The Spectrum of Psychotic Disorders: Neurobiology, Etiology, and Pathogenesis

edited by Daryl Fujii and Iqbal Ahmed; New York, Cambridge University Press, 2007, 588 pages, $150

Andrea B. Stone, M.D.

This new book, *The Spectrum of Psychotic Disorders*, is meant to evaluate the hypothesis that psychotic symptoms are caused by a neurobiologic syndrome. The authors posit that anything that may cause an alteration of the frontal systems, temporal lobes, and the dopaminergic projections to these areas can lead to psychosis. If a threshold of damage or change to these structures and systems is reached, symptoms will develop. Everyone is at risk. The degree of risk of developing symptoms is influenced by endogenous factors such as genetics and exogenous factors such as disease, trauma, and toxins. In order to prove their hypothesis, the authors examine each psychotic disorder to determine whether it affects common brain structures and chemical systems.

The book is divided into nine parts: primary psychotic disorders, mood disorders, neurodevelopmental disorders, central nervous system disorders, psychosis induced by substance abuse and medications, neurodegenerative disorders, and psychosis associated with sensory impairment, along with an introduction and conclusion. There are more than 50 contributors. Each chapter, written by different authors, is organized in the same way. For example, the chapters start with the epidemiology of the illness and review its presentation and course, the suspected neuropathology, risk factors, and treatment. The quality of the evidence for each factor is rated by using the descriptors of Oxford Centre for Evidenced-Based Medicine levels of evidence criteria, which is of particular importance to the book. Overall, the grades of recommendation rate a "C," which means that the findings are based upon case series or extrapolated from systematic review or retrospective studies. The neurodegenerative disorders, such as Alzheimer's disease and Parkinson's disease have the best quality of evidence, and psychoses induced by medication have the worst. The persuasiveness of the authors' argument depends on the value of the data.

The authors conclude that within the limits of the quality of the evidence, psychotic disorders do fulfill the criteria to qualify as a neurobiologic syndrome. The suspected neuropathology—abnormalities of the frontal and temporal lobes—and neurochemical abnormalities—dopamine related—are found to some degree in all of the examined disorders. Whatever the cause of the symptoms of psychosis, the nature and severity of the presentation correlate with the location and degree of abnormalities in the relevant brain structures and pathways. Treatment of the symptoms is similar even when the symptoms are caused by different diseases, injury, toxins, or unknown forces.

Why is any of this important? It goes to the heart of questions about diagnosis and treatment. Because psychotic symptoms can develop from multiple vulnerabilities and pressures, how can primary psychotic disorders be reliably distinguished from psychotic disorders secondary to a general medical condition or substance abuse? Is there any value to making this distinction?

The Spectrum of Psychotic Disorders is not a book to sit down and read cover to cover. Each chapter can stand alone. Students, trainees, and budding researchers would be most likely to find this useful. Even though my training years are far behind me, it was very interesting to learn about what we now know, and still don't know, about the brain and illness. ♦

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The Overlap of Affective and Schizophrenic Spectra

edited by Andreas Marneros and Hagop S. Akiskal; New York, Cambridge University Press, 2006, 312 pages, $125

Victoria Shea, M.D.

Two leading scholars and researchers in the field of mood and psychotic disorders edited this textbook, *The Overlap of Affective and Schizophrenic Spectra*. The book explores one of the most basic but complex issues facing 21st century psychiatry and is highly recommended for those who treat patients who have mood and psychotic disorders. In practice today in the United States, clinicians have become complacent in terms of thinking seriously about the phenomenology of mood and psychotic disorders. We may need to ask ourselves if we know much more than Kraepelin did at the end of the 19th century.

The editions of the *DSM* have become more than the guides they were intended to be. In clinical practice we view diagnostic categories as distinct entities. Both the editors and other contributors of this densely packed but readable text continue to question our understanding of the Kraepelinian dichotomy. In the preface, Akiskal points out that Kraepelin himself had doubts: "The symptoms we have used so far are not sufficient to always reliably distinguish between manic-depressive insanity and schizophrenia, but there are overlaps based on the origin of these symptoms from given precon-

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ditions." Kraepelin tended to look at symptoms from a longitudinal approach; later attempts were meant to distill symptoms into being pathognomonic of a particular condition.

