Annals of Clinical Psychiatry, 16:115–123, 2004

ISSN: 1040-1237 print / 1547-3325 online
DOI: 10.1080/10401230490453798

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# Book Reviews

*Cognitive-Behavioral Treatment of Obesity: A Clinician's Guide*, by Zafra Cooper, Christopher G. Fairburn, and Deborah M. Hawker, The Guilford Press, New York, New York; 2003; ISBN: 1-57230-888-5; $ 35 (hardcover), 232 pp.

Long-term studies of obesity demonstrate there are many successful ways to lose weight. A recent comparison of the Atkins Diet with other diets underscored the variety of factors that can produce significant weight loss over a 3- or 4-month period. The difficult part is maintaining weight loss over an extended period of time. Many successful weight loss programs lose their effectiveness when followed for a period of a year or more. The authors of *Cognitive-Behavioral Treatment of Obesity: A Clinician's Guide* understand this short-term effect and describe a comprehensive approach that emphasizes a weight maintenance program.

The book outlines a 24-session CBT program completed over a 44-week period. The program format is organized into nine modules beginning with starting treatment and concluding with weight maintenance. Additional modules focus on establishing weight loss, addressing barriers to weight loss, increasing activity, body image concerns, primary goals, and healthy eating. The acute weight loss plan described is common to many programs with daily caloric intake restricted to 1,200–1,500 kcal per day.

The most innovative strategies in this book target long-term weight maintenance. Following satisfactory acute weight loss, the program emphasizes defining a target weight range and establishing a weight monitoring or surveillance system. If the upper range of satisfactory weight is crossed during surveillance, a weight loss plan is re-implemented. Since the recommended satisfactory weight band is only about 8 to 10 pounds, a relatively short period of caloric restriction is required.

I found the appendix on patient handouts well-organized and helpful. Twenty-two patient handouts are provided including food diaries, strategies for dealing with social eating and vacations, as well as a body image checklist and diary. All the handouts described in the treatment sections are available with permission to photocopy for personal use to all purchasers of the book.

My only hesitancy in recommending this book is the lack of research data on the specific method described in the manual. As they say, "The proof is in the pudding." The authors indicate the program is being tested in a research study described as the Oxford study. This study may be available for examination by the time of publication of this review. Potential readers may want to examine how well this program performed in both acute and maintenance phases of obesity treatment before purchase.

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*Integrated Treatment for Dual Disorders. A Guide to Effective Practice*, by Kim T. Mueser, Douglas L. Noordsy, Robert E. Drake, and Lindy Fox. The Guilford Press, New York, New York; 2003; ISBN: 1-5723-0850-8; $ 42.00 (softbound), 470 pp.

Historically, the treatments for substance use disorders and other Axis I psychiatric disorders developed separately with different staff training, orientation, and philosophy. Separate federal funding and other third party payers' rules for treatment reinforced this segregation and assured the existence of separate treatment organizations. Today, in many locations, that separation remains as indestructible, as they would have said thirty years ago, as the Berlin Wall.

And yet, like the Berlin Wall, the segregation of treatments for substance use disorders and other psychiatric disorders can be breached. Already progress has been made with demonstration and research projects clearly establishing the benefit of "integrated" treatment—that is, one team treats a person for both substance use and psychiatric disorders concurrently. While in some localities integrated treatment is relegated to select organizations with "braided" funding (i.e., separate funding streams from mental health and substance abuse agencies), in others, there is a policy of integrated treatment.

Policy, however, is easier made than implemented. Integrated treatment runs counter to clinicians' philosophy and training. Compounding the problem, clients with co-occurring disorders are the neediest and the most difficult to engage in treatment. In this volume, Mueser and colleagues present practical suggestions for implementing integrated treatment for co-occurring disorders. It is targeted primarily to clinicians in mental health outpatient settings but includes instructions on how organizations can implement integrated treatment. The volume includes chapters on stage-wise case

management, motivational interviewing, and cognitive-behavioral counseling for individual approaches. For group interventions, there are chapters on persuasion groups, active treatment groups, social skills training groups, and self-help groups. The chapter on working with families also has a section covering family collaboration, behavioral family therapy and multiple-family groups. Chapters on other treatment approaches cover residential programs and housing options, hospitalization and criminal justice involvement, vocational rehabilitation, and psychopharmacology.

The authors begin the book by first presenting the magnitude of the problem and the costly futility of ignoring that conservatively 25% of clients with severe mental illness have a current substance use disorder. They then present different theoretical models for why co-occurring disorders exist and the relative merits of their empirical base. This discussion is more than an exercise in theory as these theories influence the belief system of clinicians. The authors then contrast alternative treatment approaches, such as sequential or parallel treatment, and conclude with data demonstrating the superiority of integrated treatment. Impressively, much of these data emanate from the authors' own research experience, reflecting the preeminence they have established in the field from its infancy.

