

year, 1856). The chapter later continues with the Feighner's research criteria and finally the DSM-III and its focus on reliability. The next chapter discusses all the minutiae of "depression in the DSM-IV." This chapter points out the conceptual flaws of some other diagnoses, such as adjustment disorder ("largely ignored by researchers" due to its flaws; p 118).

Chapter 6, "Importing pathology into the community," points out the "myth of the equivalence of community and clinical diagnoses," especially in the area of depression. It also criticizes the concept of minor depression, another fallacy of our diagnostic thinking. The seventh chapter, "The surveillance of sadness," points out the flaws of depression screenings, which in some instances leads, for instance, to pathologizing adolescent distress (again, none of the screening instruments takes the context of distressing feelings into account).

The eighth chapter, "The DSM and biological research about depression," suggests that the "conflation of normal sadness and depressive disorder in DSM criteria has handicapped biological research and created confusion that can potentially lead researchers to draw misleading conclusions from their data" (p 165). The chapter skillfully criticizes all the major approaches of biological research, such as genetics, adoption studies, focus on "chemical imbalance," etc. Chapter 9, "The rise of antidepressant drug treatments," reviews the history and various treatments first, and then criticizes various practices such as direct-to-consumer advertisement. The authors conclude that the Big Pharma triumphed in expanding the pharmacotherapy into the treatment of normal sadness.

Not to exclude other disciplines, Chapter 10, "The failure of the social sciences to distinguish sadness from depressive disorder," emphasizes that psychiatry does not exist in a vacuum and that other disciplines, such as anthropology and sociology contributed to the current mess in the concept of depression. Interestingly, the authors, both psychologists, refrain from any criticism of psychology!

The last chapter, "Conclusion," discusses the constituencies for depressive disorder (medicine, psychiatry, research community, World Health Organization, family advocacy organizations, pharmaceutical companies, Peter Kramer, "mental health clinicians" and even afflicted individuals themselves. But again, the term "psychologists" does not appear anywhere). It also addresses some possible objections to the authors' own position. It concludes with some directions for solving the problem in the diagnostic system, e.g., addressing the proportionality of the symptoms to the severity and duration of stressfulness in people's actual life.

One has to agree with Robert Spitzer that this book is a major tour de force. It brings out the major issue in our most revered (and hated) diagnostic system: reliability vs. validity. It skillfully argues for a profound change in our thinking and conceptualizing of depression as a disorder and as normal sadness. It points out that we have difficulties in distinguishing depression as a disorder and as a normal reaction—as Mario Maj recently aptly asked: "Are we able to differentiate between true mental disorders and homeostatic reactions to adverse life events?" (2).

The book is certainly not flawless. Though it is well written, it is a bit repetitive in its major argument about depressive disorder vs. normal sadness (perhaps inspired by the old saying that "Repetitio est mater studiorum/scientiae"). It uses the term "affective disorders" rather than "mood disorders." Finally, a major conceptual flaw in my mind is the fact that the authors argue what is not depression but do not define what depression is.

Nevertheless, the book is a truly great, provocative and inspiring reading which every psychiatrist, *psychologist* and other mental health worker should read and digest. It will certainly improve our way of clinical thinking about our patients and their problems.

REFERENCES

1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 3rd ed. Washington, DC:APA; 1980.
2. Maj M. Are we able to differentiate between true mental disorders and homeostatic reactions to adverse life events? *Psychotherapy and Psychosomatics*. 2007;76:257–259.

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Doing Psychiatry Wrong. A Critical and Prescriptive Look at a Faltering Profession. By Rene J. Muller; The Analytic Press, Taylor & Francis Group, New York, New York; 2008; ISBN: 978-0-88163-469-3; \$29.95 (paperback), 136 pp.

Contemporary psychiatry, considered by many as being predominantly "biological" (whatever that term means), seems to be going through a crisis. Intellectually, we have been treading water lately. Morally, we, according to some, have been selling out to the pharmaceutical industry. We also do not provide the best care to our most severely ill patients, at least in some places and some states. We have not fulfilled our spoken and unspoken promises to our patients and to society. We do not have the answers we said we were going to have. Is this something new, or has psychiatry gone through something similar before? Rene Muller, author of this volume with a catchy title, *Doing Psychiatry Wrong. A Critical and Prescriptive Look at a Faltering Profession*, seems to believe that psychiatry is failing us, and everybody else, for the first time. As he writes in the Preface to his book, his purpose is "to show that psychiatry is failing Hippocrates's injunction—first by not helping the majority of its patients, and then by harming many of them" (p IX).

This volume is divided into Preface, Acknowledgements, 10 chapters and an Epilog. In the Preface, besides suggesting that psychiatry is failing, the author also postulates that contrary to biological psychiatry beliefs, "we already know enough about the brain and the mind to do psychiatry right—and to stop dinging patients with wrong diagnoses and unnecessary medications" (p X).