Akiskal is a professor of psychiatry at the University of San Diego, and Marneros is affiliated with the Department of Psychiatry and Psychotherapy at the Martin Luther University in Halle-Wittenberg, Germany. Marneros has looked specifically at the "in-between" psychotic disorders—such as schizoaffective disorder, late-onset schizophrenia, and brief psychotic disorders—in some detail to tease out possible differences in phenomenology and clinical outcomes in these less classically defined disorders.

The in-between conditions at the interface of the psychotic and mood disorders have continued to be characterized and formulated in different ways. The trend in the United States has been to expand the diagnostic criteria of the schizoaffective disorders, first characterized as a diagnosis by Kasanin in 1933, from the *DSM-III* in evolution to the *DSM-IV-TR*.

Further complicating the picture is the lack of consistent evidence from family studies to indicate that the psychotic and affective disorders "breed true." Both psychotic and mood disorders can be found in family members of probands in either diagnostic category. Preliminary gene linkages also show that there are overlapping linkage peaks in bipolar disorder and schizophrenia. The psychopharmacologic treatments of both overlap, especially with the advent of the second-generation antipsychotics.

Finally, no matter how the diagnoses are viewed, the predominant themes appear to become part of the "spectrum"—with schizophrenia being the most affected by biology, temperament, and psychosocial factors and unipolar depression the least, with schizoaffective and bipolar disorders in between in terms of severity. The interface of this spectrum of disorders is not yet understood and needs to be studied further. As Akiskal says in the final chapter, "Lines of evidence have revealed both continuities and discontinuities between the affective and schizophrenic spectra. Perhaps what is 'in-between' represents a cross of the underlying dimensions of the two 'voluminous' spectra, or superposition of some of the contributory factors of one on the other."

One only has to wonder whether efforts could be made to unify the concepts of the *ICD-10* with a future edition of the *DSM*—that is, *DSM-V*—could be a step in the right direction toward guiding future research in terms of the diagnostic characterization of mood and psychotic disorders. ♦

Bipolar Disorder in Later Life

edited by Martha Sajatovic, M.D., and Frederic C. Blow, Ph.D.; Baltimore, Johns Hopkins University Press, 2007, 280 pages, $50

Stephen L. Pinals, M.D.
Jason B. Strauss, M.D.

The lack of evidence-based research available to guide clinicians in treating people with geriatric mental illnesses is striking. This is very much the case with regard to late-life bipolar disorder. Contrary to the popular notion that bipolar disorder "burns out" over time, this condition is becoming increasingly prevalent among elderly people as this segment of the population grows. Martha Sajatovic from Case Western Reserve University and Frederic Blow from the University of Michigan, two leaders in this burgeoning field, fill a gaping void with their book *Bipolar Disorder in Later Life*. Sajatovic and Blow recruited many experts and colleagues in geriatric bipolar research to create a comprehensive, cohesive, and crisply written work. This text will be of significant value to any clinician caring for this population, including general and geriatric psychiatrists, as well as geriatricians at all levels of training and expertise.

The editors' stated purpose is to "present the most up-to-date knowledge available, provide frameworks and resources with which to understand bipolar disorder in late life, and offer guidance to address the paucity of data on this topic." This purpose is achieved in an eminently readable manner, because the book is divided into four parts. In the first section, the editors introduce us to the epidemiology and assessment of late-life bipolar disorder. This is followed by a concise synopsis of the use and utility of mood-rating scales in assessing mania in geriatric bipolar disorder, provided by Robert Young and colleagues.

The second section concentrates on the treatment of late-life bipolar disorder, beginning with a summary of the different presentations of mania seen among elderly persons. The authors review the limited data that exist on the biological treatment of late-life bipolar disorder. Indeed, to date there has not been a single placebo-controlled trial of any agent in this population. Nevertheless, the authors do an excellent job of piecing together the available information to provide a framework for clinicians to treat geriatric bipolar disorder, focusing on minimizing potential adverse effects. The rest of this section includes valuable chapters on psychosocial interventions and treatment adherence.