The rest of the book is then devoted to the meat of the problem: assessment and treatment approaches, with a slender chapter on future research priorities. The appendices, spanning 27% of this volume, encompass helpful educational handouts and assessment forms that the authors have used in their integrated treatment programs. The inclusion of these handouts and forms may be the motivating factor for buying the book, although use of them is limited to the purchaser.

The authors have produced an appealing book, well spiced with case vignettes and tabular summaries of important points. The diversity of the authors' backgrounds strengthens the approach advocated and proven by them; they stress the core value of shared decision-making and the importance of teams in addressing the multiple needs of clients with co-occurring disorders.

This very impressive book, nonetheless, has its limitations. As stated above, it is targeted to clinicians in a general mental health outpatient setting. Issues for clinicians at substance abuse treatment programs or those treating special populations, such as adolescents or older adults, are not addressed. The discussion on addressing the needs of clients who abuse opiates is scant with no mention of the coordination required for a client enrolled in methadone maintenance. A similar limitation occurs for organizations struggling with the practicality of implementing integrated treatment. Case reports or vignettes on organizations adopting and changing their treatment approach would have been valuable.

In summary, *Integrated Treatment for Dual Disorders: A Guide to Effective Practice* by Mueser and colleagues represents a vitally needed practical guideline for clinicians who chose (or are mandated) to integrate treatment for co-occurring disorders. Each chapter is clearly laid out with both introductory paragraphs outlining the goal of the chapter and succinct summaries at the conclusion. Its clear, concise presentation of integrated treatment and accompanying educational handouts and forms will be of immense value to clinicians and organizations in meeting the demands of this most demanding population.

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*Catatonia: A clinician's guide to diagnosis and treatment.* By Max Fink and Michael Alan Taylor; Cambridge University Press, New York, New York; 2003; ISBN: 0-521-82226-2; $70.00 (hardcover), 273 pp.

Both Dr. Fink and Dr. Taylor are well known for their contributions to the psychiatric literature. Much of their previous writing has related to electroconvulsive therapy (ECT), and in some ways this book is no exception, since ECT is a frequently used treatment for catatonia. Within nine fairly brief but informative chapters, Fink and Taylor have done an excellent job of reviewing catatonia, arguing for better recognition of its various disguises, and outlining treatment recommendations. They conceptualize catatonia as a "cluster of motor features" that appear in a number of recognized psychiatric conditions.

The authors begin by reviewing the history of catatonia as a clinical concept. This is particularly useful in the topic at hand, since the concepts are still developing. They then describe the various forms that the illness may take, putting catatonia of the schizophrenic type into perspective by including extensive discussions of catatonia in other forms such as mood disorders and delirium. The catatonic subtypes described in the book include retarded, excited or manic, malignant, and periodic. There are also discussions of benign stupor, mixed affective states, and primary akinetic mutism and how these presentations may relate to classical catatonia. Neuroleptic malignant and toxic serotonin syndromes are accorded a position within the subtype of malignant catatonia. The book then discusses differential diagnosis, the relative frequency of these conditions, and important considerations in the clinical assessment of patients suspected of having catatonia and related disorders. The authors briefly return to a historical discussion with a chapter on former treatments of catatonia, followed by a very complete discussion of modern management of the condition. To underpin their view of catatonia as a symptom that crosses many diagnostic categories, the neurobiology of the condition is accorded its own chapter. The final discussion is to some extent a review of the rest of the book, as well as a

description of some research questions that need to be further addressed.

The book has brief but informative patient vignettes throughout that illustrate various points made by the authors, including one or two for each subtype of catatonia that is described. ECT, the reader will quickly find, is often utilized to bring about recovery in the examples cited. Appendices toward the end of the book give a rating scale for catatonia developed G. Bush et al. (*Acta Psychiatr Scand*. 1996; 93:137–143) and an outline for clinical examination of the catatonic patient that allows the clinician to complete such a rating scale, as well as to demonstrate the essential features of the disorder. There is an extensive listing of references, as well as a brief index.

