadekar, M.D.

A major issue facing the developers of *DSM-V* is whether to adopt dimensional diagnoses, as opposed to categorical personality disorders, such as *DSM-IV's* categorical diagnosis of borderline personality disorder or a dimension of emotional dysregulation versus emotional stability.

Thirty international authorities addressed this issue at a conference in December 2004, which laid a firm foundation for *DSM-V* developers. At the conference they considered almost twenty different dimensional models, many of which follow from studies of normal personalities. One five-dimensional example included in the book is extraversion versus introversion, antagonism versus compliance, constraint versus impulsivity, emotional dysregulation versus emotional stability, and unconventionality versus closedness to experience.

Unlike categorical diagnoses, these five would pertain to both the well and the sick, and these are five traits, not clusters. Also unlike categorical diagnoses, five scales of these characteristics could be far more exact than *DSM-IV's* categorical personality disorders, and could therefore provide the potential for greater reliability. Borderline personality disorder, for example, with its five or more of nine signs, has 256 different configurations of those nine signs.

Furthermore, there is very little evidence that the psychopathology pie is divided up as *DSM-IV* has proposed. One of us warns medical students and residents—in "Peele's dictum" —that if their presentation of a patient fits *DSM-IV* criteria perfectly, the student will know that he or she has not talked to that patient.

Why not adopt these dimensions? The dimensional approach seems consistent with today's concepts of personality; consistent with medicine's interest in the impact of traits on medical illnesses, considering that the rest of medicine has no interest in *DSM-IV's* personality disorders; more

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reliable; easier to adjust for cultural differences and more culturally sensitive than the categorical; and very rational. Several problems exist.

First, the proposed benefits are only rational, not empirical, in that we never meet a single patient in this book who has been observed to benefit from any of the nearly 20 proposed dimensional models. Not one.

Second, cutoff points are going to be a huge challenge. What is normal, and what is pathological? Taking one example, on the dimension of antagonism versus compliance, where would the cutoff be to demarcate psychopathology? Would it be the same in all settings, or would it have to be defined in relation to the environmental need? Even at the extremes, are there not some situations in which extreme antagonism is lifesaving, and others in which extreme compliance is lifesaving?

Third, what about the current categorical personality disorders? They could continue in *DSM-V*—hopefully without the word "personality" in the title, a word that unnecessarily hurts patients and postpones treatment. Most of this book implies that the dimensional would replace the categorical.

Fourth, what about the worthy experts who have given their careers to contributing to our understanding of *DSM-IV's* categorical personality disorders? If *DSM-V* retires the personality categorical disorders, the American Psychiatric Association should give each of these experts a golden parachute. ♦

Relational Processes and *DSM-V*: Neuroscience, Assessment, Prevention, and Treatment

edited by Steven R. H. Beach, Ph.D., Marianne Z. Wamboldt, M.D., Nadine J. Kaslow, Ph.D., Richard E. Heyman, Ph.D., Michael B. First, M.D., Lynn G. Underwood, Ph.D., and David Reiss, M.D.; Arlington, Virginia, American Psychiatric Publishing, Inc., 2006, 293 pages, $59

Benjamin A. Spinner, M.D.

Although empirical data and ideology both play necessary roles in diagnostic systems, neither should be used alone to determine the definition of diagnosis. *DSM-IV-TR*, like its previous edition, relies heavily on the ideology of the disease model, in which symptom sets determine diagnoses. Diagnoses are practical precursors of therapy. It may be suggested that our diagnoses recommend our therapies as much as our therapies, in reverse, recommend our diagnoses. This may be a tautology, but tautology may be inevitable in a system in which reliability and reproducibility are more easily achieved than validity. It is, for example, safer to state that one inch equals 2.54 centimeters than it is to argue that one inch is an important measurement in the first place. The *DSM*, in turn, may be reliable in assigning symptoms and consequently in defining diagnoses, although the value of these diagnoses in the determination of disease processes is not obvious.

Emil Kraepelin suggested that the developmental course of disease is fundamental to diagnosis. In his attempt to distinctly describe behavioral phenomena as diseases, Kraepelin wrote that the clinical condition is "the expression of a single morbid process." Such a perspective does not negate the existence of multifactorial contributions to disease, but it does imply that disease results from an abnormal process. Just as processes may occur within neurons, within cerebral lobes, or between synapses, processes may occur within individuals, within families, or between people. The definition of a process is a matter of perspective. And the perspective of the *DSM* is a matter of debate.