The third section focuses on the many challenges of treating geriatric patients with bipolar disorder with active substance abuse and medical comorbidities. Helen Kales provides a useful and clearly written summary of the various medical conditions that

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often accompany the presentation of late-life bipolar disorder. This section concludes with a timely and interesting account of how culture may affect the diagnosis and treatment of bipolar disorder among elderly persons.

Among the concluding chapters is a review of the significant obstacles that researchers face in filling the gaps that remain in geriatric bipolar research and care. The reader is made aware of the uneven quality of psychiatric and medical care in this special population and the dearth of adequate quality control indicators to assess these issues.

Bipolar Disorder in Later Life is an exceptionally well-written and thorough review of this emerging focus of research. Both clinicians and academicians will find it to be a necessary and useful work in its own right, and we hope that it leads to continued advances in the field. ♦

Melancholia: The Diagnosis, Pathophysiology, and Treatment of Depressive Illness

by Michael Alan Taylor and Max Fink; New York, Cambridge University Press, 2006, 560 pages, $175

Patrick Runnels, M.D.

In the preface of *Melancholia*, the authors assert that one objective of the book is to "challenge accepted doctrines" regarding the classification and treatment of depressive illness. To this end, they don't disappoint, approaching this goal with a vigor that emanates from every section. As promised, Michael Alan Taylor and Max Fink thoroughly review all aspects of melancholia; certainly, the book accomplishes this objective effectively. However, the central thrust of the book lies in the arguments the authors present for changing how the field of psychiatry approaches depression.

At the broadest level, the authors assert that melancholia, as classically defined, warrants a separate diagnostic category independent of a major depressive disorder, which they argue has been diluted by "depressive-like" illnesses that cloud clinical decision making and result in reduced quality of care. The chapters are presented as a series of small arguments concentrating on individual aspects of diagnosis, assessment, and treatment; along the way, an exhaustive body of research is compiled and analyzed in the service of these arguments. Although many assertions will feel familiar to readers, such as the contention that pharmaceutical companies have too much influence on diagnostic classification and prescribing practices, a few may be more surprising, such as the suggestion that mania might be best thought of as a melancholic variant.

Though many of the book's arguments are quite persuasive, I didn't agree with every one and found myself quite opposed to a few. However, this isn't a shortcoming. On the contrary, I think efforts like this are supposed to stoke emotions and spark debate, and in that regard, I found the book to be a resounding success. The authors are, of course, biased, and the evidence they cite certainly isn't presented in a neutral way. But their methods of analysis are transparent and that allows for readers to interpret the evidence as well.

A few small faults warrant attention. At times, the authors indulge in overly focused evidence review, particularly with regard to presenting differential diagnoses. Such excessive detail detracted from the overall effectiveness of the book, and some readers may choose to skim these sections. Additionally, although the authors contend that this book focuses on melancholia, they spend significant time citing evidence that questions the validity of nonmelancholic depression and the use of selective serotonin reuptake inhibitors. Although it is beyond the scope of the book, the failure to address such large issues after so provocatively raising them may leave readers somewhat unfulfilled.

Despite these faults, I recommend the book without reservation. The authors targeted this book to all clinicians who are "responsible for the management of patients with mood disorders." Although I agree, I would add that *Melancholia* is ideally suited to residents and early-career psychiatrists who will not only gain knowledge but will also nurture the valuable skill of critically assessing mainstream psychiatry. ♦

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Psychotic Depression

by Conrad M. Swartz and Edward Shorter; New York, Cambridge University Press 2007, 344 pages, $85

Nancy T. Block, M.D.

A brief introductory paragraph, reprinted on the back of this book's jacket, defines psychotic depression as "a distinct and acute clinical condition along the spectrum of depressive disorders. . . .often [inducing] physical deterioration, mortally dangerous acts toward self or others, or completed suicide." It further promises that "Medical readers of this book will come away able to diagnose and readily treat psychotic depression and thus will be able to serve their patients better. Non-physician readers will come away with the message that this is a terrible illness, but there is hope." It concludes that "This book fills an important gap in the realm of psychiatric literature."

