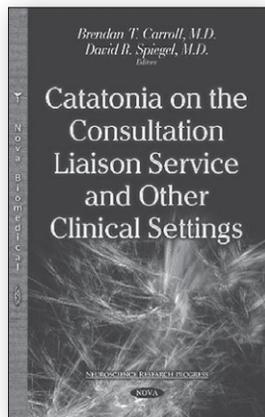


BOOK REVIEWS

Catatonia on the Consultation Liaison Service and Other Clinical Settings



Edited by Brendan T. Carroll and David R. Spiegel; Hauppauge, New York; Nova Science Publishers; 2015; ISBN 978-1-63463-809-8; pp 125; \$110 (hardcover).

Catatonia is a puzzling neuropsychiatric entity or syndrome. During the last century it mostly has been classified as a subtype of schizophrenia. However, it has been recognized that catatonia, as a syndrome, could occur in the context of other mental and physical disorders. Therefore, DSM-5 finally acknowledged that, “Catatonia can occur in the context of several disorders, including neurodevelopmental, psychotic, bipolar, depressive disorders, and other medical conditions (eg, cerebral folate deficiency, rare autoimmune and paraneoplastic disorders). The manual does not treat catatonia as an independent class but recognizes a) catatonia

associated with another mental disorder...b) catatonic disorder due to another medical condition, and, c) unspecified catatonia” (p 119).¹ Because catatonia occurs in various settings and—contrary to some beliefs, is not rare—it could present a diagnostic and management problem for those not familiar with this syndrome/disorder. Consultation-liaison psychiatrists could be called to evaluate patients with catatonia in a medical or surgical setting, in the emergency room, nursing homes, or even at child and adolescent clinics. Brendan Carroll and David Spiegel, the editors of this small volume, gathered a group of clinicians to put together a comprehensive and useful text on catatonia. As they write, this book is not supposed to be another perfunctory review of catatonia; it also intends to bring forth some new ideas about this entity and its conceptualization.

The book consists of 10 brief chapters discussing issues such as the nosology of catatonia on the consultation-liaison service; a 100-year cohort of catatonia; the possibility that catatonia and autism spectrum disorders (ASD) share an underlying pathology; treatments of catatonia including electroconvulsive therapy (ECT); screening for catatonia in the general medical setting; detecting catatonia using nursing diagnoses;

and several interesting cases of catatonia, including one in Creutzfeldt-Jakob disease.

A clinically useful chapter on catatonia on the consultation-liaison service points out that the link between catatonia and a causal medical condition might not be clear in the initial stages of clinical assessment and treatment (p 24) and that “catatonia may be difficult to differentiate from diffuse encephalopathy and non-convulsive status epilepticus” (p 25). The discussion of nosology points out that “Catatonia has been classified into two different categories: retarded and excited. The former usually includes mutism, negativism, staring, rigidity and catalepsy; while the latter presents with excitement, disorganized speech, disorientation, impulsiveness, and combativeness” (p 26). The latter form is less known and less recognized by many clinicians. This chapter also includes a brief review of available treatments—high doses of benzodiazepines (lorazepam, 6 to 20 mg/d) work in most cases (80%); ECT can relieve the rest. The authors also recommend using IV benzodiazepines (lorazepam, diazepam) or oral zolpidem for verifying the catatonia diagnosis, because these medications provide a quick relief of catatonia symptoms.

The chapter on catatonia and autism warns that using antipsychotics for treating ASD with co-occurring catatonia is problematic because of the association between antipsychotics and malignant catatonia and neuroleptic malignant syndrome. The chapter also emphasizes that “Catatonia should be considered in any patient with an ASD, of any age, when there is an obvious and

BOOK REVIEWS

marked deterioration in movement, vocalization, pattern of activities, self-care, and practical skills” (p 52). The chapter on ECT includes a few useful tables on the complications of catatonia and treatment implications, and on considerations for patients with catatonia who require ECT. The chapter reviewing catatonia treatments includes some interesting information about pharmacologi-

cal approaches to treating catatonia other than benzodiazepines, such as carbamazepine and memantine. Several case reports included in this volume contain a wealth of clinical information and a good description of psychopathology.

The authors intended to provide clinical information useful to all those encountering catatonia in various settings (physicians, nurses, students).

