

The Strengths Model: Case Management With People With Psychiatric Disabilities, Second Edition

by Charles A. Rapp and Richard J. Goscha; New York, Oxford University Press, 2006, 320 pages, \$55

Curtis Adams, M.D.

The helpful and practical book *The Strengths Model* guides willing case managers toward a recovery-oriented approach for the people they serve. Its brevity increases the likelihood that this important text will be read, and it will not leave the reader feeling shortchanged on content.

The authors encourage improving the language and behaviors of case managers, but they do not rid us of the term “case manager.” They reintroduce the term “traveling companion,” which was used by Dietchman (1), but recognize that it has yet to replace the term “case manager.” Their stated intent is not to change terms but to change behaviors. The authors and the rest of us remain stuck with the dehumanizing terms “case manager” and “case management” for now.

The opening chapter entitled “History Critique and Useful Conceptions: Toward a Strengths Paradigm” could be renamed “The Weakness Model: How We Misunderstood and Mistreated the Mentally Ill and Continue to Do So.” We are reminded of how we have labeled people with our terms, dictated the duration and type of treatment they are to receive, and required that they come to our turf and play by our rules. If not, they are labeled as “noncompliant” and are described as “lacking insight.” We set goals such as “structure” and “socialization,” as if someone prefers those over a job, friends, a home, and a life.

It is our good fortune that the remaining chapters direct us from the weakness model to the strengths model. Rapp and Goscha chide some of us for claiming to carry out the strengths model when what we are doing actually falls a bit short of the mark. They teach us how to do

strengths assessment and how it can replace the typical problem-based assessment. We also learn how to create a personal plan with real goals instead of the typical, one-size-fits-all individual treatment plan that is loaded with our terms and goals.

Later in the book the authors direct us to see the community as full of helpful people and useful services in the chapter titled “Resource Acquisition.” We learn how to find strengths in the community and not solely in the client, and we are encouraged to look outside the mental health services sector to help people enhance their lives. Another chapter demonstrates how to create an organization that is

top-down but has the clients at the top, not the chief executive officer. We are taught how to structure teams, how to optimize their size, how to support them, and how to supervise them using strengths-based methods.

Case managers and those who supervise them will greatly benefit from this highly readable text. Anyone who is familiar with the strengths model will be gratified by reading the book and can use it to improve his or her skills. Clients and family members can use the book as an advocacy guide and a template for the services that they deserve. In all, it’s a book that needs to be read and that advocates methods that must be used. ♦

Reference

1. Deitchman WS: How many case managers does it take to screw in a light bulb? *Hospital and Community Psychiatry* 31:788–789, 1980

Juvenile Justice: Child and Adolescent Psychiatric Clinics of North America, Volume 15, Issue 2

by Robert Vermeiren, M.D., Ph.D., and Vladislav Ruchkin, M.D., Ph.D.; Philadelphia, W.B. Saunders, 2006, 240 pages, \$85

Thomas Grisso, Ph.D.

This is the first issue in the Clinics series devoted to juvenile justice, and it provides an overview of mental health issues relevant to the juvenile justice system. As the book’s preface explains, in the United States and many other countries during the 1990s the juvenile justice system became increasingly retributive and less rehabilitative in its objectives. But a few years ago research began to reveal that a large proportion of youths in juvenile justice programs—around two of three—met clinical criteria for one or more mental disorders. This has fueled new interest and attention regarding ways to respond to the mental health needs of youths as they enter, are processed through, and are in the custody of the juvenile justice system.

This interest has produced other

recent works devoted to the topic, but few with the breadth and diversity of this volume. Its 13 invited articles are clustered in three sections that cover a wide range of topics, including the nature and prevalence of mental disorders among youths in the juvenile justice system, methods and issues in identifying youths’ disorders, and reviews of treatment methods within the context of juvenile justice objectives, programs, and resources.

Another source of diversity for this volume is its international perspective. Its editors are Robert Vermeiren of Leiden University in the Netherlands, and Vladislav Ruchkin of the Karolinska Institute in Sweden and

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Yale University. Almost half of the articles are authored by North Americans, and the rest are by authors with primary or joint affiliations in Europe or Russia—with some collaboration with American authors. In addition, the authors represent a balanced blend of psychiatrists and psychologists, all of whom value and apply a decidedly empirical perspective in their reviews and discussions of the issues.

