Dialectical Behavior Therapy With Suicidal Adolescents

by Alec L. Miller, Psy.D., Jill H. Rathus, Ph.D., and Marsha M. Linehan, Ph.D.; New York, Guilford Press, 2006, 346 pages, $40

Barent Walsh, Ph.D.

This long-awaited volume is the first full-length publication from the dialectical behavior therapy (DBT) establishment since Marsha Linehan's seminal works in 1993 (1,2). The focus is the treatment of suicidal and self-injuring adolescents, using a considerably modified form of DBT. The book thereby formalizes what is already well known among DBT practitioners: that the treatment can be employed with diverse clientele—well beyond the original trials with adult suicidal women with borderline personality disorder—and that it can be modified, with due caution in regard to adherence.

For those not familiar with DBT, it is an empirically validated, cognitive-behavioral treatment informed by the mindfulness practices of Zen Buddhism. It has four major components: weekly highly structured individual therapy (using a hierarchy of behavioral targets and diary cards); weekly group skills training that focuses on four major skill areas: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness; as-needed coaching between sessions to assist clients with skill acquisition and generalization; and a weekly consultation meeting for the treatment team, designed to enhance learning of DBT and to provide peer support and supervision. These modes of treatment are designed to teach self-destructive and self-defeating clients to employ healthier emotional regulation and interpersonal skills and thereby achieve an improved "life worth living" (1,2). Via the consultation team, the treatment is also designed to "treat the treaters," a phenomenon that may be unique to DBT.

DBT is a complex, intensive, and comprehensive treatment that is not meant for everybody. As noted in the book's introduction. "This book is not intended for the prototypical teen exhibiting fairly benign mood lability. . . . Nor is DBT intended for an adolescent with a single episode of major depression who makes a first suicide attempt following an acute stressor. . . . We believe that DBT is most appropriate for those suicidal teens who exhibit a more chronic form of emotion dysregulation with numerous coexisting problems."

The treatment described in this book is for youths whom I have described elsewhere as "poly–self-destructive" (3), meaning individuals who present with recurrent suicidal behavior in combination with other forms of self-harm, such as nonsuicidal self-injury, eating disorders, substance abuse, and risk-taking behaviors. DBT emphasizes an approach that is supported by considerable research; namely, that treatment that targets self-harm behaviors directly rather than underlying mental disorders—such as depression or anxiety—is more effective.

The book begins with a discussion of the research on suicidal behavior among youths. It provides a very useful summary of the distal and proximal risk factors. The book then moves to a review of the literature regarding treatment of suicidal youth. The authors note with regret that no randomized controlled trials have been conducted that document effective treatment of suicidal behavior of teens. The authors indicate that DBT is the only treatment that has been replicated in demonstrating effectiveness in reducing suicidal and self-injurious behavior of adults. They add that a number of these DBT studies have included older adolescents—18- to 21-year-olds.

Therefore, the authors argue that it is quite reasonable to apply a version of DBT in the treatment of adolescents. They also cite several of their own studies of outpatient DBT that provide promising results about reducing suicidal behavior in youths, although they concede the studies have not been randomized controlled trials.

After the discussion of suicide treatment research, the authors provide a summary of the components of standard DBT. This is useful because it is relatively brief and is considerably more accessible to the naïve reader than the original DBT text (1).

The real contribution of the book is in the next eight chapters, as the authors describe their treatment in detail, citing both the consistencies with and the modifications to standard DBT. Some of the more important changes include the length of the treatment, which is reduced from one year to 16 weeks—with the possibility of 16-week "graduate group" extensions; the inclusion of at least one family member—most often a parent, but in other cases, a grandparent, guardian, or even a teen spouse—in group skills training; the creation of a fifth skills training module, named "Walking the Middle Path;" and modifications to skills training lectures, handouts, and diary cards based on the developmental characteristics and learning styles of adolescent clients.