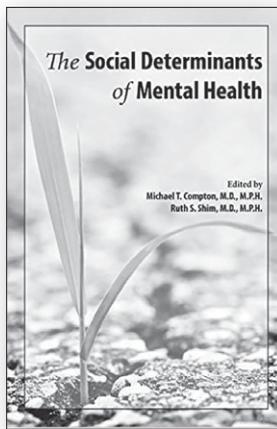
In a way, they succeeded. However, I am not sure whether this goal is not going to be hampered by the price of the book, which in my opinion, is too high for such a small volume.

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REFERENCE

1. Diagnostic and statistical manual of mental disorders, fifth edition. Washington, DC: American Psychiatric Association; 2013.

The Social Determinants of Mental Health



Edited by Michael T. Compton and Ruth S. Shim; Arlington, Virginia; American Psychiatric Publishing; 2015; ISBN 978-1-58562-477-5; pp 294; \$58 (paperback).

The etiology of many physical and mental illnesses is multifactorial. Psychiatry has embraced George Engel’s biopsychosocial model of illness and healing. However, for various reasons, psychiatry deals mostly with the “biopsy-

cho” part. Yet the impact of social and environmental factors on health, wellness, and illness is unquestionable. Social factors also play an important role in the course of chronic illnesses. Some of the reasons for medicine’s and psychiatry’s lesser involvement in social aspects of illness and healing are the lack of involvement of medicine and psychiatry in social policies and lack of resources to impact social factors and determinants of illnesses. Interestingly, the social and political responsibilities of medicine have been voiced more than 100 years ago in statements attributed to the famous German pathologist Rudolf Virchow, who stated, “Medicine is a social science, and politics is nothing else but medicine on a large scale,” and that “if medicine is really to accomplish its great task, it must intervene in political and social life” (p 159).

Because the editors of this book Michael Compton and Ruth Shim felt that there is not enough attention

paid to social determinants of mental illness, they put together this volume authored by experts in the area of social determinants of mental illness. The volume focuses mostly on the United States—although the topic is relevant to the entire globe—because they feel that “The United States lags behind in terms of implementing effective interventions to address the social determinants of health” (p xix). In the Preface, they emphasize, “The social determinants of mental health are largely the same as those underpinning chronic physical health conditions (eg, diabetes, hypertension, cardiovascular disease, cancer). We specifically delineate the social determinants of mental health in order to translate the existing body of literature to the mental health arena, again allowing for articulation of specific action that clinicians, policy makers and others can make” (p xx). They add, “Although numerous *social risk factors* have been identified and are familiar to mental health professionals, we focus instead on the more far-reaching and pervasive social determinants that have clear policy implications. For example, being unmarried, living alone and having

BOOK REVIEWS

had a family member who committed suicide are commonly cited social risks factors for suicide, and a more urban upbringing, cannabis use in adolescence, and declining social functioning in adolescence are widely known as some of the social risk factors for schizophrenia; however, such individual-level, proximal risk factors are not addressed in this book. We focus instead on the broader, deeper social factors affecting society as a whole and those with clear policy implications” (p xxi).

Ten of the 11 chapters of this book focus on the social determinants of mental health starting with a general overview and following with discussions of specific topics: discrimination; adverse life experiences; poor education; employment, underemployment and job insecurity; economic inequality, poverty and neighborhood deprivation; food insecurity; poor housing quality and housing instability; adverse effects of built environment; and poor access to health care. The last chapter written by the former Surgeon General David Satcher and Ruth Shim is “A call to action: addressing the social determinants of mental health.” All chapters are similarly structured, using case examples and ending with summary key points.

The general overview points out the 5 key social determinants of health identified by the U.S. federal document *Healthy People 2020*: economic stability, education, social and community context, health and health care, and neighborhood and built environment (p 13). (For those, who, like me, may not be familiar with the term *built environment*:

“The built environment is characterized by four key attributes: 1) it comprises all things humanly created or modified; 2) its purpose is to serve human needs, wants, and values; 3) it helps humans manage the natural environment to increase comfort and well-being; and 4) it shapes the physical and social environment within which humans function and therefore affects virtually all aspects of human existence and quality of life” [p 194].) The chapter on discrimination is a mixture of a few interesting points and a lot of vague policy text. It mentions the important point that minorities with mental illnesses often face double discrimination. On the other hand, the concept or “microaggressions” in the context of discrimination is mentioned just in a passing comment. One would think that discussing it in a more clinical context would be more useful, but this is more a policy book than a clinically oriented text.

