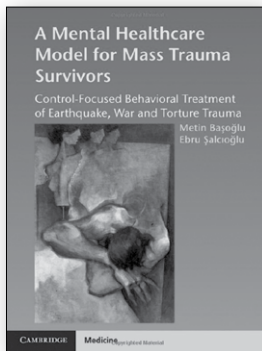


BOOK REVIEWS

A Mental Healthcare Model for Mass Trauma Survivors: Control-Focused Behavioral Treatment of Earthquake, War and Torture Trauma



By Metin Başoğlu and Ebru Şalcioğlu.
New York, NY: Cambridge University Press;
2011; ISBN 978-0-521-88000-8; pp 284;
\$105 (hardcover).

As the authors of this book point out, “mass trauma events, such as wars, armed conflicts, acts of terror, political violence, torture, and natural disasters affect millions of people around the world” (p 1). Mass trauma events pose a major challenge for the mental health field, because there is no suitable model of effective, timely, and “affordable” care for addressing the psychological needs of mass trauma survivors. However, mass traumas also may provide unique opportunities to explore the psychological consequences of various traumas and their possible management or treatment. The ability

to study these consequences and their potential treatments requires expertise, long-term, if not lifelong, focus, and the opportunity to be “there”—if not frequently then at least repeatedly.

Drs. Başoğlu and Şalcioğlu, 2 Turkish experts in the field, have spent at least 2 decades studying the consequences of mass trauma and their possible treatments. Living and working in Turkey—a country frequently inflicted by major earthquakes, and where torture of political activists occurred in the aftermath of a military coup—provided them with ample and unique opportunities for this kind of study. This book is a summary of their extensive work in this area, their learning theory of traumatic stress, their recommendations for assessment and treatment of mass trauma survivors using what they call control-focused behavioral treatment (p 79), and implications of their theory and treatment approach to the care of mass trauma survivors.

The book is divided into 3 parts (Theory; Assessment and treatment; and Implications for care of mass trauma survivors), and includes 3 appendices. In the introduction (which is largely a brief summary of this volume), the authors point out that any

effective dealing with mass trauma, especially in developing countries, requires interventions that are “(1) theoretically sound, (2) proven to be effective, (3) brief, (4) easy to train therapists in their delivery, (5) practicable in different cultures, and (6) suitable for dissemination through media other than professional therapists, such as lay people, self-help tools, and mass media” (p 1). The introduction also emphasizes that behavioral intervention designed to enhance the sense of control over—or resilience against— anxiety cues or traumatic stressors “needs to aim for anxiety tolerance and control rather than anxiety reduction” (p 2). They also bring our attention to their serendipitous discovery of the fact that “many survivors, without any instruction or guidance from a mental health professional, used self-exposure in their natural environment to overcome their fear of earthquakes” (p 3). This discovery “suggested that self-help is not only a viable approach in survivor care but also one that carries great potential” (p 3).

The 2 chapters in Part 1 discuss the learning theory formulation of earthquake trauma, and torture and war trauma. Both chapters stress the unpredictable and uncontrollable nature of both earthquake and war and torture traumas. It also is important to note that earthquake trauma is not a single stressor, but “rather a prolonged trauma period of stressors starting with the initial major shock and followed by hundreds of aftershocks that may last for months or even more than a year” (p 16). The major psychiatric consequences of mass traumas are posttraumatic stress disorder (PTSD) and depression. There also are physi-

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cal consequences, such as increased blood pressure, myocardial infarction, stroke, and increased incidence of gastric and bleeding ulcers.

The authors also describe cognitive and behavioral responses to earthquake and other mass traumas, such as the quest for safety (eg, people who feel safer knowing that the contractor who built their apartment lives in the same building as them), reliance on safety signals, fatalistic thinking (eg, more specified to Turkey and Arabic-speaking countries, the notion of *Tawakkul* or “to resign oneself unto God” [p 22]), and avoidance. Weaving all these facts together the authors then present their learning theory formulation of earthquake trauma, emphasizing the role of unpredictability and uncontrollability of stressors in the development of fear, helplessness, avoidance, and traumatic stress response such as PTSD and depression. The chapter discussing torture and war trauma is filled with many interesting observations that are quite relevant to the field of mental health, especially in a world filled with numerous conflicts and other stressful, violent events.