Going from the 52 weeks of standard DBT to 16 weeks is a substantial reduction. It suggests that the treatment can be delivered in a more abbreviated fashion with similar results. However, this is not really the claim of the authors. Rather, they note the "extremely high rate of treatment drop out of suicidal adolescents" and recommend the shorter regimen as a strategy to engage adolescents, who notoriously avoid treatment. The authors recommend convincing adolescent clients to accept a relatively brief 16 weeks of treatment as a first step; then, once teens have experienced the benefits of firsthand treatment, they are far more likely to commit to an additional round. The authors note that in this manner some youths remain in DBT treatment for as long as two years.

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The addition of the new fifth module, "Walking the Middle Path," is another significant contribution of this book. The terminology reflects the Zen Buddhist roots of DBT and refers to the need for adolescents and their families to make peace with certain fundamental "dialectical dilemmas." The three new dialectics featured in this new module are framed as transactional paradoxes that parents, therapists, and youths need to understand and balance. The dilemmas are choosing between excessive leniency and authoritarian control, normalizing pathological behaviors versus pathologizing normal behaviors, and forcing autonomy versus fostering dependence. Therapists working with teens, and parents living with them, will recognize these dilemmas as fundamentally important in facilitating growth in adolescents. DBT offers a framework for understanding these dilemmas and the skills to navigate them.

The middle-path module also teaches skills of self-validation and other forms of validation and principles of basic behavior change, including extinction, punishment, and reinforcement. Thus, parents and children learn together in multifamily groups how to validate and effect positive change in themselves and their significant others.

I was struck by the discussion of how to conduct therapy with teens on an interpersonal level. I've never read a better, concise description of what it takes to work with adolescents than the following: "A key strategy to working with adolescents involves conveying a down-to-earth, friendly, egalitarian, and open demeanor, while maintaining an understated degree of expertise and credibility."

Of course, any book review should include some criticisms. First, the title of the book is delimiting. The treatment described is likely to be useful for a broad range of persistently and emotionally dysregulated adolescents, not just those who are suicidal. I also found the list of mindfulness exercises provided in appendix A to be somewhat disappointing. Although the diverse list of activities is helpful, I regret that more examples of mindful breathing exercises weren't included. My own experience in running DBT programs is that breathing skills are especially useful in assisting clients to regulate their emotions more effectively. Plus, such skills are immensely portable; breathing techniques require no equipment, other persons, or special circumstances. I have found that mindful breathing is often helpful for adolescents in dealing with such challenges as tests and exams, athletic competitions, peer conflicts, dating anxiety, authority figures, and agitated parents (3).

These are modest criticisms regarding an important contribution to the literature on the treatment of self-destructive adolescents and their families. What remains, as duly noted by the authors, is for randomized clinical trials to be conducted that support the efficacy of the treatment. ♦

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3. Walsh BW: Treating Self-Injury: A Practical Guide. New York, Guilford, 2006

Competency in Combining Pharmacotherapy and Psychotherapy: Integrated and Split Treatment

by Michelle Riba, M.D., M.S., and Richard Balon, M.D.; Arlington, Virginia, American Psychiatric Publishing, Inc., 2005, 168 pages, $42.95

Jeffrey L. Moore, M.D.

This book is the fifth and last in the core competencies series, edited by Glen Gabbard. The series has done a great deal to illuminate the requirement of the Psychiatry Residency Review Committee (RRC) of the American Council for Graduate Medical Education first introduced in 2001, to train residents in specific forms of psychotherapy. The authors of the latest text are well known and have published previously on related topics in the training of psychiatry residents. The intended audience for the book is clearly psychiatric residents and their teachers, although it will likely be of some interest to other educators and psychiatrists in practice.

The book is divided into three parts. The first section, on integrated treatment, uses plain language to describe a practical approach to psychiatric treatment in which the resident provides both medication and psychotherapy. In the second section, the same themes are repeated but elaborate the complexities that are introduced when another professional provides the therapy and the resident sees the patient for medication alone. Suggested competencies are set off in boldface throughout this section; these competencies are collected together in the third part, which deals with evaluation, monitoring, and supervision of trainees.

The entire book might be used as a course text or an introduction to outpatient psychiatry. There are excellent discussions of general issues in starting treatment, performing an initial evaluation, planning and sequencing treatment, and ending treatment. In the section on split treatment, there is appropriate emphasis on the importance of good communication between the therapist and resident and on the many pitfalls that can arise. Training directors will find the last section quite helpful in documenting competencies for the RRC.