Overall the articles are well written and well researched, and most of them offer up-to-date information with excellent depth and a degree of synthesis that avoids a tedious study-by-study review. The articles that review mental disorders avoid clinical generality and instead discuss disorders in the context of delinquent youths specifically. Regarding assessment of youths, the chapters on mental health screening and on violence

risk assessment are especially strong, but the volume offers little for students of juvenile forensic assessment, such as evaluations to address specific legal questions related to transfer to criminal court and competence to stand trial. The reviews of treatments focus on what can be applied practically and what works within juvenile justice settings specifically.

International reviews focusing on legal or systematic questions run the risk of offering discussions that are relevant for some countries but not for others because of jurisdictional differences. The risk in this case was worth it. Indeed, one is impressed by the many cross-national commonalities faced by clinicians who are concerned with the relationships between mental disorders and delinquency, as well as identification and treatment of mental disorders within a juvenile justice context. ♦

stress disorder,” an increasingly recognized entity in children.

More complicated medical problems and their accompanying psychological difficulties are discussed in later chapters. Other chapters address pediatric oncology and organ transplantation. The section on palliative care describes dying children who will “dose themselves,” tempering sadness with moments of relief: crying one minute and playing the next. Much advice is provided on alleviating the child’s distress from medical procedures. Simple techniques include preserving the child’s room as a safety zone and giving the child a modicum of control, such as letting him or her choose which arm to use for blood draws. Hypnosis, a technique particularly helpful for children given their natural imaginative abilities, is presented as an option.

Because this book is a manual, its focus is on practical applications, with multiple sidebars outlining salient points. These points include the more complex issues, such as psychodynamic theories and developmental perspectives. Younger children may misinterpret what is occurring as punishment for bad behavior. Alternatively, the child may consciously or unconsciously use the illness to avoid stressful academic and social activities. For adolescents, physical illness can interfere with the crucial developmental tasks such as gaining autonomy from parents and fostering social acceptance from peers. The frequent result is treatment nonadherence, a frustrating but common behavioral outcome in pediatric medicine.

The concluding chapters primarily focus on treatment, both for the individual and for the family. Parents may have guilt and adjustment difficulties because of the loss of a “complete child.” Siblings, often overlooked, have their own set of questions and conflicting emotions. There is a progressive organization of family life around the ill child. Advice is given on how to reestablish routines and regain equilibrium so that illness does not consume family life. There is extensive information on pharmacology, including a section on pain manage-

Clinical Manual of Pediatric Psychosomatic Medicine: Mental Health Consultation With Physically Ill Children and Adolescents

by Richard J. Shaw, M.D., and David Ray DeMaso, M.D.; Arlington, Virginia, American Psychiatric Publishing, Inc., 2006, 480 pages, \$52

Matthew Kleban, M.D.

The multifaceted role of a pediatric psychosomatic medicine consultant extends beyond helping the patient to cope with emotional adjustments of illness or addressing acting-out behaviors that may ensue. Interventions include addressing physical symptoms, helping to manage physical pain, considering side effects of medication, and minimizing potential drug interactions. The consultant’s role goes beyond the needs of the child and encompasses providing support and education for families as well as serving as, in the truest sense of the word, a liaison among the patient, the family, and the primary medical team. Written by Richard Shaw and David DeMaso, *Clinical*

Manual of Pediatric Psychosomatic Medicine helps to navigate these complexities.

Introductory chapters describe general principles and techniques of assessment. They discuss forensic issues, particularly the thorny issue of parental consent and its exceptions among pediatric patients. Subsequent chapters each address a specific psychiatric disorder: delirium, mood disorders, anxiety disorders, somatoform disorders, and pain. Each chapter takes a pragmatic approach that attempts to untangle the diagnostic dilemmas that take place at the mind-body interface. Depression may present with nonspecific somatic complaints, such as chronic abdominal pain and headaches, rather than classic symptoms. Stress related to illness can trigger anxiety symptoms to form a picture of “medical posttraumatic

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ment and a more general chapter discussing uses of medication in particular disease states.

Although the book is primarily geared toward psychiatrists working in a hospital consultation setting, there is much here that is applicable to those who work in outpatient settings. At best, most children have minor medical issues at some point, and at worst, some have a chronic medical illness or have family members with such problems.

One notable weakness of the book is that data from studies of children are often described interchangeably with data from adult studies. There is little attempt to distinguish the two as the authors try to fill in the gaps in this relatively young and uncharted field. Despite this limitation, this book succeeds in being both highly readable and very informative, providing useful insights and practical advice for treating this challenging population. ♦

young and, too often, is a movement that has been defensive and self-consciously self-promoting. For example, one national American Association of Family Therapy convention adopted the theme "Family Therapy Works!"