Chapter 1, "Seeing through the illusion of biological psychiatry," fairly and squarely criticizes our diagnostic system and points out that the meaning of symptoms of mental illness is rarely if ever ascertained. The author also criticizes the "unjustified conclusion that *all* mental illness is biologically driven" (p 2). He suggests that patients "tend to accept the promises of biological psychiatry because it gets them off the hook as creators of their own problems, while offering a solution that does not require them to change their lives" (p 5). Thus, as Dr. Muller concludes, we believe what we want to believe, reaching the level of illusion. Biological psychiatry then has slowly become "not only an illusion, but a *collective illusion*, being subscribed to by so many—patients, doctors, drug makers, insurers—whose needs it meets, if inauthentically" (p 5). The final point of this chapter is that psychiatrists have surrendered to market forces (p 6). A pretty strong opening salvo. Yet, not the last strong shot. The second chapter, "How biological psychiatry lost the mind and went brain dead," continues in the criticism of the DSM diagnostic system, pointing out that, "subjectivity has yielded to objectivity and that validity (accurately naming a patient's pathological experience) has taken second place to reliability." Later on, Dr. Muller suggests that, "in spite of the emphasis traditionally put on the study of physical and biological science in medical schools, psychiatrists are really not all that well trained in science" (p 18). He also suggests that a quasi-religious fervor marks the commitment of many to biological psychiatry. The following chapter points out that "the brain cannot account for what we think, feel, and do" (chapter 3, p. 21), and that we lost the art of psychiatric diagnosis (chapter 4). The author emphasizes that "to diagnose is to see through and to know something completely—to know its meaning" (p 27); (many may disagree with this and other statements). He also states that the DSM volumes (DSM-III and DSM-IV) "were not intended primarily for diagnosing and treating mentally ill patients. Instead, these volumes were meant to accommodate the needs of those who do psychiatric research" (p 28).

The following chapter, "A blatant misdiagnosis of schizophrenia," is a case presentation of a young male, who, according to the author, was misdiagnosed and wrongly treated for schizophrenia due to "almost willful disregard by his psychiatrists of the facts of this case." Chapter 6, "How psychiatry created an epidemic of misdiagnosed bipolar disorder," presents some important issues related to the diagnosis of bipolar disorder, such as the fact that this "diagnosis often serves as an explanation, as well as justification, for a person's unacceptable behavior" (p 55) or that there is as yet no empirical evidence that bipolar II is a milder version of bipolar I disorder (p 50). Dr. Muller also quotes Ross Baldessarini, an expert in this area, who warned of possibly misleading widening and dilution of the bipolar disorder concept (p 52). The next chapter, "Willing psychotic symptoms," discusses, using the famous case of John Nash, "schizophrenia as a strategy invented to live through an intolerable situation" (p 62). The author reminds us that the concept of psychosis is only "consensually validated,"

and, as the author points out, consensual validation "is a term covering the multitude of ways that 'normal' people have agreed to do things" (p 64). Continuing in pointing out how psychiatry deals with various disorders wrongly in Chapter 8 the author focuses on depression. He describes various problems associated with antidepressants and suggests that they may work as psychostimulants and psychoanalgesics rather than targeting the depression-causing imbalance in the brain. Dr. Muller suggests that antidepressants may be ultimately boosting the dopamine circuits that underlie the reward response.

The final two chapters, Chapter 9, "Saving psychiatry from the brain," and Chapter 10, "Doing psychiatry right," are supposedly focused more on what to do than on what went wrong. However, even these chapters are filled with critical statements, such as "We have lost at least a generation of psychiatrists to the illusion of biological psychiatry—often ironically dubbed a 'revolution'—which is a monster that is eating the mental health profession alive, ensnaring both clinicians and consumers. Patients need to be saved from psychiatry and psychiatry needs to be saved from itself" (p 79). The last chapter discusses the work and philosophy of Sir John Eccles, a neurophysiologist and philosopher whose philosophy is considered dualistic, yet according to Dr. Muller it is dialectical. The author also discusses the work of Paul McHugh and Phillip Slavney and their suggestion of a new classification and diagnostic system (categorical rather than dimensional understanding of pathological behavior). The Epilog presents a clinical story of "A man, crippled by anxiety, who was previously misdiagnosed with bipolar disorder: therapy leading to structural change."

While this book contains some interesting reading and some of its criticism is right on target (the validity vs. reliability of the DSM), and the author's frustration is understandable, my final impression is mixed at best for several reasons. I do not believe that contemporary psychiatry is just purely biological. I could not find much constructive or "prescriptive" writing or suggestions in the text, which I found outright hostile at times. I do not believe that psychiatry faces an intellectual crisis for the first time. We have had at least one that I can remember—the failures of the purely psychoanalytical era. Psychoanalysis also failed to fulfill the hopes and answer all the questions. Not that it was truly able answer all question and fulfill all the hopes and that I would like to criticize it for its failures and inability to do so. It is just a fact that has to be put into a historical perspective. The dramatic rise of biological psychiatry came partially in response to the "failures" of psychoanalysis the disillusion of some with it. Existentialism, clearly preferred by Dr. Muller, has not provided us with all answers, either. There is no one direction, philosophy or research orientation which is going to provide us with all answers. I do not think that attacking one branch or orientation in psychiatry is really helpful. We need synthesis and collaboration, rather than criticism and division, to move on to the next level (maybe using the approach to diagnosis suggested by McHugh and Slavney). Evoking religious fervor among biologically oriented psychiatrists only calls for evoking religious fervor among the followers

of some psychotherapy schools . . . and the old proverb that, "People living in glass houses should not throw stones."