The authors have very definite opinions about catatonia as a specific cluster of signs and symptoms, and they obviously do not feel that the current Diagnostic and Statistical Manual of Mental Disorders does catatonia justice, although they do note that the fourth edition adds some additional diagnostic options. Whether one agrees with their conceptualization or not, there is no doubt that their positions are well thought through and the advice on diagnosis and treatment useful. This book would be especially useful for psychiatrists practicing in consultation–liaison (psychosomatic), state hospital, and academic settings, and could be helpful to anyone who sees difficult and perplexing patients. It covers only one topic, but catatonia is a frequently confusing condition, and this book brings together clear clinical thought and rigorous research data in a way that is both insightful and helpful. It is also very readable, partly due to the frequent use of the brief but relevant patient vignettes that are sprinkled liberally throughout most of the text.

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*Depression in later life: A multidisciplinary psychiatric approach*, edited by James M. Ellison and Sumer Verma, Marcel Dekker, Inc., New York, New York; 2003; ISBN: 0-8247-4246-X; $165.00 (clothbound), 349 pp.

This is the twenty-third book in a series entitled “Medical Psychiatry” and written under the leadership of series editor, William A. Frosch, M.D. Drs. Ellison and Verma have joined with twenty-four other contributors to produce this comprehensive review of late-life depression. The book contains fourteen chapters, divided into two sections: “Overview and Common Manifestations” and “Therapeutic Interventions and Outcomes.” Each chapter tends to repeat some of the general data, so chapters can stand alone if one wishes to read only portions of the book.

The first chapter covers the epidemiology of late-life depression. In it, the authors review a large amount of statistical and demographic information. They also make a point that most geriatricians and geriatric psychiatrists will already know, that depression is not a normal part of aging. Another important point made in this chapter is that depression is typically recurrent. Literature is cited stating that depression recurs more often the older one is at first episode, whereas a later chapter, 14, cites data that refutes this assertion. However, this sort of thing is not uncommon in books having so many contributors and a topic for which there is not much reliable data. Chapter 2 discusses barriers to treatment, and I was a bit surprised that it was not placed in the second portion of the book, which deals more generally with treatment. Be that as it may, barriers are nicely divided into those related to the patient, the provider, the organizations and financial resources available, society as a whole, and specific treatments or interventions used. The final segment of the chapter is a brief research agenda for attaining data to improve access to care. The third chapter deals with issues of diagnosis and common symptoms. The authors make the point that DSM-IV—TR concentrates more on the differences in symptoms of depression for children and adolescents than it does on differences within the elderly population—and I think we are all aware of the fact that the DSM doesn’t really cover childhood disorders all that well. The chapter discusses rating scales (many of which have not been standardized for the elderly and the chronically medically ill), laboratory testing (best for ruling out physical causes of depressive symptoms), and neuroimaging (the hope of the future). The definitional problems in late-onset versus late-life depression are discussed, with late onset meaning, of course, that the first episode does not occur until the older years. Chapter 4 covers geriatric “nonmajor” depressions—the “subsyndromal” or “sub-threshold” mood disturbances. Some have even called these “sub-clinical” depressions, but that would imply by definition that treatment is not needed, with which these authors would certainly disagree. This chapter covers dysthymic disorder and minor depressive illness (found in an appendix within DSM-IV—TR) and then goes into potential adverse life events that tend to pile up as one ages—things like deaths of family, friends, and even pets. The chapter does give tips on the diagnosis of such conditions and points out that they can cause disability and even early death. The authors note that antidepressants may help these milder but disabling conditions, and that certain psychotherapies may be more helpful still. Chapter 5 covers bereavement as well as complicated grief, and discusses some treatment issues. Chapter 6 reviews depression concurrent with medical illnesses. There is a brief segment on diagnosing depression in the medically ill, but while what is said certainly seems accurate, there is really very little that is novel or helpful. The condition of “vascular depression”—that related to stroke, vasculitis, or

agiopathy—has a short chapter, number 7. This concept has arisen from brain imaging studies and may have a worse prognosis. Chapter 8 discusses caregiving, caregivers and their burden, both objective and subjective, and treatment for these sometimes "hidden patients." There are several case vignettes in this chapter, and a list of resources for caregivers included at the end of the chapter should be very helpful as long as it remains current.