In contrast to this type of promotion, in the chapter "Research Using the McMaster Model," I found a statement that says much about the scholarly integrity of this research group: "To date, our preliminary analysis in the treatment studies have not shown a direct cause and effect between receiving family therapy and patient outcome." As someone who has reviewed much of the major work on family therapy over the past 20 years and who, since 1960, has earned his living teaching and practicing family therapy, that is a statement that could arguably be made about much work in family therapy.

We, as a movement, are a work in progress, too often proceeding as much on conviction and faith as on indisputable, hard-science demonstration of our effectiveness. That these authors can fearlessly and unashamedly make such a statement demonstrates their commitment to truth, science, and scholarship and represents in part the coming of age of a major portion of the family therapy moment. I urge the purchase of this timely, impressive, and indispensable book. ♦

Evaluating and Treating Families: The McMaster Approach

by *Christine E. Ryan, Nathan B. Epstein, Gabor I. Keitner, Ivan W. Miller, and Duane S. Bishop*; New York, Routledge, Taylor, and Francis, 352 pages, \$39.95 softcover

William Vogel, Ph.D.

The McMaster model of family functioning originated at McGill University in Montreal approximately 50 years ago under the direction of Nathan Epstein. Development of the McMaster model continued at McMaster University in Hamilton, Ontario, and progressed further at Brown University in Providence, Rhode Island, where Epstein had moved and originated the Family Research Program. The research has involved a major team effort.

I have reviewed many books in family therapy that have presented a wide spectrum of theories and practice models, and this book is truly outstanding. It represents a major development in the coming to maturity of the field of family therapy. It is a very important and impressive piece of scholarly work, which embraces and builds upon other earlier models.

So how is this approach different? First, many workers have attempted to design a highly structured, therapeutic approach, without always managing to do so. This book convincingly presents just such an approach. Secondly, many have tried to develop a short-term, six-

to 12-week crisis-centered model without quite demonstrating that they have developed a workable, practical, functional approach; these authors demonstrate that they have done so. Third, the model is clearly evidence based.

Half the book presents us with research instruments and research studies that substantiate many of the authors' claims. The group's research is well done and, unlike much of the research in family therapy, meets the basic requirements of scientific quality, using control or comparison groups, suitable numbers of study participants, appropriate statistics, objective assessment techniques, and hard-headed, rigorous evaluation of findings.

The McMaster model originally emanated from psychodynamic models but is not wedded to psychodynamic or psychoanalytic models. It is essentially a systemic, behavioral approach. To quote the authors, "insight is not a necessary or sufficient ingredient for change to occur in the system. Our concern is not what produces pathology in the individual, but with the process occurring within the family that produces the behavior. Therapy is directed at changing the system and thereby changing the behavior of the individual."

The family therapy movement is

The Evolving Brain: The Known and The Unknown

by *R. Grant Steen, Ph.D.*; Amherst, New York, Prometheus Books, 2007, 435 pages.

Lewis A. Opler, M.D., Ph.D.

The author of this book, a neurophysiologist in the field of psychiatry, has superbly described breakthroughs in basic neurobiology, debunked "intelligent design," and both argued and demonstrated the need for cross-disciplinary collaboration to address issues such as consciousness,

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creativity, and self-knowledge. Well written and informative, *The Evolving Brain* is recommended to a broad audience, including students wishing to gain an appreciation regarding how neurobiology can help address big questions in both normal psychology and in psychopathology, as well as established clinicians and researchers wishing to see the larger panorama within which their own focused work resides.

I personally found the review of basic neurobiology, from the action potential to emergent complexity, reinforcing in areas where I am knowledgeable (mental disorders and their biological correlates), informative in areas where I am less adept (computer modeling of mental processes), and refreshing throughout in its interdisciplinary breadth.

Paradoxically, given its title, the only area that I felt was not handled expertly was in its handling of how and why evolution had chosen us—*Homo sapiens*, with our large prefrontal cortex and our increased plasticity and capacity for learning and communicating—to be the rulers of planet Earth. Possible answers include intelligence, language, communication, theory of the mind, and activation of pleasure circuitry because of affiliative behavior—all lead to collaboration and sociality of our species.

But what external changes emerged 50,000 years ago allowing this to give us a selective advantage? Evolutionary theory itself has evolved, and this is not addressed. Specifically, whereas early models suggest that individual traits gradually take over because of their conferring an increased chance of procreating by their host, punctuated equilibrium argues convincingly that speciation confers stability, with new species emerging only when external factors throw ecosystems into disequilibrium. A clear example of this, supported by the fossil and geographic record, is the sudden end of the dinosaurs after a meteor hit Earth rendering it uninhabitable by dinosaurs and giving mammals a selective advantage. So what factors gave us, the intelligent affiliative communicator, a leg up? Did a planet lacking an

adequate food supply select us because we, by virtue of our ability to collaborate, could hunt in tribes and follow game, as well as develop societies where agriculture and breeding of other animals could occur? I do not know. But I had hoped that Dr. Steen's book about the evolving brain would answer such questions.