The authors describe several stressor categories associated with experiences of imprisonment: 1) falling captive to an enemy, 2) interrogation and manipulation designed to induce distress, fear, and helplessness, 3) acts designed to inflict physical discomfort or pain, and 4) deprivation of basic needs (p 39). The discussion of interrogation and helplessness-inducing psychological manipulation brings forth numerous fascinating examples, including the “good cop/bad cop” strategy, stripping the detainee naked,

sham executions, or confronting the detainee with an impossible choice (eg, if a detainee does not comply, they are told that a close relative will be arrested, raped, or tortured in front of them [p 41]). According to the authors, survivors often describe forced viewings of others being tortured “as one of the most distressing aspects of their past experience” (p 41). Another important observation is that those who experienced a perceived risk of death during the process of torture (ie, sham execution) appeared more traumatized by that experience than by torture methods involving physical pain but posed no real threat to their life (p 41). The chapter also discusses coping with captivity and torture. Coping with physical torture occurs on 3 overlapping levels: psychophysiological, behavioral, and cognitive. The authors state that the behavioral and cognitive strategies seem to be geared towards maintaining a sense of perceived control. Interestingly, some cognitive factors, such as awareness of broader political dynamics, seem to have a protective effect against the cognitive impact of torture. When summarizing the discussion of natural recovery from captivity and torture trauma, the authors emphasize that resilience factors—such as immunization against traumatic stress—appear to be the most important in determining successful coping and recovery. This part is quite fascinating and interesting to read.

The 4 chapters in Part 2 review the assessment and treatment of mass trauma victims. The chapter on assessment reviews several assessment tools (eg, Screening Instrument for Traumatic Stress in Earthquake

Survivors [SITSES]; the child variation of SITSES; and Screening Instrument for Traumatic Stress in Survivors of Wars [SITSOW]). The authors write that despite what some suggest, use of these instruments does not traumatize the victims, and may be useful in the therapeutic process. Chapter 4 describes the central aspect of this book—the control-focused behavioral treatment (CFBT)—in great detail, from the initial assessment through to treatment sessions (steps of the first session include identifying trauma cues and avoidance behavior, explaining the treatment and its rationale, defining treatment tasks, and giving self-exposure instructions—including some very concrete, focused self-exposure exercises) and treatment termination (when clinically significant improvement occurs [eg, $\geq 60\%$ reduction in traumatic stress and depression scores and much or very much improved ratings on self- and assessor-rated global improvement scale]). Chapter 4 also discusses comorbid conditions, the use of medication, specific aspects of treatment of children, and single-session applications of treatment of earthquake survivors (single session CFBT, single session group CFBT, and single session earthquake simulation treatment [using an earthquake table or room simulator]).

The next chapter of this section reviews the assessment and treatment of prolonged grief. The final chapter of this part presents an overview of treatment efficacy and mechanisms of recovery. The third part of this book discusses a mental health care model for earthquake survivors, issues in care of mass trauma survivors, and issues in rehabilitation of war and tor-

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ture survivors. The outreach treatment program for earthquake survivors includes treatment delivered via a self-help manual, single-session treatment involving self-exposure instructions, single-sessions involving therapist-administered exposure, and full-course treatment delivered on average over 4 sessions. The outreach program is crucial in the aid of victims scattered across various refugee shelters. The authors also describe the dissemination of treatment through self-help tools, lay therapists, and mass media.