Conrad Swartz, the first author, af-

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filiated with Southern Illinois University School of Medicine, is identified as "a board-certified psychiatry professor who has written and lectured extensively on depression, anxiety, and the use of [electroconvulsive therapy (ECT)] for severe depression." He is presumably responsible for the bulk of the content. His coauthor, Edward Shorter from the University of Toronto, who has written three books on the history of psychiatry, seems to have contributed two chapters titled "History of Psychotic Depression" and "Treatment in Historical Perspective." Both chapters are well written and interesting and meet the challenge of capturing the evolution of psychiatric terminology in tandem with changing clinical concepts through modern times. Both authors have done their homework. More than 300 references are in the bibliography, and some are in several European languages as well as English, dating from 1900 to the present, one-third of them since 2000. Though 20 of the references are from Dr. Swartz's own writings, they appeared in well-respected professional publications. There are also a detailed index and two appendices offering summary guides to psychiatric concepts as well as to psychotropic medication—a very extensive inventory—and other treatment modalities.

The agenda of the book, which frequently carries a tone of frustration and even outrage at the status quo in psychiatry, is to focus attention on psychotic depression, indisputably one of the most devastating afflictions of humankind. Swartz correctly perceives that psychotic depression is misdiagnosed and improperly treated, if it is treated at all, in a shameful number of cases. His mission is to make sure that it is not missed and that it is properly diagnosed and promptly treated in an effective manner. He offers his perspectives on classification and treatment with numerous case histories to illustrate his arguments, based on years of experience in urban settings among a largely underprivileged population. He struggles mightily to bring clarity to the diagnostic morass that arguably still characterizes the nosology of depressive and related conditions, and he has little use for *DSM* paradigms, except for administrative—but not research or treatment—purposes. In a separate chapter, Swartz also tries to convey the depressed patient's excruciatingly painful experience of the illness and its consequences, such as posttraumatic stress disorder.

In outlining detailed treatment strategies, Swartz demonstrates hands-on expertise in psychopharmacology, but his recurring plea is for better acceptance and far more frequent use of ECT than at present. He offers evidence, personal and from a large body of literature, for ECT as being an extremely useful, even essential tool in the successful treatment of the severest of psychiatric illnesses. He makes many valid points, in my opinion. I found Swartz's categorization of psychotic depressive states—with a heavy load of bipolarity—potentially quite useful, though he has not succeeded in avoiding embroilment in the same troublesome depression descriptors such as "melancholic," "atypical," and "reactive" that he is trying to sort out for his readers, which often results in confusing, even contradictory, phraseology.

I believe this book might better engage its intended readership if it were tightly edited down to its essential diagnostic and treatment principles. However, it has practical wisdom to offer, and the crafters of *DSM-V* could well give thought to some of its provocative concepts. ♦

Psychiatric Epidemiology: Searching for the Causes of Mental Disorders

by Ezra Susser, Sharon Schwartz, Alfredo Morabia, and Evelyn J. Bromet; New York, Oxford University Press, 2006, 544 pages, $69.50

Hunter L. McQuistion, M.D.

If only all textbooks were written like this one. The authors of *Psychiatric Epidemiology* have assembled a highly cogent examination of the past, present, and possible future of psychiatric epidemiology, doing so in a way that anyone interested in the scientific method—including its limitations—can be immersed.

As expected, the chapters follow each other logically. But here, the sequence progressively draws us into a tale of the discipline's evolution. The authors have developed a coherent vision such that any researcher, policy maker, clinician, or program planner can understand psychiatric epidemiology. Using factor analysis of risk as a foundation, they lead us on a journey through experimental design and then, with great clarity, to the basic tenets of statistical analysis. In illustrating their themes, the authors use examples of major psychiatric epidemiologic studies, weaving them through the topical phases of the book to illuminate technical practice while also addressing the studies' importance.

A section on experimental methodology in biological psychiatry is of interest to psychiatrists. While laying out relevant case-control design, the textbook frankly discusses historical differences between biological and epidemiologic researchers, noting how they have been respectively caricatured as excessively reductionistic and overly focused on social causality. Instead, the book's contributors reach for integration, positing disease as a phenomenon with interacting proximate (neurobiological) and more distal (often environmental) antecedents.