Throughout the book, integrated treatment is clearly preferred when possible, illustrated by use of the term "split" instead of "collaborative"

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treatment. The authors decry the fragmentation of the system of mental health care and the lack of organization and planning in its construction. At the same time, they offer practical, real-world advice on recognizing the drawbacks of split treatment and dealing with them in a way that optimizes the treatment of patients. For example, there is an especially good discussion of issues in split treatment of patients with borderline personality and guidance on how to manage them.

The authors are not afraid to take a firm position on certain possibly contentious issues in split treatment. These include a recommendation that residents should develop the ability to potentially reformulate a case, a clear statement that "thirty minutes is not adequate for any initial evaluation," and recognition that the resident must determine when not to prescribe medication in a split-treatment arrangement.

The structure of the book allows for the first and second sections to stand alone, although the resulting repetition of material can be irritating in a single read through. The section on integrated treatment might benefit from more discussion of mind-brain issues, addressing questions of when symptoms and responses should be understood as relevant to the therapy or the psychopharmacology.

Competency in Combining Pharmacotherapy and Psychotherapy is a wonderful addition to residency training, with a comprehensive approach to the teaching and evaluation of competency in combined treatment. ♦

Diagnostic Issues in Dementia: Advancing the Research Agenda for DSM-V

edited by Trey Sunderland, M.D., Dilip V. Jeste, M.D., Olusegun Baiyewu, M.D., Paul J. Sirovatka, M.S., and Darrel A. Regier, M.D., M.P.H.; Arlington, Virginia, American Psychiatric Publishing, Inc., 2007, 165 pages, $45

Janis Petzel, M.D.

Can you imagine a more onerous job than trying to revise the *Diagnostic and Statistical Manual of Mental Disorders*? But *DSM-IV* is getting old. Whether or not you agree with the categories that are being emphasized by the revision planners, you have to admire the effort.

Diagnostic Issues in Dementia follows a collection of white papers, *Advancing the Research Agenda for DSM-V,* in the slated progress toward the creation of *DSM-V*. David Kupfer is chair of the *DSM-V* Task Force, and Darrel Regier is the vice-chair. This gargantuan, decade-long revision process involves an international collaboration between the American Psychiatric Association (APA), the World Health Organization, and the National Institutes of Health. In 2005, the Dementia Work Group, chaired by three of the editors of *Diagnostic Issues in Dementia*, invited a small, international panel to convene in Geneva, Switzerland. The papers from that conference were published in the *Journal of Geriatric Psychiatry and Neurology* and have been republished, most without apparent change, in the book reviewed here.

This book summarizes in very few pages—146 pages, including references—what leaders in the fields of geriatric psychiatry and dementia research see as pertinent information. As such, it represents a manageable overview of the field for students, geriatrics residents and fellows, academics preparing lectures, or those studying for board exams. Chapters cover normal and abnormal aging of the brain, epidemiology of dementia, diagnostic criteria for various dementias, mild cognitive impairment, neuropsychological testing and neuropsychiatric syndromes, biomarkers, neuroimaging, and genetics.

All of the chapters take care to describe a historical perspective about what is known and how disorders became classified, which I found to be valuable and intriguing. Gaps that need more investigation are also identified. For example, it is still not clear if the depression associated with dementia has the same biological basis as major depression in younger people. This distinction has important ramifications for treatment, especially because the few studies that have looked at antidepressant use in depression in dementia have been, in the aggregate, less than convincing about the benefits of pharmacologic treatment.

Brief summaries of the presentations from the Geneva conference can be found online at dsm5.org. The information, prepared by Michael First, does an excellent job collating the highlights of each presentation. Some material from the conference was left out of the book, which is unfortunate. For example, there was a discussion by John Saunders on substance use and cognition that does not receive its own chapter in the book. Breakout sessions at the conference made recommendations for possible changes to *DSM-V*; however, this information does not appear in easily accessible form in the book. Ideas for changes are embedded in the text of each chapter, but there is no wrap-up or final summary. There is a one-page appendix of recommendations attached after the reference section for Chapter 3—"Diagnostic Criteria in Dementia"—but I found it by accident.