Part 2, on treatment and outcomes, begins with a chapter on pharmacotherapy. In very concise fashion, the authors review some 71 English-language, randomized controlled trials, 4 meta-analyses, and an expert consensus panel report. This chapter makes excellent use of a table to describe the findings. The bottom line finding is that SRIs are probably the best pharmacotherapeutic agents we have at present for this population (unless the depression is caused by a stroke), followed closely by secondary amine tricyclics. MAO-inhibitors are also cited as useful, especially for atypical depressions, but tricky to use in older adults. Stimulants are concluded not to be first line. Chapter 10 discusses barriers to medication compliance and strategies for improving adherence (spelled out conveniently in several tables), and chapter 11 covers electroconvulsive therapy briefly but fairly completely. Chapter 12 discusses psychotherapy in a fair amount of detail. The author, a psychologist from McLean Hospital and Harvard School of Medicine, reviews the efficacy literature, discusses how the stoicism and self-reliance of the current elderly population may have developed to such a degree that they weigh against willing participation in psychotherapy, and mentions some barriers to psychotherapy that are simply age-related, such as hearing loss. He uses multiple examples of portions of therapeutic encounters to enliven the discussion, and covers multiple special applications, such as the approach to the depressed older man, suicidal older adults, and cross-cultural considerations, as well as the interactions of depressions with personality disorders or dementias. This chapter has a number of excellent suggestions. Chapter 13 goes into more detail relating to late-life suicidal urges, and following some descriptive information, discusses prevention efforts that might be useful for primary care, community interventions including telephone services, and education. Chapter 14 is mostly a summary and review, although it is entitled "Factors Affecting Long-Term Prognosis and Maintenance Treatment Outcomes." There is a helpful index at the end of the book.

This book would be most useful for primary care providers, since much of the information is more widely known within the psychiatric healthcare professions. It would also be helpful in the training of geriatric medicine and psychiatry fellows. It is concise, readable, and intersperses interesting facts and problems with suggestions and possible solutions. Several chapters make good use of clinical vignettes and organize the more complicated material into easy to follow tables and figures. The only drawback might be the price, which Dekker's website lists as $165.00 for the hardback or the e-book version.

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*Handbook of Forensic Neuropsychology*, edited by Arthur MacNeill Horton, Jr., and Lawrence C. Hartlage, Springer Publishing Company, New York, 2003, ISBN 0-8261-1884-4, $72.95 (hardcover), 560 pp.

The two editors and twenty-seven additional contributors have put together a work that tries to cover all of the pertinent areas within the relatively new field of forensic neuropsychology. These include an opening segment on history and models for the field, followed by sections on brain injury, practical issues such as depositions and testimony, ethical matters, and then a final, miscellaneous section entitled "Special Areas." The book is somewhat uneven in its coverage of the field, not atypical in an edited book by multiple primary authors.

The section on history and general review of the field is called "Foundations." It provides a somewhat dated overview of neuropsychology with a heavy emphasis on the work of Luria and Reitan. This section also covers the rules of science in relation to the rules of law that have been used in their interpretation in the courtroom. The last chapter in this section by Grant L. Iverson on detection of malingering is very good. He describes current approaches to assessment of malingering and the recent research on this topic in an integrated and effective manner. Useful case examples are included which provide an excellent glimpse into the clinical approach necessary in addressing these cases.

The brain injury section is composed of four chapters, which cover epidemiology, neuroimaging, the range of expected behavioral changes, and rehabilitation planning. The chapter on the epidemiology of traumatic brain injury fails to satisfy due to a limited review of the best studies on neuropsychological outcome from head injury and a tendency to take a plaintiff's orientation. The chapter on "Behavioral Change Following Traumatic Brain Injury" is too brief to do justice to this subject matter. This is unfortunate, since traumatic brain injury represents an inordinately large part of the practice of forensic neuropsychology. The chapter on rehabilitation touches on concepts of impairment, disability, and handicap. Although the role of neuropsychology in relation to other disciplines in rehabilitation is discussed, a review of controlled studies on the effectiveness of cognitive or neuropsychological rehabilitation was absent.

The section on "Practice Issues" includes a very helpful "how-to" for giving depositions and testifying in the courtroom in the chapter on preparation for deposition by John E. Meyers and Harold Widdison. These authors provide useful information on challenges to admissibility of neuropsychological testimony, such as Frye, Daubert, and the Federal Rules of Evidence. There is also a chapter in this segment on "Diagnostic Issues: Attorney Perspective," but it restricts itself to cases involving traumatic temporomandibular joint disease and orofacial pain and may not generalize well to other issues likely to arise in the field of forensic neuropsychology.

The ethics section contains an excellent chapter by Dorrie L. Rapp and Paul S. Ferber on release of raw—that is, non-interpreted—data. It is well written and the assertions in it are uniformly supported by research and case law. The issue of release of raw data is described from the viewpoints of the defense and plaintiff attorney as well as expert and treating psychologist. Specific strategies, step-by-step guides, and templates for correspondence are included. This chapter has something for both the psychologist and attorney and includes extensive references.