The authors also note that “uncritical acceptance and use of treatments developed in western countries is a common problem in developing countries, reflecting a cultural tendency to view everything coming from the west as ‘good’” (p 159). Another cultural issue pointed out is the fact that many psychiatrists in developing countries tend to prescribe antidepressants first in mass trauma victims

without acknowledging alternative, evidence-based, or psychological interventions (p 167). In the final chapter of this section, as is the case with many others, the authors present a lot of their own data. For instance, the authors did not find any evidence to support the theory that war, torture, and earthquakes differ substantially in their subjective impact and cognitive effects, or the nature, prevalence, and severity of their mental health outcomes (p 187). In the conclusion of the book’s final chapter, the authors write that empowerment of trauma survivors is essential to their recovery, and point out that only a small fraction of survivors are likely to need more intensive mental health care.

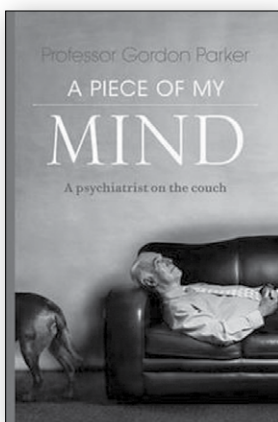
Appendix A includes a number of questionnaires; Appendix B features a control-focused behavioral therapy manual; and Appendix C contains a self-help manual for recovery from earthquake trauma. Both the control-

focused behavioral therapy manual and self-help manual are instructive and concrete texts.

This is a solid, informative book for anyone interested in the psychological consequences of mass trauma, and their respective treatments. The book includes a good number of clinical examples, but also, probably unfortunately, the results of the authors’ own research. I am calling this unfortunate because it dilutes the instructive and clinical usefulness of this valuable book a bit, because readers may get lost in the conclusions of some chapters. Nevertheless, all those involved with mass trauma survivors will find this book interesting. Those of us treating victims of other traumas may try incorporating CFBT or its parts into our treatment plans.

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A Piece of My Mind: A Psychiatrist on the Couch



By Gordon Parker. Sydney, Australia:
Pan Macmillan Australia; 2012;
ISBN 978-1-742-61074-0; pp 340;
\$AU32.99 (paperback).

I confess that I like memoirs, biographies, and autobiographies because they frequently bring an interesting point of view, new information, or a more complex picture of a person, era, or topic. I usually look forward to reading those that we occasionally receive in the mail for re-

view. However, I was a bit uneasy and hesitant when it came to *A Piece of My Mind: A Psychiatrist on the Couch*. It was sent by the author himself with a personal letter; maybe a bad sign of self-promotion? I procrastinated, but finally decided to open the book and give it a try. I started to read the introduction and became even more hesitant after reading the first few pages, asking myself what I was getting into and wondering about this guy, Gordon Parker (for those who don’t know, Gordon Parker is a well-known Australian psychiatrist, researcher in the area of depression, and founder of the Black Dog Institute). The book contains a lot of quotes attributed to

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others, and lots of suggestions that he is going to offend many. In all fairness, Dr. Parker defends these 2 features eloquently, paraphrasing Michel de Montaigne (“I quote others to better express myself”) and quoting Ricky Gervais (“If you’re not offending someone, you’re not doing anything”). Then the Introduction got a bit more interesting, with Dr. Parker quoting my favorite contrarian, the late Christopher Hitchens, and then stating that “serendipity or luck (though some create their own ‘luck’) have little to do with career trajectories and more to do with people’s innate (and often unexpressed and therefore unrealized) potential strengths” (p 9). I was becoming more interested and finally got into the full swing of reading this book.