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The quest for integration reaches a high order in the sections that explore new trails. There is great detail in describing how genetic epidemiologists search for environmental risk factors among phenotypes and endophenotypes and then relate them to genetic changes. Discovering the relationship between some people of holding the APOE4 allele and the appearance of Alzheimer's disease is cited as a way in which epidemiologic family case-control studies are critical to uncovering a cause of illness. This holds promise for other disorders, such as schizophrenia, that have sketchy and complex genetic and environmental relationships.

Finally, causal complexity is the book's watchword, and the lucid discussion of this issue is its greatest conceptual contribution. The authors grapple with challenges in measuring risk factors that are rarely static. In the book's beginning, the authors orient us to a concept of "insufficient but necessary" causes that conspire to yield disease. They build on this methodically toward the book's final section and identify a developing movement throughout science to somehow quantify nonlinear and nontemporal causative effects, invoking chaos, systems, and nonlinear dynamics theories. The authors do not pretend to hold the solution to this problem, but they take the critical step of recognizing reality and stress that linearity and gross causative factors are simplistic. Hence, for the psychiatric epidemiologist, environmental events occur, individuals interact even within populations to alter risk factors, and cohorts are affected in different ways and at different times across the life cycle. Add to this a certain cultural fluidity of psychiatric disorder. The challenge is to capture new ways to measure these effects and more precisely identify the emergence of disease. ♦

Treatment Collaboration: Improving the Therapist, Prescriber, Client Relationship

by Ronald J. Diamond and Patricia L. Scheifler; New York, W. W. Norton, 2007, 208 pages, $29.95 softcover

Thomas A. Simpatico, M.D.

Medication has become widely accepted as a cornerstone for the treatment of serious mental illness. As our understanding of how brain chemistry influences mood, thought, and behavior has continued to grow, there has been a corresponding growth in the acceptance of the role of medication by both our patients and society at large. Medication is a tool that can help people manage their mental illness and achieve their preferred roles and life goals. On the other hand, it is sometimes used without adequate consideration of what improvement it is expected to provide.

The debate over whether medication is good or bad can obscure clear thought about how a person can best achieve a more independent life and sustained recovery. Overall, shortening the period of untreated psychosis, particularly during the early stages of illness, can minimize disability and life disruption. The length of time a person remains acutely psychotic is often prolonged when the person does not believe that he or she has a mental illness, a cruel but common consequence of having schizophrenia. In addition, the person often has an array of cognitive deficits that make it difficult for them to collaborate with care providers. The person may also be disinclined to seek treatment as a function of attitudes expressed by individuals in his or her social and support networks.

Longer periods of untreated psychosis are harmful, as they often result in predictably longer recovery periods with lower subsequent baseline levels of functioning; unnecessarily long lengths of stay in involuntary hospital settings, with an associated decline in the ability to function in the community; avoidable injuries to the person suffering from psychosis and to others; unnecessarily chaotic climates on treatment units where other people are working to gain control of their illnesses and move toward recovery; and undue economic burdens on the person suffering from the psychosis, his or her family, and society in general. Untreated psychosis may also strengthen the stigma of mental illness by providing the general public with dramatic glimpses of uncontrolled psychosis that reinforce negative stereotypes.

Treatment Collaboration is a book about how clients, therapists, and prescribers can work together to make medication decisions so that medication is as effective as possible in helping patients achieve personal goals. It is essential reading in a time when the care of persons with serious mental illness is largely provided by teams of professionals who must view their work through the common lens provided by their patient.

The authors, Ronald Diamond and Patricia Scheifler, are distinguished clinicians who have years of experience helping persons with serious mental illness achieve and sustain recovery. *Treatment Collaboration* affords us the benefit of their collective experience and is organized by key topical areas, such as how to manage the inevitable conflicts that will arise in the course of care management, how to help the patient deal with medication side effects and choose when medication should be changed, and how to remember that the patient's recovery is the goal, not medication adherence per se.