The section entitled "Special Areas" is highly diverse. There are chapters covering forensic neuropsychological evaluation of children, neurotoxicology, applicability to criminal cases (much of the earlier writing deals with civil litigation), and a chapter by Michael D. Franzen on competency evaluations, which does an excellent job of laying out the issues to be addressed when assessing fiduciary, testamentary, and criminal competency and competency to consent to treatment. There is, finally, a chapter which looks to "The Future of Forensic Neuropsychology" including use of the Internet and managed care. This chapter touches on the important issue of board certification; however, only a cursory description of the options available for certification is offered. No analysis of the history, processes of review, and strengths or weaknesses of the different options is described, although this would presumably be of interest to attorneys working in the area.

Where this book succeeds, it is most useful to the practicing clinical psychologist who has occasional forensic experiences as a part of his or her clinical practice. It is less clear that the book will be helpful to forensic psychiatrists or lawyers who use neuropsychological experts. Where the book fails, it is too superficial or cursory in its examination of a topic, has limited or dated reference material, or worse, tends to take mostly the plaintiff's side in the uneasy plaintiff–defense interplay.

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*Insomnia: Principles and management*. Edited by Martin P. Szuba, Jacqueline D. Kloss, and David F. Dinges; Cambridge University Press, New York, New York; 2003; ISBN: 0-5210-1076-4; $ 50 (softbound), 285 pp.

Sleep disturbances are a prominent complaint of patients seen by psychiatrists and therapists. In fact, the authors suggest that as many as 90% of patients with psychiatric disorders have this complaint while 50% of patients with primary sleep disorders have psychiatric problems. This slim, very readable volume deals with one such disturbance, insomnia, which the authors consider to be "a neglected orphan" of sleep disorders. The late Martin Szuba, M.D., Jacqueline Kloss Ph.D., and David Dinges Ph.D., who are affiliated with the Sleep and Chronobiology Program of the University of Pennsylvania and Drexel University, are the editors. Chapters include contributions by 18 other specialists in the field. The focus and tone of the book are clinical as illustrated by the lovely forward by J. Christian Gillin. Dr. Gillin presents a patient with insomnia as her chief complaint but who is determined to have multiple psychiatric and physical disorders and stresses. The patient attempts to self-medicate with disastrous consequences. Using this case as a springboard, Dr. Gillin describes the numerous difficulties encountered in evaluating, referring, and treating patients with insomnia. The remainder of the book deals with the issues raised.

The book is divided into five sections broadly dealing with the definition, sequelae, treatment, special needs populations, neurophysiologic basis, and directions for future research of insomnia. Chapter 1, by Daniel J. Buysse, M.D., describes the difficulties of establishing uniformly accepted criteria for insomnia and related disorders. He notes that DSM-IV has only a single diagnosis for insomnia not related to mental, substance abuse, or medical disorders. This is too broad to be useful to sleep specialists who require more specific divisions and criteria. It also lacks polysomnographic criteria used frequently by such specialists. Dr. Kloss then discusses the sequelae of insomnia and the problems separating these from other etiologies (e.g., psychiatric or somatic). This is complicated by the subjective nature of daytime sleepiness, poor sleep, individual coping styles, and their effects on performance and treatments. The concept that patients with insomnia actually have a problem with hyperarousal and not sleep deprivation expands these difficulties. An excellent chapter by Drs. Kloss and Szuba that is of particular relevance to psychiatrists deals with the relation of insomnia to mood, generalized anxiety, panic, and posttraumatic stress disorders.

The second section opens with a series of vignettes to illustrate the difficulties of assessing and treating insomnia in a broad context. Other areas covered in this section deal with the behavioral approach to treatment utilizing the hyper-arousal/hyper-anxious model of insomnia as well as

pharmacologic treatments. Special note is given to the effectiveness of melatonin for circadian rhythm disorders, the long-term use of hypnotics and the unsubstantiated claims for the usefulness of many herbal and alternative therapies. This chapter is supplemented by an excellent appendix listing medications used in insomnia treatment as well as their advantages and disadvantages which appears at the end of the book.

The section dealing with special populations is particularly relevant for those treating sleep problems in children and the elderly. Problems associated with shift work, jet lag, sleep-phase syndromes and irregular sleep/wake patterns are discussed also.

Section four reviews current knowledge of the neuroanatomical, biochemical, and physiologic bases predisposing to insomnia. Emphasis is placed on the view that insomnia is a hyper-arousal phenomenon. The role of amygdalic and hypothalamic pathways contributing to this state are elaborated upon. The placement of this section near the end of the book serves to clarify concepts discussed throughout the book and is to be commended.