Relational Processes and DSM-V was conceived as a group of papers to address the gap, acknowledged by the American Psychiatric Association, in the *DSM's* approach to relational disorders. The book is a diverse, empirically oriented collection of chapters, each of which explores the impact of human or animal relationships on behavior and on illness. The book's title itself is indicative of two different agendas: the editors have not put together a book that can simply be titled *Relational Disorders*, because the chapters do not fully define relational disorders, nor do they claim to do so. Rather, the discussions in this text elaborate numerous factors of "morbid process" within the context of relationships.

In addition, the title implies a discussion of the *DSM* itself with reference to relational processes; such a discussion is also not fully achieved in this book. For example, in the chapter "Refining the Categorical Landscape of the *DSM*"—rich in its discussion of basic science, with a clear presentation of data culled from animal research, especially rats—the rats nibble off more than they can chew. The chapter does not adequately address the issue of categorical versus dimensional diagnosis. The discussion of hormones, neurotransmitters, and neural morphology may indeed provide data for a discussion of detriments of a categorical diagnostic scheme but does not provide a basis for the authors' assertion that "the current categorical organization of *DSM-IV-TR* has effects on misdiagnosis, assessment, and treatment." On the whole, however, the text does contain a very large amount of useful empirical data relevant to a discussion on relational processes.

Certain chapters, such as "Neurobiology of the Social Brain," do go further than others by providing a conceptual construct with which to frame the data. The authors of that chapter delineate four components of social relationships: recognition, motivation, approach, and bonding. This

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seems the sort of successful translation from research to behavioral constructs that might then permit a second translation from behavioral constructs to nosologic constructs.

Other topics include childhood maltreatment, marriage, and expressed emotion—the latter in two separate chapters—which are each explored with regard to health and pathology. Among the 15 chapters are discussions of epidemiology, psychology, biology, and taxonomy. The data described in *Relational Processes and* DSM-V seem significant. It will be necessary to shape these data into conceptually coherent concepts in order to ensure their eventual inclusion into a new manual in which, one hopes, neither empiricism nor ideology alone consistently determine the definition of a diagnosis. ♦

Managing Metabolic Abnormalities in the Psychiatrically Ill: A Clinical Guide for Psychiatrists

edited by Richard A. Bermudes, M.D., Paul E. Keck, M.D., and Susan L. McElroy, M.D.; Arlington, Virginia, American Psychiatric Publishing, Inc., 2006, 326 pages, $49 softcover

Brian B. Sheitman, M.D.

This volume addresses an extremely important topic for psychiatrists given that many of the medications available for patients with severe mental illness have considerable risk of inducing or worsening weight gain, dyslipidemias, and diabetes mellitus, all risk factors for cardiovascular disease. Furthermore, it is very timely in light of the recent report from the National Association of State Mental Health Program Directors that patients with severe mental illness die, on average, a startling 25 years earlier than patients without these illnesses, with most of this difference because of medical causes.

The authors, distinguished researchers and experts in their field, divided the book into nine chapters. Chapters 1, 2, and 5 provide an excellent review and update on diabetes, the metabolic syndrome, and cardiovascular disease, respectively. Chapters 3 and 4 review the literature on the overlap of severe mental illness and obesity and diabetes mellitus, respectively. Chapters 6, 7, and 8 focus on the effects of antipsychotic medications on weight gain, glucose metabolism, and serum lipids. Chapter 9, titled "Metabolic Risk Assessment, Monitoring and Interventions: Translating What We Have Learned Into Clinical Practice," then attempts to synthesize this information.

The clear strength of this volume is the very scholarly literature reviews presented on each of the topics. At the end of the chapters I felt that I had a good grasp of the relevant literature. Furthermore, the reviews of obesity, diabetes, and cardiovascular disease are written in a very readable manner.

Where the book falls somewhat short of expectations is in not meeting one of the stated objectives, which is to address "the unmet need of the lack of integration of general medical care with psychiatric care, and the related problems of barriers to collaboration and communication among health care providers." Although the authors acknowledge that there is some disagreement among psychiatrists about whose responsibility it is to monitor the general medical conditions of people with mental illnesses, there is an absence of discussion about what the specific issues are and possible collaborative models. I suspect that this may reflect a gap in the research literature because the style of the book is congruent with a research review of the topic.

Overall, I think this volume is well worth reading. The specific topics are extremely relevant for the practicing psychiatrist. Though 326 pages long, the book is a relatively quick, easy, and painless read. Given the published literature reviewed, it is becoming increasingly clear that what tardive dyskinesia was for the older antipsychotics, metabolic abnormalities are for the atypical antipsychotics. This book not only helps us make sure that we are aware of the issues, but it also provides us with practical aids to monitor for these serious medical conditions. ♦

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Assessing and Managing Violence Risk in Juveniles

by Randy Borum and David Verhaagen; New York, Guilford Press, 226 pages, 2006, $35

Frank DiCataldo, Ph.D.