Steen unequivocally delivers a slam-dunk victory for evolution over intelli-

gent design. But I kept waiting for cutting-edge neurobiology and psychology to meet cutting-edge evolutionary theory, and this did not occur.

But, other than this, I found this book a tour de force. Paraphrasing Steen's closing sentence—"If great science is revolutionary, it follows that good science should be at least subversive"—the book is at least subversive. ♦

What Is Mental Retardation? Ideas for an Evolving Disability in the 21st Century

edited by Harvey N. Switzky and Stephen Greenspan; Washington, D.C., American Association on Mental Retardation, 2006, 358 pages, \$59.95

Lee Combrinck-Graham, M.D.

This book is both an elaboration of and debate about the 2002 update of the criteria for "diagnosing" mental retardation published by the American Association on Mental Retardation. Facing 358 pages of arguments, explanations, historical review, and references on the subject is truly daunting but fascinating, both because of the passion and erudition of the contributors and because naming and diagnosing are at the heart of how we work throughout the health and mental health fields.

The condition now referred to as mental retardation has been called idiocy, feeble-mindedness, and mental deficiency. In fact the previous name of the American Association on Mental Retardation used to be the American Association on Mental Deficiency. And the name, itself, is still in evolution: the term "intellectual disabilities" has recently come into common usage among professionals.

The 1992 update of criteria claimed "a new paradigm," a focus on the adaptation of the individual in society rather than on "absolute" measures, such as IQ. The essence of changes in

definition in the most recent publications is the increasing focus on functionality and service needs and decreasing reliance on IQ test measurements as determining the diagnosis. Some of the authors disdain this relativism as ignoring science and ultimately degrading the definition.

As the many polemics in the book elucidate in one way or another, there is a significant tension between a definition that provides a platform for research—based on measurable parameters—and a definition that supports the individual's qualifications for services. An example that has always been frustrating for those of us who work in schools is that a child whose IQ is above 75 does not qualify for special education services, unless the child is identified as having a specific learning disability. If there were a proper classification for "mental retardation" with appropriate educational interventions associated with it, then such children might receive a more effective and relevant education.

David Coulter, in his chapter on neighbors and friends, states, "Families are looking for help so that their child can become a valued, productive, and responsible member of the community." A definition that focuses on the interaction between the individual and society as the object of assessment and intervention seems most appropriate for furthering this

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objective. At the end of his chapter, Coulter describes a dream trip through his community populated with individuals with intellectual disability working along with others as students, teammates, waitresses, condominium owners, and even representatives in local government.

DSM-III introduced five axes for diagnosis to identify general medical and psychosocial factors in psychiatric functioning, as well as to try to distinguish state and trait. A major problem in practice has been the emphasis on axis I and sometimes on axis II and a

relative failure to use the information from axes III, IV, and V significantly in treatment planning. As for research, axes IV and V seem to be problematic. This has led to procrustean distortions of axis I diagnostic categories, forcing developmental, historical, and traumatic outcomes into disease states.

The 2002 American Association on Mental Retardation classification is nowhere near perfect. But as this book illustrates, the effort to get minds around these challenges is heroic. ♦

national Classification of Functioning, a framework for measuring health and disability.

In the seventh chapter, Harris exhaustively describes the known genetic causes of intellectual disability, behavior, and behavioral phenotypes. He goes into the details of the genetic influences on behaviors in several syndromes, including Down's syndrome, the velocardiofacial syndrome, fragile X syndrome, and others. Each description includes prevalence, genetics, prenatal testing, physical features, behavioral phenotype, cognitive profile, neuroimaging, and treatment.

Harris refuses to treat intellectual disability as a static condition but as an evolving process in the life span of a person. He details changes that can occur with proper diagnosis, treatment, care, and vocational placement. He touches on moral development and the role of the family.

Overall this is a remarkable and timely book that will be welcomed by all professionals and students who venture into the thorny field of intellectual disability. ♦

Intellectual Disability: Understanding its Development, Causes, Evaluation and Treatment

by James C. Harris, M.D.; New York, Oxford University Press, 2005, 448 pages, \$45

Ramakrishnan S. Shenoy, M.D.