The final section by David Dinges summarizes the volume and suggests future directions for research in the field. He also pleads for increased awareness of and utilization of sleep specialists and clinics to advance knowledge of insomnia. The book concludes with appendices that provide guidelines for various therapies including stimulus control, sleep hygiene, sleep restriction, and medication. A list of sleep societies is included. Each chapter is organized in a similar fashion noting the problem discussed, a review of current evidence-based literature, therapies and their problems, and suggestions for future research. An extensive reference list concludes each chapter.

This short book is well written, concise, and a delight to read even for someone unfamiliar with the subject. It is a tribute to the contributions and efforts of Martin Szuba who passed away just prior to its publication. I found the book informative and enlightening, providing a collaborative summary of current scientific knowledge of insomnia. By increasing awareness of this subject it will serve to benefit sufferers and hopefully reduce their reliance on alcohol, other illicit substances, and unproven over-the-counter nostrums. For these reasons alone it should serve as a source book for everyone confronted by a patient who complains of not being able to sleep. I suggest that it will be useful to psychiatrists, therapists, and general physicians as well as to specialists in the field.

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*Handbook of clinical sexuality for mental health professionals.* Edited by Stephen B. Levine, Candace B. Risen and Stanley E. Althof; Brunner-Routledge, New York, New York; 2003; ISBN: 1-5839-1331-9; $ 95 (hardcover), 473 pp.

For a long time I have been saying that psychiatrists abandoned sexuality and treatment of sexual disorders and sexual problems, though they could and should be uniquely qualified for dealing with sexual disorders and problems. The recent developments in "sexual pharmacology," such as the arrival of phosphodiesterase-5 inhibitors, raised the hope for return of sexual issues to the realm of psychiatry. However, these new drugs are prescribed mostly by primary care physicians, cardiologists, and urologists, not by psychiatrists. As Stephen Levine points out in the introduction to the *Handbook of Clinical Sexuality for Mental Health Professionals*, "…at least half of the men do not refill their prescriptions" for phosphodiesterase-5 inhibitors. He believes that this drop-out rate is probably due to psychological/interpersonal factors rather than to the lack of the drugs' efficacy. He also believes that, "most physicians who prescribe sildenafil are not equipped to deal with the psychological issues that are embedded in the apparent failures." (p. xv) I think that all psychiatrists and mental health professionals would agree with Levine's statement, probably adding that all those specialists also have no time to deal with psychological issues of sexual functioning. Who is then equipped to deal with not only the psychological issues embedded in the apparent failures, but also with the psychological issues inherent to all sexual problems, disorders and worries? Levine says mental health professionals are. I would say psychiatrists are, especially though not exclusively. They could also deal with other areas of treatment of sexual disorders, such as pharmacology and related medical problems.

Stephen Levine states that what lead him and his co-editors to putting together their *Handbook of Clinical Sexuality* was the perception that mental health professionals need to be better educated in sexual issues. Again, everybody would probably agree with this perception. I would add that psychiatrists are the ones who could actually benefit the most from educating themselves in sexual issues by using books such as this one.

The Handbook is divided into five parts and contains 25 chapters written by experts in the field. Part 1, "Adult Intimacy: Hopes and Disappointments," deals with some interesting, yet not frequently taught issues, such as what patients mean by love, intimacy, or desire; infidelity; life processes that restructure relationships; and dealing with the unhappy marriage. This otherwise very interesting part is a bit marred by the weak first chapter devoted to "listening to sexual stories." Nevertheless, this part sets the stage well for the next four parts and contains a lot of interesting observations and advice. The chapter on unhappy marriage is

especially informative. For instance, I was surprised to find out that couples without children have higher marital quality.

Part 2, "Women's Sexual Issues," discusses in six chapters issues such as when do we say a woman's sexuality is dysfunctional; low sexual desire and sexual avoidance; painful genital sexual activity; sexual aversion; facilitating orgasmic responsiveness; and the sexual impact of menopause. The discussion of when do we call sexuality dysfunctional makes a very important point—"the failure to be above average is not the definition of dysfunctional." (p. 98) The author points out that we live in a culture where average equals mediocre and below average equals deficient! However, this should not be applied to sexual functioning. We always need to define where we draw the dysfunction-indicating line and outline dysfunctionality in terms of something.

The third part, "Men's Sexual Issues," reviews in four chapters areas such as young men who avoid sex; psychogenic impotence in relatively young men; erectile dysfunction in middle-aged and older men; and rapid ejaculation. The chapter of erectile dysfunction notes a profound change in evaluating men's sexuality—the new treatment models "strongly emphasize the need for sexual inquiry in all middle-aged and older men but deemphasize the value of intensive medical or psychological assessment in most cases" (e.g., penile cavernosography or nocturnal penile tumescence are not performed frequently anymore).