The book consists of 3 parts; only Part I of this disjointed volume is autobiographical, covering everything from family roots to justification of the inclusion of the book’s other 2 parts. Dr. Parker describes his family, “gene pool,” schooling, and progress to becoming a psychiatrist in “chapters” with names illustrating what they are about (“Parental impact on psyche and career choice,” “Peaks and troughs of my school career,” “A university education,” “Brain waves and undines reprised,” “Showing up in the mother country,” “Welcome to psychiatry,” “An academic and administrative psychiatrist,” and “My research career as a paradigm chaser”). The author analyzes himself and certain aspects of his behavior. He reveals, among many other things, that he is a contrarian, stating, “the word ‘compromise’ is not one that sits comfortably with me and, when involved in

negotiations where I detect someone is seeking to control me, my instinct is to play the man and not always the issue or the problem by itself” (p 57). He was—and still is—a multitalented man, having written a TV show as a young physician. He began publishing his observations quite early and developed into an astute observer and skillful physician. The description of his medical and psychiatric education reads a bit like the history of medicine and psychiatry of the last 50 years, with colorful illustrations. Those who dislike administration will appreciate Dr. Parker’s description of the administrative part of his career.

He also reflects on his personality throughout the book. When discussing being an administrator, he admits, “My personality has limited any lobbyist potential. My tendency to cut to the chase means that social proprieties such as a comment on the weather or even a ‘good morning’ are exemplars of inefficiency to me, although I do admire and appreciate such characteristics in others—up to a point, and as long as they get to the point before too long” (p 135). When describing the constant pressure to maintain a successful academic career, he quotes Irving Berlin who said, “The toughest thing about success is that you’ve got to keep on being a success” (p 138). When musing about what drives a researcher, he refers to an anonymous observer who said that “science, like sex, has a function, but it’s not why we do it” (p 139).

The last chapter of Part I—“My research career as a paradigm chaser”—gradually merges into Dr. Parker’s justification for the contents of the rest of the book. He discusses

various aspects of his research endeavors: interpersonal relationships, seasonality research, alternative research. The latter includes a fascinating-but-true explanation of the adequacy of chiropractic and other alternative approaches, stating that “most regions of the world have a two-tier system of health practitioners. In third-world countries, people generally first attend a local ‘healer’ and only go to a western-trained healer if treatment fails. In western countries, the reverse phenomenon is more distinctive. If orthodox medicine fails, alternatives will be sought that have a level of credibility and where practitioners inspire hope” (p 149). The author later shares his observations on antidepressants—eg, aside from being an antidepressant, selective serotonin reuptake inhibitors have the capacity to mute “emotional dysregulation,” and appear to have mood stabilizing capacities in bipolar II disorder. He gradually comes to the same conclusion that other astute clinicians have, that no antidepressant therapy has universal relevance (p 157). He started to criticize various research conclusions and models and, as he claims, gradually got into a conflict with academic establishment outside of Australia with increasing rejection of his thought-provoking submissions... until he, as he writes, found out that all of his future submissions to some unnamed journals would be rejected. He admits that he failed at “being insufficiently astute to know exactly how and when to tackle certain targets” (p 169).

Then he comes to the principal reason for writing this book—Part

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II. This part contains Dr. Parker's views on depression. The chapter titles are illustrative and reflective of Dr. Parker's—and contemporary psychiatry's—problems with the classification and management of depression (“Understanding ‘depression,’” “The cementing of the Unitarian model in the DSM-III And ICD-10 classifications,” “Major depression’: A mix of black and blue,” “Our alternate model for classifying melancholic depression,” “Our alternate model for classifying the non-melancholic depression,” and “Summary concerns about the classification and management of the depressive conditions”). Dr. Parker clearly sees that clinical depression is poorly defined and poorly managed (p 2), and that it is not a unitary condition. He (along with many others) strongly advocates the classification of melancholic and non-melancholic depression as 2 distinct conditions. He states that “pandemonium still reigns with psychiatry's current non-specific and meaningless diagnostic groupings” (p 174), and arguably criticizes various thinkers left and right (mostly justifiably)—especially those who in his view have pushed the Unitarian dimensional view of depression (eg, Adolf Meyer and Hagop Akiskal). He cites Ned Shorter, a respected psychiatry historian, as describing Meyer as a “second-rate thinker and a verbose writer” who was never “able to disentangle schools that were absolutely incompatible, and ended up embracing whatever came along” (p 178). Dr. Parker's take on the DSM-III's problematic definition of depression is well taken and clear-