The chapter on adverse early life experiences reminds us that traumatic experiences in a child’s social environment that result in negative physical health outcomes similarly are associated with negative mental health outcomes (p 55). The chapter also discusses the concept of the Adverse Childhood Experience Study Pyramid (from adverse childhood experience through several steps to early death) with all its evidence and scientific gaps. The discussion of poor education notes, “Graduating from high school is associated with decreased risky health behaviors, reduced burden of illness, delays in the consequences of aging, increased life expectancy, and decreased disparities in health...and

...Having more formal education is linked to lower death rates and later death” (p 80).

The remaining chapters, in sync with their focus, bring to the reader’s attention to the extensive evidence supporting the link between unemployment, underemployment, and job insecurity and poor mental health outcomes, including depressive, anxiety, and alcohol use disorders, and suicide (p 115) (and that mental health providers have a responsibility to engage patients in a discussion about employment-related issues); similar links (with stronger or weaker evidence) exist between poor mental health outcomes and poverty, neighborhood deprivation, food insecurity, poor housing and housing instability, and poor access to health care. The text reminds us that these social issues are not rare. For example, 17.9 million U.S. households (14.9%) were food insecure at some time during 2011, and 6.8 million households (5.7%) had *very low* food security” (p 150). Regarding mental health, the text cites the estimates of needed number of psychiatrists to adequately address the needs of the U.S. population (35 psychiatrists per 100,000 adults) and the approximate real numbers (16.5 psychiatrists per 100,000 adults in 2011—and these psychiatrists are not evenly distributed). Finally, the call for action chapter reminds us about the World Health Organization’s phrase, “No health without mental health.”

Although this book presents important issues, I am not sure what the take home message for a clinically oriented psychiatrist would be—assuming that a good clinician

BOOK REVIEWS

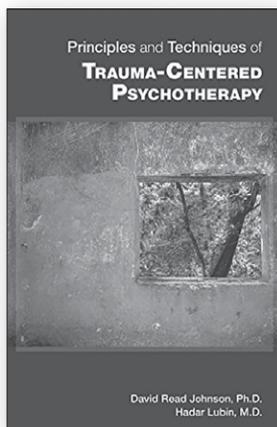
asks about early adverse life events, education, employment, and hope-fully can touch on discrimination. The difficulty for a general reader is the book's focus on the broader,

deeper social factors affecting society as a whole and those with clear policy implications (p xxi), which probably makes an interesting reading for policy makers but is only a reminder

of social determinants of mental health for the rest of us.

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Principles and Techniques of Trauma-Centered Psychotherapy



By David Read Johnson and Hadar Lubin;
Arlington, Virginia; American Psychiatric
Publishing; 2015; ISBN 978-1-58562-514-7;
pp 357; \$59 (paperback).

The reader may ask, *Why a book on yet another new psychotherapy? Why another trauma-focused intervention?* True, many new trauma-focused interventions, such as prolonged exposure, eye movement desensitization and reprocessing, trauma-focused cognitive-behavioral therapy, cognitive processing therapy, or narrative exposure therapy, and others have been introduced over the last 2 decades. Many of these inter-

ventions could be, as the authors of this book write, *trauma informed*, or *trauma focused* (p xii). However, as they continue, “These terms are not well defined, but basically those interventions that are trauma informed use the knowledge of trauma and its effects but may not directly engage the client in discussion about the traumatic event. Many trauma-informed interventions may emphasize skills training, relaxation and psychoeducation... Trauma-focused interventions, on the other hand, privilege the discussion and processing of the traumatic event throughout the treatment...many trauma-focused interventions include some form of exposure treatment. The term *trauma centered* is proposed for an intermediate approach where the exploration of the trauma is conducted in the initial phase of therapy and then is utilized as a foundation as the therapy moves into current issues. Thus, the impact of the past traumas on current functioning remains central to the psychotherapeutic work but does not constrict the breadth of exploration as much as trauma-focused approach must do” (p xii).