In addition to all the argumentative weaknesses, the writing in this book is repetitive at times (the issue of the scapegoat called the DSM is addressed several times, and the fact that the author evaluated 3000 patients in the ER—so what?—is also repeated). Nevertheless, it is a provocative and intellectually stimulating piece of work which some may appreciate as bedtime reading.

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Improving Medication Adherence. How to Talk with Patients About their Medications. By Shawn Christopher Shea; Lippincott Williams & Wilkins, Philadelphia, Pennsylvania; 2006; ISBN: 0-7817-9622-9; \$34.95 (paperback), 158 pp.

As the author of this little book suggests in its preface, "this is a small book about a big topic" (p. xiii). Medication adherence, compliance or whatever we call it is a very important, if not, according to some, the most important part of pharmacotherapy. Patients may not get better without taking the medication and without taking it as prescribed. Yet, as the author, Dr. Shea, writes, patients with chronic diseases take their medications as prescribed only about 50% to 60% of the time (p 3). He also cites findings that "about one third of patients comply reasonably well with recommended treatment, about one third have moderate problems with adherence, and about one third take their medicines poorly or not at all (p 3–4). We, as a profession (and I mean all medicine, not just psychiatry), clearly have a huge problem on our hands. A lot has been written about this issue, yet most of the literature on adherence/compliance issues describes and analyzes the issue rather than telling us what to do about it.

Dr. Shea took a different approach. Combining his own vast clinical experience with the ideas and advice given to him by the audiences of his numerous workshops on medication adherence, he wrote a small book focused on how to *talk* to patients to improve their medication adherence. The book consists of Preface, Foreword (written by the former Surgeon General C. Everett Koop), nine brief chapters and one Appendix.

In the first chapter, "Nonadherence: the extent of the problem," Dr. Shea outlines the scope of nonadherence and also points out that there is a clear evidence that patients who do not adhere to their medication regimen fare worse than those who stick to it. The second chapter, "The crux of the problem: the nature of medication nonadherence," discusses the many roots of nonadherence, such as cognitive problems, confusing directions, not enough money, lack of trust and other reasons. The following chapter, "How do patients choose to take a medication?" brings up the "choice triad" which people use when deciding to take medication:

1. They feel that there is something wrong with them;
2. They feel motivated to try to get help with what is wrong through the use of medication; and
3. They believe that the pros of taking the medication will, in the long run, outweigh the cons (p 23).

This chapter also points out how difficult it is for patients to adhere to medication during the initial phases of some chronic illnesses (e.g., diabetes mellitus) when their symptoms are minimal or the disease is just defined with "abnormal" numbers (e.g., hypertension). The fourth chapter, "Is it really noncompliance," the author discusses the difficulties with the terms adherence and compliance, and then introduces what he calls "medication interest" (p 38). This term suggests, according to the author, that we are primarily teachers and motivators in the process of administering medication. This chapter also explores the issue of "medication sensitivity" (p 40) and the inaccurate view of many patients that they are unusually sensitive to medication.

The following four chapters explore why patients choose to stop medication. The fifth chapter, "Outside the office: the weighing of the pros and cons," emphasizes that there are three different belief sets that determine whether a patient will stay on medication:

1. efficacy of medication,
2. cost of medication, and
3. psychological meaning of medication.

Each of these belief sets forms its own continuum (p 52–53). The next three chapters, chapters 6–8, explore these three issues. The chapter on efficacy brings up the issue of "proactively recommending discontinuation" (p 69). The chapter on cost discusses another interesting issue—the hidden costs, e.g., inconvenience to get the medication (e.g., elderly patient driving to the pharmacy). The chapter also provides some useful tips on how to remind patients to take medications as prescribed by association with some routine (e.g., medication next to toothbrush or alarm clock). The chapter on the medication meaning focuses on some very important issues, such as dismantling the myth of addiction (e.g., in the case of antidepressants), dismantling the myth of crutch, how to approach tapering the medication if the patient is determined to do it anyway, probing the resistance from the patient's spouse/partner and anticipating friends' opinions on medications.

The last chapter, "Medication interest redux—caring for the patient," is discusses how to help patients in making the right choice. It summarizes the core principles of the "medication interest" philosophy. It also, among others, suggests how to deal with alternative methods of treatment and people who practice it—the author suggests to show the patient that one is open to these methods and willing to discuss them.

I have, so far, summarized the main content of the chapters, however I left out the most important component of this book: interviewing tips. The text of the chapters is interspersed (in appropriate places) with 43 interviewing tips on addressing