ly more and more reflected in related discussions in psychiatric journals these days. He cites Shorter's criticism of the DSM-III, which says it “was not really a scientific document but a political one, with decisions often made on advocacy and the need to be inclusive and avoid confrontation” (p 184). The entire section on depression is peppered with interesting personal and historical observations. Dr. Parker also reminds us of the serious limitations of trials that evaluate antidepressant drugs, and does not spare judgment of trials of other depression treatments either. He says that “the spotlight on antidepressant drugs being positioned as placebo therapies is somewhat unbalanced, when the same concerns hold (but are rarely considered) for CBT” (cognitive-behavioral therapy) (p 202). I loved his descriptions of observations made during his visit to Aaron Beck's unit in the early 1980s, where he noted that all therapeutic group leaders were attractive, blonde females, age 25 to 35, who had distinctive cleavage. Beck supposedly responded to his observation by saying that “somehow CBT seems to work better that way” (p 230). A very important notion on Dr. Parker's side is that “the formal literature regrettably minimizes the practical benefits of commonsense advice, counseling and simple problem-solving approach provided by an empathic professional for non-melancholic reactive depressive condition” (p 231). This is clearly not just a placebo effect! In the final pages of this section Dr. Parker also criticizes evidence-based medicine, quoting Kathryn Montgomery's

(book *How Doctors Think*) concerns about evidence-based medicine as “a tendency toward generalization without particularization... a reliance on generalization, one-size-fits-all rule-making, without the particularizing countermove required by clinical judgment” (p 239). This part of the book is a thought-provoking read that would be appreciated by any astute clinician.

Part III of this book focuses on being a clinical psychiatrist—a crucial issue of contemporary psychiatry. Interestingly, Dr. Parker advocates that he would choose a technically brilliant professional over a “caring” one, though he recognizes that most patients weigh a clinician's style over their substance. He makes a sound argument for the importance of clinical judgment—yet he recognizes that clinical judgment is not celebrated, quoting Kathryn Montgomery as saying that “a celebration of clinical judgment is likely to be seen as ignorance or the dismissal of science.” He even muses about whether psychiatric judgment can be taught; it could be honed, but not always taught, and cites John Ellard's *The Music of Psychiatry* (“Some have the music. Others can hear it. A small number are tone deaf forever”) (p 280). This part is provocative, intellectually stimulating, and important for any practicing clinician.

A reader may ask, what is the verdict on this book? It is an interesting read. The first part veers off at times, and for those uninterested in Dr. Parker's life and defense of his “gadfly” style, could be skipped altogether. However, the second and third parts of this book—the

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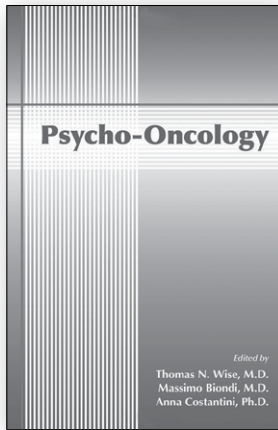
real reasons for Dr. Parker's writing of this text—address complicated issues, are written in an easy-to-read style, and are an interesting, significant, and stimulating read. It

contains a lot of history of “psychiatric thinking of the last fifty years.” Readers may find the provocative style of the first part of the book a bit difficult to absorb, but it fits in with

the rest of the book well, and makes it an enjoyable read.

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Psycho-Oncology



Edited by Thomas N. Wise, Massimo Biondi, and Anna Constantini. Arlington, VA: American Psychiatric Publishing; 2013; ISBN 978-1-58562-423-2; pp 360; \$74 (paperback).