It has been a quarter century since John Monahan (1) first problematized the clinical prediction of dangerousness, ushering in the paradigmatic shift to a public health model of violence risk as a continuum. The paradox of Monahan's critique has been the spread—not its demise—of violence risk assessment to every corner of mental health practice. Concern about violence risk lurks behind every patient-clinician interaction.

The systematization of violence risk assessments for psychiatric patients, thanks in large measure to the recent MacArthur Violence Risk Assessment Study (2), is more advanced than it is for children and adolescents who find themselves ensnared within the various systems devised for dealing with youths in trouble. *Assessing and Managing Violence Risk in Juveniles* will undoubtedly help close that gap. It is the best resource presently available

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for the mental health professional faced with the complex task of having to provide empirically anchored assessments of the risk of violence among young people.

Randy Borum and David Verhaagen have done a masterful job of distilling the expansive theoretical and empirical literature from developmental criminology, adolescent psychopathology, and research on youth violence. They translate this vast store into a concise and clearly presented practice manual to guide the clinician from data collection, to the synthesis of findings, and to the construction of a comprehensive and relevant report regarding violence risk and its management and reduction. It will be an indispensable resource for the clinician working within any of the numerous "at-risk-youth" sites, where risk assessments are routinely produced.

Although the book will likely be a favorite among the clinicians who conduct risk assessments as a regular part of their clinical practice, it will likely fail to satisfy scholars concerned about the media-fueled panic about youth violence, which is behind the recent legal trends calling for the criminalization of delinquency and the ever-growing overrepresentation of youths from minority groups within the criminal justice system. Concern about violence risk among youths is everywhere these days. The adolescent in our midst has become a figure to be regarded with fear, and our fears are no longer confined to youths within the halls of juvenile court. They have spread to our schools and are reaching down to younger and younger children. The book sidesteps these larger problems that have more to do with our systems of thought about youths than with the youths themselves.

The assessment process prescribed within the book will undoubtedly result in better assessments. Let's hope that it doesn't also promote the idea that more assessments are necessarily better. Better quality and less quantity could be a more valuable outcome. ♦

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Unstrange Minds: Remapping the World of Autism

by Roy Richard Grinker; New York, Basic Books, 2006, 340 pages, $26.95

Yael Dvir, M.D.

"Unstrange," a neologism coined by the poet E. E. Cummings, is very appropriately used in the title of this book. As Roy Richard Grinker states in his introduction, "the process of understanding autism itself parallels the work that anthropologists do, since the minds of people with autism are sometimes as hard to understand as foreign cultures." Grinker is a professor of anthropology at George Washington University and is interested in the intersection between culture and illness. He is also the father of a daughter with autism.

In this beautifully written, captivating book, Grinker looks at autism from a cultural viewpoint and observes how culture dictates the way we view autism. He examines the historical events leading to the current rise in the prevalence of autism and critically inspects the available evidence. "Is there really more autism, or are we just seeing it more?" he asks. Grinker argues for the latter.

In the book's first part, Grinker reviews the significant changes that psychiatry has undergone leading to the "tipping point" in this "epidemic," from Leo Kanner's first description of autism as a biological syndrome rather than a symptom to Bruno Bettelheim's blaming mothers in *The Empty Fortress.* Psychoanalysis was gradually replaced with the *DSM*'s attempts at standardized psychiatric diagnosis. Autism was not included in the *DSM-II* as a distinct disorder, whereas *DSM-III,* called autism a "pervasive developmental disorder" and no longer a psychosis.

Gradually, we arrived at where we are at today, with broad diagnostic criteria including pervasive developmental disorder not otherwise stated and Asperger's disorder, which now makes up as many as 75 percent of new cases in the spectrum. Grinker criticizes the comparison between prevalence studies in the past and present, arguing that the diagnostic criteria have changed so much that this comparison is not reliable: "Diagnosing a mental disorder in a child is like describing a moving target." Epidemiological methods used today are much more aggressive, and public awareness as well as earlier detection is leading to increased numbers.

In the book's second part, we are introduced to captivating and uplifting personal stories of families around the world living with autism. From the suburbs of Washington, D.C., to France, India, South Africa, and South Korea, these tales shed light not only on this illness but on humankind. The parents of children with autism, no matter how remote and impoverished, seek a diagnosis and treatment for their children and are helping autism in "becoming visible." They fight for awareness and better education, form advocacy groups, and change beliefs. As Grinker says in the introduction to his book, "We should stop, step back and take a closer look at our fears about autism."

Unstrange Minds is a well-written, carefully presented work of scientific research, looking at the cultural implications of autism. It manages to address key points about autism today, both internationally and very personally. I believe that anyone touched by autism, whether physician, psychologist, teacher, or parent, should read this book. ♦

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