The problem that I, as a geriatrics psychiatrist, have with *DSM-IV* definitions in dementia is their lack of specificity and the need to rule out so many other, less likely, diagnoses before I can give a name to a patient's symptoms. Any dementia will, at some point, cause problems with speech, recognition, ability to carry out patterned tasks, or executive function.

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When I have a question about diagnosis in dementia, I don't reach for the *DSM-IV-TR* for clarity; I reach for my beloved copy of *Dementia: A Clinical Approach* (1) and then try to retrofit my diagnosis to the *ICD/DSM* codes. If patients have mild cognitive impairment or are clearly disabled by dementia but their memory has been thus far spared, *DSM-IV* is more of a hindrance than a help.

Based on the material presented in *Diagnostic Issues in Dementia*, *DSM-V* may improve in these areas. *DSM-V* may get rid of the concept that age 65 is an important diagnostic consideration in Alzheimer's disease. I may include mild cognitive impairment as a diagnostic category, broaden the scope of the vascular dementia criteria to include more than multi-infarct dementia, and recognize that loss of function, not simply memory impairment, is the hallmark of some early dementias. Neuropsychiatric syndromes in dementia—in particular, psychosis and agitation—do not have as much evidenced-based clarity but are receiving appropriate discussion. These ideas for *DSM-V* resonate with my clinical experience.

However, some of the discussion in this book made me very nervous—in particular, the chapters on neuroimaging and on biomarkers. The chapter on neuroimaging was actually fascinating, but I shudder at the cost of doing imaging on an ever-increasing geriatric population. It's great as a research tool; I just hope the imaging will be used to identify treatments and not to expand the roster of routine clinical procedures. Likewise, the idea of doing routine lumbar punctures for diagnosis is unpalatable because of the cost but even more so because of the implications for patient care. The idea that "the lumbar puncture procedure itself can be streamlined and improved to markedly reduce the threat of lumbar puncture headaches" seemed so out of line with reality in nonacademic, rural, or non-Western settings that I pray that cerebrospinal fluid findings will never be part of diagnostic criteria for Alzheimer's disease. Maybe this procedure is necessary for rare dementias when diagnosis can't wait, but certainly not for routine diagnosis. I was horrified that researchers involved in *DSM* discussion panels even mentioned brain biopsy in the context of future changes in risk assessment for dementia diagnosis.

And then there is the issue of the pharmaceutical industry influence in these discussions. It's all well and good that the APA limited participation in the *DSM-V* Task Force to those who have received less than $10,000 a year from pharmaceutical companies in the past few years, but what about all of the folks who have already advanced their careers by receiving industry grants and now serve on panels and editorial boards and grant review committees? Is that taken into account anywhere? How has that affected creativity in research? Of the 27 members of the APA *DSM-V* Task Force, only eight members had no industry relationships in the past 36 months to report. In the volume reviewed here, 11 of 21 authors reported conflicts of interest. I fear that it's no coincidence that the pharmaceutical industry has achieved treatments for middle to end stages of Alzheimer's disease and that research in dementia has clustered, for the most part, in the same clinical ballpark. As the first chapter of this book makes clear, plaques and tangles are hardly the end of the story for Alzheimer's disease. People with no known dementia or with non-Alzheimer's dementias have the pathophysiologic findings, and a fair number of patients with dementia have neither plaques nor tangles. Maybe it's time to expand our horizons.

A surprise in this book is that genetics "has only meager offerings for *DSM-V* . . . those who expect a gene test or genetic profile that defines Alzheimer's disease or another dementia will be sorely disappointed." The issue of apolipoprotein E as a risk factor is clearly reviewed. Even though apolipoprotein E testing is not advised as a clinical tool, it is being used in research to enrich the sample of patients who may develop cognitive problems. As Gary Small points out, "combining apolipoprotein E genetic data with other relevant biological information (neuroimaging in his case) has proved to be a useful strategy for early detection of subtle brain abnormalities."