As the editors of *Psycho-Oncology* aptly write, “research has transformed many types of neoplastic disease into curable or chronic conditions rather than rapidly fatal disease. With an increasing number of long-term treated “cancer survivors,” there is a greater recognition of the psychosocial and psychological reactions to, and psychopathological consequences of confronting the threat of recurrence—the sequel of life-saving but traumatic and possibly disfiguring treatments. Despite such medical advances, surveys indicate

that cancer is the most feared disease state. Such interactions between a disease label and an emotional reaction, fear, underscore the profound psychosocial issues involved in oncology. Because more than 40% of individuals will experience a diagnosis of cancer during their lifetime, practitioners in all health care specialties must have a knowledge base in oncology” (p xiii). The role of psychiatry and allied mental health professions in helping patients and their families cope with cancer-related fears, depression, demoralization, anxiety, and other psychological sequelae is paramount. The field of psycho-oncology, a derivative of psychosomatic medicine (p xiv), has developed to better address the needs of the growing number of cancer patients and their families. There also has been an increased need for communication and education in this developing area of medicine. The journal *Psycho-Oncology* was established 22 years ago, and various texts and textbooks have appeared on the subject. The latest volume of *Psycho-Oncology*, edited by Drs. Wise, Biondi, and Constantini is not to be confused with *Psycho-Oncology* edited by Jimmie Holland and others, which was published originally in 1998 and then as a second edition in 2010.

This volume, authored by an international group of experts, offers an overview of clinical issues with “a core focus on the essential caregiver-patient dyad” (p xiv). The authors’ intent was to provide “a ‘bench-to bedside’ approach to benefit the everyday clinical practice for all health professionals who treat patients with neoplastic disease” (p xiv). Wise and colleagues used the concept of psychosocial staging to frame their writing. The first stage is the initial diagnostic stage (the discovery of cancer); the second stage is the treatment of cancer. The first stage is usually a time of great anxiety while the second stage is frequently a time of demoralization and depression. Skillful communication with patients and their families is an essential ingredient for both these phases.

The book includes an Introduction and 12 chapters. All chapters conclude with key clinical points, some of which include solid, clinically oriented case vignettes and appendices. Chapter 1, “The crisis of discovery: psychological and psychopathological reaction to the disease,” begins by addressing death and the disease in a historical context (in the 14th century, life expectancy in Europe was between 30 and 35 years!). The chapter then discusses reaction to the diagnosis, which has all the characteristics of shock trauma. The impact of cancer on people’s

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lives is related to 4 areas: the existential threat of the disease, psychosocial consequences, consequences of the morbid disease process (eg, pain, fatigue), and treatment and its effects (p 5). The determinants of the reaction to the diagnosis represent a complex interplay of biological, psychological, spiritual, and social factors. The style of coping process can be divided into 2 sequential stages: evaluative and executive (p 9). There are 3 different types of coping strategies: emotion-focused (aimed at “affect regulation”); problem-focused (directed at mitigation or resolving the impact of stress); and avoidant (eg, escape) and approach (eg, confront). Chapter 1 also deals with the discovery of cancer in advanced stage. Here the text reviews some of the writings of Heidegger, Jaspers, and Kübler-Ross (the stages she described are denial, anger, bargaining, depression, and acceptance). The text also emphasizes the importance of differentiating between a “normal” reaction and “psychopathological” reaction to cancer (p 13). This chapter includes 2 appendices: 1-A (Consultation-liaison clinical cases), and 1-B (Existential psychotherapies [supportive-expressive group psychotherapy; dignity therapy; meaning-centered psychotherapy]).