The estimated prevalence of intellectual disabilities is about 1%, which is roughly the same as the prevalence of schizophrenia. Despite this, books about the developmental, genetic, psychiatric, vocational, and family impact issues in the population with intellectual disabilities are rare compared with those on schizophrenia and other mental disorders. James C. Harris, a professor in psychiatry and pediatrics at Johns Hopkins University School of Medicine, has done an admirable job with this comprehensive book, which can be used as a reference or a textbook for psychiatrists, medical students, researchers, and treating professionals of all types.

Harris has meticulously reviewed a wide range of clinical research on etiology, prevalence, pathogenesis, and clinical features, including treatment and genetic issues, with an emphasis on behavioral genetics and the educational and social aspects of intellectu-

al disability. His tenth and last chapter is devoted to ethics and spirituality, a subject seldom if ever addressed in a scientific publication.

Each chapter contains a thoroughly researched historical background of the subject, which adds perspective to the topic and stimulates the reader's interest. In the third chapter, entitled "The Classification of Intellectual Disability," Harris compares the various systems that are currently being used to diagnose and classify people with intellectual disability. Each system varies in slight details of definition and classification. He provides case vignettes to illustrate the differences between the tenth revision of the *International Classification of Diseases*, the *DSM-IV*, and the American Association on Mental Retardation (AAMR). Overall, the AAMR system is the most comprehensive. It emphasizes the parallel aspects of adaptive behavior and intellectual disability, the etiology, the environmental aspects, and the individual's desired outcomes, which can influence the environmental supports. One of the dimensions of the AAMR classification incorporates the World Health Organization's emphasis on functioning as described by the Inter-

Posttraumatic Embitterment Disorder: Definition, Evidence, Diagnosis, Treatment

by Michael Linden, Max Rotter, Kai Baumann, and Barbara Lieberei; Cambridge, Massachusetts, Hogrefe and Huber, 2007, 155 pages, \$29.80

Yael Dvir, M.D.

Michael Linden, a physician at the Seehof Rehabilitation Center in Berlin, saw an increasing number of patients with symptoms that he described with a new term: posttraumatic embitterment disorder. After Germany's reunification, Linden observed an increase in the rates of reactive disorders. Several years later,

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patients continued to struggle with severe psychological reactions to negative life events. Linden and his colleagues argue that such reactions cannot be classified as posttraumatic stress disorder, adjustment disorder, or even depressive disorder, and suggested posttraumatic embitterment disorder as a new reactive disorder.

In their book, Linden and his coauthors lay out the conceptual issues, empirical evidence, and treatment perspectives for their suggested new illness. The book includes a thorough review of the relationships between stress and life events and a review of the shortcomings of the descriptions of current adjustment disorders including reactions to stressful life events that are not transient. They argue that "the trigger event in posttraumatic embitterment disorder is an exceptional, though normal negative life event such as conflict in the workplace, unemployment, the death of a relative, divorce, severe illness, or experience of loss and separation. The illness develops in the direct context of the event. Characteristic is a prolonged feeling of embitterment." This differentiates posttraumatic em-

bitterment disorder from posttraumatic stress disorder, because the event is not life threatening or fear provoking.

The authors review the empirical evidence they have gathered in the book's second section, which includes diagnostic interviews and criteria, self-rating scales, and epidemiology. The third and last part reviews cognitive-behavioral therapy that has been adapted to treat this disorder.

As I was reading this protracted article in book form, I found it unconvincing that this "disorder," posttraumatic embitterment disorder, is indeed a separate entity, a psychiatric diagnosis that stands on its own. Specifically, in the section describing empirical evidence and discussing psychiatric diagnosis among patients with the purported disorder and control patients, the findings indicate a high degree of comorbidity or diagnostic uncertainty in posttraumatic embitterment disorder: 66% adjustment disorder, 40% dysthymia, 34% generalized anxiety disorder, 18% social phobia, 18% agoraphobia, and 16% personality disorder. In my opinion, with such a large scattering of di-

agnoses across the DSM, a common feeling of embitterment does not make a diagnosis.

Moreover, the study group as well as the control group appears to have been quite skewed: all study patients were recruited through the Department of Behavioral Medicine and Psychosomatics of the Seehof Rehabilitation Center. As the writers note, this is a rehabilitation clinic where the majority of patients are treated for work-related incapacities. The screening questionnaire was tested on 158 passengers traveling on trains from Berlin to Frankfurt, making this a culturally biased study that might be difficult to apply outside of this particular population.

These objections notwithstanding, the concept of a common psychological reaction after a stressful event that does not necessarily qualify as traumatic but results in a debilitating disorder is an interesting and thought-provoking concept. This book, however, provides a somewhat lengthy discussion. For those interested in the field of posttraumatic and adjustment disorders, I would recommend reading the shorter, original article first. ♦