As a final harangue, I worry about the *DSM* as it tries to incorporate so many ideas from so many sources. One hopes that form follows function, but what does that mean when the end product will be used by clinicians as well as by the general public, certain businesses, and those in research? My hope is that they don't create something that makes it easier for insurance companies to deny treatment for my patients. *DSM-V* should appear sometime in 2011. ♦

Reference

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Clinical Manual of Geriatric Psychopharmacology

by Sandra A. Jacobson, M.D., Ronald W. Pies, M.D., Ira R. Katz, M.D., Ph.D.; Arlington, Virginia, American Psychiatric Publishing, Inc., 2007, 289 pages, $74 softcover

Othmane Alami, M.D.

Medication management in the field of geriatric psychiatry is a real and constant challenge. Elderly patients tend to be on multiple medications, have multiple comorbidities, be more sensitive to side effects, and have issues that can impair their adherence to treatment. To make matters worse, there is a lack of empirical evidence that can guide the clinician because a majority of clinical trials for psychotropic medications are done with young individu-

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als. These elements make the decision to start psychotropic treatment of an elderly patient a real challenge because the clinician has to assess the risk-benefit ratio.

In the first chapter of this book, the authors give valuable general advice on how to maximize the therapeutic effects of the medications, how to minimize the adverse side effects, and how to simplify the treatment plan in order to improve adherence. The basics of geriatric psychopharmacology are covered in the second chapter, with useful figures and tables. The chapter could have been more extensive, but the purpose of this book is, after all, to be an easy-to-use book, thorough yet practical. Each major class of psychotropic medication—antipsychotics, antidepressants, mood stabilizers, and sedative-hypnotic drugs—gets a full chapter. Each chapter has treatment algorithms, rating scales, tables covering the adverse side effects, and quick-reference summaries on selected drugs.

The last chapters are dedicated to the treatment of substance-related disorders, movement disorder, dementia, and cognitive disorders. Finally, a full chapter is dedicated to analgesic medications. Some may be surprised to find a full chapter covering analgesic medications. This is quite appropriate because a large percentage of the elderly population, often in nursing homes, have an underlying pain condition. The authors could have spent some time discussing how to prescribe in the context of the constraint of Medicare Part D. Because elderly patients may end up receiving electroconvulsive therapy, covering the management of medications for a patient about to receive or undergoing electroconvulsive therapy could also be useful.

If the authors were trying to come up with a reference that is easy to read yet thorough, a book that can be used by all health professionals working closely with elderly patients regardless of the setting—inpatient, outpatient, nursing home—then they did a great job. ♦

Patient Compliance: Sweetening the Pill

edited by Madhu Davies and Faiz Kermani; Hampshire, United Kingdom, Gower Publishing, 2006, 220 pages, $165

Brian B. Sheitman, M.D.

Though it is obvious, we sometimes forget that no matter how good a treatment is, it will work only if the patient complies with it. This book focuses on one aspect of treatment: medications. The book is written from the perspective of medication compliance as it pertains to all medical disorders without any special focus on psychiatric issues. Furthermore, large segments of the book are written from the viewpoint of the pharmaceutical industry. Although I confess to being a card-carrying member of the club that is extremely skeptical of almost anything reported by the pharmaceutical industry, I found this particular volume to be very informative, well written, practical, and unbiased.

The authors are experts in the field of pharmacology, with considerable clinical trials experience. The contributors are an impressive group of experts who are mostly from the United Kingdom but also from the United States, France, Japan, and Australia. This diversity results in an interesting cross-cultural perspective on the issues.

The book is divided into four parts that comprise a total of 14 chapters. The four parts are titled "What is Compliance?," "The Challenge of Compliance," "Building for Success," and "Achieving Compliance: Looking to the Future." The final chapter, written by Kermani, helps to pull together concepts from throughout the book.

I found that the real strength of this book is the editors' approach that medication compliance is a problem that has an impact on all areas of medicine, especially chronic conditions, and that compliance is not solely an issue facing mental health professionals. Chapter 4 provides extensive data about the challenges of achieving treatment compliance with hyperlipidemia and hypertension, two conditions for which proven treatments are available. Other strengths are a thoughtful review of practical issues that affect medication compliance and new technologies that are now available to help promote compliance. The authors' aim to "explore the key factors which drive compliance and the part that healthcare professionals can play in improving this" is clearly achieved.