Chapter 2, “Cancer: a family affair,” notes that “when a person develops cancer, it is the family members who endure this experience. However, the family itself is often profoundly affected by the intrusive presence of the disease and the unpredictable outcome” (p 33). Family adaptation to cancer is a continuous process with many critical cycles (p 33). Families cope in different ways,

based partially on family resilience; there are low-resilience variables (eg, rigidity, helplessness, and resentment) and high-resilience variables (common values, meaning, flexibility, and problem-solving). Within and outside the family, patients often cite their spouses as their primary source of support (p 37). The authors also emphasize that “the prognosis of chronic and terminal illness reverses the illusion of immortality and takes away the fantasy of an infinite tomorrow for the intensity of today” (p 41). The text reviews some psychological family interventions, emphasizing empathic listening. “Family intervention should be seen as an educational approach in which the therapist respectfully accepts each member’s thoughts and feelings, regardless of differences among them” (p 49). The chapter also suggests that although family members have the ability to decide who they will or will not reveal news of the illness to, yet they “may be psychologically unprepared to hear and communicate the diagnosis or prognosis at one specific moment” (p 51). Chapter 3, “Communicating with cancer patients and their families,” is probably the most important and useful chapter of this volume. Reading it, one feels like paraphrasing James Carville and saying, “It’s the communication, stupid.” The authors emphasize the relationship-centered model of oncology in contrast to the “traditional,” medical model, and provide examples of different characteristics of communication in these 2 models (eg, the provider explains treatment options vs the provider chooses treatment). “Communication skills, especially the

more complex ones, must be learned and practiced in order for clinicians to be effective in using them” (p 62). This chapter further reviews cancer and mood disturbance (including the mistaken belief that depression is a normal part of cancer experience), purposes of communication, key communication skills for routine encounters with patients and families, communication challenges in the clinical setting, and how to communicate “bad” news. Chapter 3 also contains a useful list of web-based resources on effective communication.

Chapter 4, “Demoralization and depression in cancer,” points out that there is a difference between depression and demoralization, although those are interrelated experiences. “Depression is a very common consequence, but no cause, of cancer. Demoralization develops when the meaning and purpose of life are lost, limiting coping and reducing the value anticipated in life” (p 108). The chapter also touches upon the treatment of depression (therapy, medication) and demoralization (for demoralization without depression: dignity therapy, meaning-centered therapy). The following chapter, “Counseling and specific psychological treatments in common clinical setting. An overview” notes that as in other areas, the effectiveness of therapy rests with the skills or competence of the therapist, and the strength of the therapeutic relationship (p 121). The chapter provides an interesting example of recommendations for a 4-tier psychological provision used in the UK cancer services. Chapter 6, “Genetic counseling and testing for hereditary cancers: psychosocial

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considerations,” summarizes the area of genetic counseling for cancer (ie, the hereditary breast ovarian cancer syndrome-related mutations, Lynch syndrome-related mutations, issues such as the psychological impact of undergoing genetic testing, and counseling and family communication about genetic testing).

Chapter 7, “Dimensional psychopharmacology of the cancer patient,” promotes a shift from categorical to dimensional psychopharmacology. Although these 2 are complementary, the authors suggest establishing the categorical diagnosis first and following up with a dimensional diagnosis. They do not consider anxiety or adjustment disorders as separate entities from depression. The dimensional approach helps in defining the treatment of psychopathological syndromes rather than entities. Dimensions to consider for treatment in patients with cancer include sadness/demoralization, apprehension/fear, anger/irritability, activation, apathy, obsessiveness and somatic preoccupation, and reality distortion and thought disorganization. Appropriate psychopharmacological treatments for each dimension are discussed. This chapter also includes common drug interactions, and a discussion of psychotropic drugs to target somatic symptoms and psychiatric referral for psychopharmacological treatment. Chapter 8 reviews how to advance medical education in existential dimensions of advanced cancer and palliative care, and chapter 9 is a nice summary of a rapid psychometric assessment

of distress and depression. A good summary table of rapid psychometric methods (scales) for emotional disorders is included. Chapter 10 then discusses “The value of quality of life assessment in cancer patients,” including the interpretation of quality of life scores. An interesting part of this chapter also reviews the telemonitoring of quality of life.