Part 4, "Sexual Identity Struggles," addresses problems such as male and female homosexuality in heterosexual life; transgendered phenomenon; sexual compulsions and lack of control of sexual behavior in men; and paraphilias. The chapters on transgendered phenomenon and on paraphilias are especially well written, informative, and entertaining. The discussion of sexual compulsions focuses a lot on online sexual compulsivity. Online sexual compulsivity and other activities have been growing fast as the Internet provides access, affordability, and anonymity in this area. I missed and would like to see a discussion here on the murky area of legality of online sexual compulsivity.

The last part, "Basic Yet Transcendent Matters," deals with issues such as integration of treatment techniques; sexual potentials and limitations imposed by illness; sexual side effects of medications; the effects of drug abuse on sexual functioning; sexual trauma; and understanding and managing professional–client boundaries. The chapter on professional boundaries emphasizes that, "as a profession, we were not doing nearly enough to prepare our students to competently manage psychological intimacy in the professional setting." (I do not believe we are doing enough even now.). The chapter on sexual functioning during drug abuse is quite interesting and informative. It dispels some myths, especially about alcohol and sexuality (I liked the quote from Shakespeare's Hamlet that, "It provokes and unprovokes: it provokes the desire, but it takes away from the performance"). However, it also brings the reader's attention to the fact that some substances of abuse (e.g., ecstasy, marijuana) may enhance sexual functioning, especially during the initial phase of abuse.

This is an important and informative book. I found it quite interesting even after discounting the bias of my own professional interest in sexual pharmacology and sexual functioning. Does it fulfill its goal to educate mental health professionals about sexual topics? It does. Is it useful for clinically oriented psychiatrists? Definitely. During the times of increased interest in sexual issues and arrival of new pharmacological agents, psychiatrists have the unique potential to integrate all available treatments of sexual disorders, problems, and worries. They will find a wealth of useful information in this book, especially in the area of psychology and psychological treatment methods of sexual disorders and problems. The book is filled with good case reports applicable to and useful for clinical practice.

The book has its weaknesses—the writing style is uneven across the chapters, the book could be tied together more editorially (a tough task, though), there are some typographical errors (names of medications), some areas could be covered in more detail, and some may find the chapter introductions worth skipping at times.

However, the book is a great start for anyone who would like to became better educated about clinical sexuality. I would strongly recommend it to such a person. I also believe that this book could be a useful text for teaching psychiatric residents about the basics of treating sexual disorders, problems, and worries. Compared to many other texts, this one is worth the money.

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*The anatomy of hope. How people prevail in the face of illness*. By Jeremy Groopman; Random House Inc., New York, New York; 2004; ISBN: 0-3754-3332-5; $ 24.95 (hardcover), 248 pp.

Last year I heard a lecture in which the speaker, a well-known psychiatrist, exhorted the significance of hope, stating forcefully and convincingly that, "hope is the most important thing we give to our patients." Like probably many, I have always been aware of hope being an important 'emotion' and of its possible role in healing and surviving. However, I have not been thinking about hope being the most important thing we give to our patients. Thus, this statement started me brooding about hope and its role in our life and the lives of our patients. And when I saw the book with a seductive title, *The Anatomy of Hope*, I became captivated.

Like the author of this book, hematologist/oncologist Jeremy Groopman, I started to ask, "Why do some people find hope despite facing severe illness, while others do not?" and "How do hope, and despair, factor into the equation of healing?" Groopman has been searching for answers to these questions for a long time. His book describes his journey, tries to answer questions about hope which we all have, and presents his vision of hope being the very heart of healing.