We as mental health professionals must remember not to equate the care we provide solely with strategies for medication adherence. Diamond and Scheifler rightly argue that using medications is an active process that requires a partnership between the

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client, the physician, and often a therapist or counselor. It is only when such treatment teams practice effective shared decision making that the advantages and disadvantages of a particular intervention may be assessed in the context of the client's personal aspirations and stage of recovery. Such collaborations remain the surest way for people with serious mental illness to enjoy a full and sustained recovery. ♦

ADHD Grown Up: A Guide to Adolescent and Adult ADHD

by Joel L. Young, M.D.; New York, W. W. Norton, 2007, 240 pages, $24.95

Micah J. Sickel, M.D., Ph.D.

If, as you read this paragraph, your mind wanders to that magnificent dinner you had at the French Laundry or the Richard Serra retrospective that you missed at the Museum of Modern Art, this book may just be for you. In this well-researched and equally well-written tome on attention-deficit hyperactivity disorder (ADHD) among adolescents and adults, Joel Young has created not only a guide, as the title states, for the general public but also a really good reference text for child and adult psychiatrists and any clinician who may be working with this population.

I knew *ADHD Grown Up* was going to be a good text when this up-and-coming diagnosis, at least up-and-coming in the adult psychiatry scene, was compared head-to-head with the current diagnosis du jour of the child and adolescent psychiatry world, bipolar disorder. Young goes through a number of other diagnoses that get mixed up with ADHD, including anxiety and depressive disorders. The book starts with a very didactic first chapter, "Diagnostic Screening Process"; it lists a number of rating scales and checklists, some of which are available free on the Internet, that can help to lead clinicians to an appropriate diagnosis.

ADHD Grown Up feels like Young is leading a young resident or first-year child fellow by the hand through the various steps involved in making a good diagnosis. He even has some sample dialogues that can be very helpful in guiding the trainee. From my experience as a second-year child fellow, it did not feel pedantic or condescending, but rather I found myself making mental notes of what to look for with the adolescents and adults who may have ADHD. When treating a child for ADHD, one may need to ask a teacher to fill out a Conners scale or make a call to the after-school program director to gauge how the child is doing there. When treating an adolescent or adult without a diagnosis of ADHD, one may look for multiple traffic tickets, marital problems, procrastination, disorganization, and forgetfulness about projects and other important things, such as where he or she put the car keys. These latter few characteristics may combine synergistically into what might be referred to as laziness, just plain rudeness, or incompetence. And these problems have very real-world consequences, such as not getting pay raises or being fired, as Young describes for a number of his patients.

Another major problem Young addresses in several parts of the book is substance abuse. Amazingly, the risk to someone not treated for ADHD is a three- to fourfold risk of substance abuse, such that in one study, 18% of control-group adolescent boys used drugs, 25% of adolescent boys with treated ADHD used drugs, and a whopping 75% of adolescent boys with untreated ADHD used drugs.

Adolescent boys and girls with ADHD may be engaging in substance abuse, early and unprotected sex, and reckless driving, and they also may not be performing well in school. Young identifies those with purely inattentive-type ADHD as one of the groups that may not be identified as having a problem. These adolescents and adults may be seen as flighty and flaky or just "bubbly." Unfortunately, when these individuals are written off in this way, they never get the appropriate help and never realize their full potential. One full chapter is devoted to gender issues, specifically how young women with ADHD are different from young men with ADHD. The women often get overlooked because their symptoms do not typically present as the in-your-face attitude of a boy with ADHD, something that looks more akin to oppositional-defiant behaviors. Young women tend to be more introverted, shy, and distractible and may even be treated for depression or anxiety, although the overriding problem is in fact ADHD.

Young reviews the treatment modalities, including medication and therapies, in the final few chapters of the book. Treatment often evokes the common problem of prescribing a stimulant medication to a former drug abuser. The goal is to treat the problem without causing other problems. If the clinician does not want to take the risk, there are always nonstimulant medications for this patient population, such as atomoxetine and modafinil, neither of which has any abuse potential.

With this book in hand, psychiatrists, nonpsychiatric physicians, and the lay public all get a very good view of ADHD in the adolescent and adult populations, the real face of this problem, and the pitfalls of not treating it, as well as the pitfalls faced during its treatment. ♦

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