Chapter 11, “Support of the dying patient: psychological issues and communication,” is another very important part of this book. It discusses 5 key elements of psychological support for a dying patient, including an integrated model of adaptation to existential threat; discussion of the main psychological challenges that impending death represents for the patient; different psychotherapeutic interventions in palliative care; the support for clinicians which includes physicians, nurses and other health professionals working with the dying patient; and identification of communication challenges in palliative care, together with information about communication skills training (p 289). Support for clinicians, physicians, nurses, and other health care professionals working with a dying patient is also discussed. In the interesting discussion on coping and defense mechanisms, the authors remind the reader that “coping strategies, which are conscious and modifiable through learning, can help to resolve problems or emotional tensions and must be distinguished from defense mechanisms” (p 292). The discussion on psychological challenges of a dying patient includes

loss of control, facing uncertainty and separation, and facing the future and reflecting on the past. The text reviews different psychotherapies used in palliative care (ie, psychodynamic, cognitive-behavioral therapy, existential, and systemic), and includes a section on supporting the supporters—up to 30% of oncologists experience psychiatric morbidity and report high levels of exhaustion, demotivation, and low levels of achievement! The final chapter, “Psycho-oncology and optimal standards of cancer care: developments, multidisciplinary approach, and international guidelines,” is a standard feature in many books like this, and includes examples from various countries throughout Europe and the rest of the world.

This is a clinically useful and easy to read book that would be a welcome addition to the libraries of all clinicians involved with cancer patient care. It would also be useful for training psycho-oncology specialists (either in psychosomatic medicine fellowships or other specialized training programs). Many clinicians may find at least parts of this book educational and thought provoking. I especially enjoyed the chapter on communication, as it addressed a major issue for many clinicians I know—a lack of solid, thoughtful communication skills. The discussion of palliative care also is quite revealing for those, like myself, who are not involved in this difficult and stressful area of medical care. This text is a definite buy.

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BOOKS RECEIVED

The following books have been received or otherwise obtained and will be reviewed by selected individuals, the courtesy of the sender is acknowledged by this listing.

The Age of Insight: The Quest to Understand the Unconscious in Art, Mind, and Brain, from Vienna 1900 to the Present. By Eric R. Kandel. New York, NY: Random House; 2012; ISBN 978-1-40006-871-5; pp 636; \$40 (hardcover).

Psycho-Oncology. Edited by Thomas N. Wise, Massimo Biondi, and Anna Constantini. Arlington, VA: American Psychiatric Publishing; 2013; ISBN 978-1-58562-423-2; pp 360; \$74 (paperback).

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. American Psychiatric Association. Washington, DC: American Psychiatric Association; 2013; ISBN 978-0-89042-555-8; pp 947; \$88 (paperback).

Brainwashed. The Seductive Appeal of Mindless Neuroscience. By Sally Satel and Scott O. Lilienfeld. New York, NY: Basic Books; 2013; ISBN 978-0-46501-877-2; pp 226; \$26.99 (hardcover).

What Do Women Want? Adventures in the Science of Female Desire. By Daniel Bergner. New York, NY: HarperCollins Publishers; 2013; ISBN 978-0-06190-608-4; pp 210; \$25.99 (hardcover).

Making the DSM-5. Concepts and Controversies. Edited by Joel Paris and James Phillips; New York, NY: Springer; 2013; ISBN 978-1-46146-503-4; pp 180; \$39.95 (paperback).

Cultural psychiatry (Advances in Psychosomatic Medicine, vol 33). Edited by RD Alarcón; Basel, Switzerland: Karger AG; 2013; ISBN 978-3-31802-394-7; pp 133; \$59 (hardcover).

CORRECTION

In the article "The Canadian Network for Mood and Anxiety Treatments (CANMAT) task force recommendations for the management of patients with mood disorders and select comorbid medical conditions" (*Ann Clin Psychiatry*. 2012;24(1):91-109) Table 1, page 95 contained an error. In the rows for paroxetine and amitriptyline, the Pezzella et al study should be in the "Positive trials" column. In the "Level of evidence" column for amitriptyline, "Negative evidence" should be replaced with "2." The table has been corrected online.