The weakness of the book is ironically also its strength. Outside of a few references to problems of compliance with the long-term treatment of depression there is no particular emphasis on psychiatric disorders. Given the challenge in the mental health field of treating patients with disorders that often include a lack of insight, an additional chapter on this topic would, in my opinion, be beneficial.

Overall, this volume is very informative to me as a psychiatrist despite the lack of emphasis on psychiatric conditions. In addition, anyone involved in the broader area of medication compliance could certainly benefit from reading this. Based on the data provided, expecting patients to be fully compliant with medications over a prolonged period of time is unrealistic for most people. As the authors emphasize, an enhanced effort to ensure compliance with treatment is essential to an individual patient's well-being and also remains a major public health concern. ♦

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Psychiatry in the Scientific Image

by Dominic Murphy; Cambridge, Massachusetts, MIT Press, 2006, 422 pages, $35

Jeffrey S. Barkin, M.D.

Dominic Murphy is assistant professor of psychiatry in the Department of Philosophy, California Institute of Technology. His *Psychiatry in the Scientific Image* is a scholarly and rigorous volume that straddles clinical psychiatry and the boundaries of scientific theory. What emerges is a thorough discussion of psychiatric disorders at a deep theoretic level.

Murphy attempts, largely successfully, to understand and classify mental disorders. He tackles theoretic underpinnings in the cognitive neurosciences to foster a deeper philosophic description of what constitutes a mental illness. He takes us on a rigorous journey suggesting that categorical descriptions detract from allowing a deep understanding of mental phenomena. He posits that understanding psychiatric diagnosis must instead be rigorously defined by the scientific method and incorporate explanation from the cognitive neurosciences. We are shortchanged by atheoretic systems, such as the *DSM*, he argues, as we fail to adequately describe and understand what a mental disorder even is.

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Murphy starts the book by defining what constitutes a mental disorder. At what point are certain unusual behaviors considered to be psychiatric disorders? Though persons with Tourette's syndrome demonstrate behavioral symptoms they are not psychotic. Motoric behaviors are not a departure from the reality that defines a psychotic state. Indeed, the categorical taxonomic description detracts from permitting an understanding of etiologic causality.

Murphy then draws upon the work of Guze and Kandel to define the medical model of explanation in psychiatry. Indeed, his description of Kandel's framework of biologic psychiatry is one of the excellent sections in this volume, and he chooses the work of Kandel as a model of scientific reductionism. Murphy then describes the work of Nancy Andreasen to define cognitive neuroscience as a series of convergences from numerous disparate models. He then makes a transition to define the very boundaries of mechanistic explanation of psychosis, addiction, and psychopathy. This section of the book is derived more from philosophy than psychiatry and is more difficult to grasp.

Murphy then segues into a theory of explanatory power that is more intellectually rigorous than simple construct validity. Indeed, in this section his central idea is realized: we must strive to understand psychiatric conditions based upon a group of symptoms that derive from understanding the causal features of normal mental functioning. Rather than a simple categorical description, we will be on firmer ground if we instead view mental disorders based upon underlying etiologies.

This volume is provocative in its intellectual indictment of conventional methods of classifying mental disorders. Murphy strives to understand psychiatric illness from the lens of normal mind- and brain-based behavior. This volume is not readily accessible to the clinically focused reader but will instead be of interest to students of cognitive neuroscience and hypothesis testing related to diagnostic classification. ♦

Additional Book Reviews Available Online

Reviews of three additional books are available as an online supplement to this month's book review section on the journal's Web site at ps.psychiatryonline.org:

- Marguerite A. Hawley, M.D., reviews *The Best Seat in the House: How I Woke Up One Tuesday and Was Paralyzed for Life,* by Allen Rucker
- Richard J. McNally, Ph.D., reviews *Encounters With the Invisible: Unseen Illness, Controversy, and Chronic Fatigue Syndrome,* by Dorothy Wall
- Felicia Kuo, M.D., reviews *Fragile Innocence: A Father's Memoir of His Daughter's Courageous Journey,* by James R. Reston, Jr.