Several chapters of the book are based on stories of hope of the author's patients and illustrate some important points about hope in the lives of our patients and in physicians' practice. The first chapter, 'Unprepared,' points out how unprepared students and novice physicians are to deal with dying, hope, and hopelessness. Groopman, as a medical student, deals with a young woman afflicted with breast cancer, who had no hope that she will survive her illness, and, in a narrow view, equated her disease with punishment for sin. Groopman points out that, "hope can arrive only when you recognize that there are real options and that you have genuine choices." (p. 26) The second chapter, 'False hope, true hope,' points out, among others, how poorly prepared the author felt (and we are) to convey bad news to patients and how it could be difficult to encourage true hope and not to instill false hope. He also reminds us how physicians, out of necessity, "learn how to compartmentalize emotions, lest they interfere with the care of living." The third chapter, 'The right to hope,' is a very interesting story of a Harvard pathologist, specialist in stomach cancer, who becomes ill with stomach cancer. Despite the advanced stage of his cancer and poor prognosis, he chose the most aggressive combination of treatments, which others considered to be 'pure madness.' He prevailed and survived. Years later, he told Groopman that he found his colleagues' argument against the aggressive treatment patronizing, as he deeply wanted to live and had to fight. He felt that it was his right to choose what he did, that he had a right to hope. Groopman expands on these ideas, emphasizing that "a doctor should never write off a person a priori." He cites Oliver Wendell Homes, who cautioned, "Beware how you take away hope from another human being." (p. 79) In chapters four, 'Step by step' and five, 'Undying hope,' the author continues to describe his personal interest in hope as a healing phenomenon in more patient stories. He gets to the discussion of the five stages of dying described by Elisabeth Kubler-Ross (denial, anger, bargaining, depression, and acceptance). However, Groopman takes an issue with Kubler-Ross as he feels that there is not always such a discrete unfolding of five stages leading to acceptance—"Sometimes denial persists to the end. Other times anger is unrelenting." (pp. 143–144) He also does not agree with Kubler-Ross' definition of hope, as he sees hope as more "real and undying."

In chapter six, 'Exiting a labyrinth of pain,' Groopman switches from patients' stories to his personal experience with severe back pain due to a ruptured lumbar disc. He suffered for nineteen years and finally recovered through rehabilitation. As Groopman writes, the surgeon who operated on his back said to him "what I had so ineptly said at times in my career to others; that here was no hope." On the contrary, the rehabilitation specialist gave him hope and he prevailed. This chapter serves as an opening for the last two chapters, chapter seven, 'The biology of hope,' and chapter eight, 'Deconstructing hope.'

In "The biology of hope" Groopman describes his discussions with Harvard's Bruce Cohen about the true effects of placebo and its connection to hope. He reminds us that placebo was initially given by a doctor to appease demanding or desperate patients. Placebo is known, as he writes, not to be inactive, and to have even some significant biological effects. According to Dr. Cohen, placebo could provide one of the clearest windows into the nexus between body and mind, particularly on how belief and expectation may affect pain and physical debility. Groopman describes several other experiments in this area, including sham surgery. He mentions another scientist, Ted Kaptchuk, who sees "the environmental cues and the behavior of an authority figure as part of the ritual of medicine that dates to ancient shamans" (Similar to what E.F. Torrey writes about psychotherapy). (1). Groopman further delves into possible biological underpinnings of hope, discusses the role of endorphins and enkephalins ("pain amplifies our sense of hopelessness; the less hopeful we feel, the fewer endorphins and enkephalins and the more CCK we release"). He emphasizes the negative role of fatigue on hope and how he looks for ways to alleviate some of the fatigue. He also reminds us again that patients who "are hopeful, largely because of their religious faith and their trust in the physician, have a more rapid return to health and a higher rate of survival." (p. 185) Finally, he writes about the spectrum of response, genetic differences that could account for some of the placebo response, and about the molding influence of environment throughout life.

In the final chapter, Groopman describes his debate about psychology and biology of hope with Richard Davidson of Madison, Wisconsin. According to Davidson, hope as an emotion is made up of two parts, cognitive and affective. These two components are not separate, but interwoven. Hope according to him also involves "affective forecasting"—the comforting, energizing, elevating feelings one experiences when projecting in ones mind a positive future. The chapter also discusses the role of the prefrontal cortex, amygdala, anterior cingulated hippocampus, and reward circuits "rich in dopamine" in hope. Very intriguing seems to be the question of how we turn off negative emotions and summon courage. The final part of this very interesting chapter discusses resilience and the role of cortisol in resilience. In his words to Groopman, Davidson emphasizes that there is no single hope center or hope neurotransmitter in the brain.

In the conclusion, 'Lessons learned,' Groopman summarizes his main understanding of hope and its underpinnings. He again reminds the reader that, "Doctors are fallible, not only in how they wield a scalpel or prescribe a drug but in the language they use." (p. 209) In the acknowledgements, in agreement with the speaker who inspired me to brood about hope, Groopman states that the thing beyond any treatment he could offer to his patients is hope.

This is a fairly interesting book with a catchy, seductive title. It provides the reader with a fair assessment of whatever we know about hope and its possible biological underpinnings. It offers a new view, a new way of thinking about hope. It also educates us about the importance of true hope, which we can provide to our patients. Interestingly, at times, the explanatory notes are more interesting reading than the text itself. In sum, this is an entertaining bedtime reading volume for those interested in what hope is, what it could and should mean to our patients and to all of us, and what role it could play in the process of recovery from a serious illness.

## *REFERENCE*

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