Therefore, Drs. Johnson and Lubin, co-directors of the Post Traumatic Stress Center at Yale University and experts in trauma treatment and in this new, trauma-centered approach, wrote a book “for clinicians who wish to conduct a trauma-centered conversation with their clients” (p xi). In addition to Preface, the book includes 19 chapters, References, Answers to Study Questions (each chapter ends with several questions related to the content of the particular chapter), and 3 Appendices (“A: Consent to treatment;” “B: Traumatic life events questionnaire;” and “C: Clinical interview for assessment of trauma history”).

The chapters provide a detailed guide on how to do trauma-centered therapy. They review issues such as the development of cultural context of trauma-centered psychotherapy; axioms of trauma-centered psychotherapy; establishing the trauma-centered frame; principles of trauma-centered psychotherapy; 4 main techniques; the first session; getting the details of patient and trauma history; conducting ongoing treatment (trauma-centered therapy could be lengthy, from 6 months to years); addressing the gap; long-term process in treatment; and hardening the edges (dissociative reactions, violence, property damage, arrest, self-harm, substance abuse, no memories of abuse). The chap-

BOOK REVIEWS

ters focused on special topics include working with patients with dissociative identity disorder or borderline personality disorder; trauma-centered group psychotherapy; trauma-centered couples and family therapy; adjunctive methods (narrative, pictorial, ceremonial, and role-playing ones); strains on therapists; and limits to trauma-centered approach.

The Preface, in addition to outlining the book, presents the definitions of some terms such as *traumatic experience and memory*; *trauma schema* (set of ideas, feelings and behaviors that arise *after* a traumatic event and form the person's adaptation and integration of the traumatic experience); *neurotic schema* (set of ideas, feelings, and behaviors that arise from childhood experiences and are further shaped and smoothed out by additional experiences in life); and *primary and secondary emotions*. The first chapter on the cultural context on trauma-centered psychotherapy discusses 4 major perspectives on the cause of traumatic reactions: character weakness in the victim, responses to social oppression, physical processes, and overwhelming arousal. The authors emphasize the importance of balance between containment and expression in human systems: "Too much containment can lead to the denial of important social problems and to the creation of secrets within social units. On the other hand, too much expression has been associated with increases in disability, malingering for secondary gain, and false accusations" (p 3). The following 4 chapters present the 3 levels of the basic frame of trauma-centered psychotherapy. First, 4 axiomatic con-

cepts of trauma-centered psychotherapy are discussed: (1) trauma schemas arise in order to reduce the primary emotions of fear and shame; (2) both client and therapist will be participating in avoidance to some degree all the time; (3) the client's trauma narrative always is incomplete; and (4) trauma schemas are relational. These axioms "provide a foundation for the work and situate the encounter between the therapist and the client within certain boundaries" (p 27). These boundaries become the trauma-centered frame, reviewed in chapter 3. The authors emphasize. "What underlies trauma-centered psychotherapy is that *imaginal exposure is the primary therapeutic element in trauma treatment*" (p 40). Chapter 4 reviews 3 clinical principles of trauma-centered psychotherapy: of immediacy, of engagement, and of emotionality. These principles are specific to trauma-centered work and serve as guides to the therapist in successfully managing an approach to trauma (p 47). "These principles, when followed, concretize the trauma-centered environment for the client, communicating forcibly to him or her that the interaction with the therapist will not be like other therapeutic interactions" (p 27). Writing about the principle of immediacy, the authors state, "Trauma-centered psychotherapists will be dispassionate but clear. They will speak about the trauma and tell the client that together they will revisit the pain in order to get it out and that the client will feel better as a result. The therapist will be optimistic but direct" (p 49). The direct review of the trauma is an important distinction between

this therapy and other trauma-related therapies. Finally, chapter 5 discusses the 4 main techniques: getting the details, decoding current behavior, introducing discrepancy, and disclosing the perpetrator.

The next 6 chapters are focused on detailed technical aspects of trauma-centered psychotherapy with a multitude of clinical examples. Chapter 9, "The gap," explains that "Trauma schemas are interpersonal, relational structures that serve to stabilize the client's inner feeling of uncertainty regarding the boundaries between the past and the present, and between danger and safety... The unfortunate paradox is that in the attempt to reduce ambiguity (and the possible re-experience of fear), the trauma schema re-creates the division between victim and perpetrator from the original event, imposing the past upon the present again. When this occurs within the therapeutic interaction, it is called the *gap*" (p 117).

The following 5 chapters discuss work with special populations (dissociative identity disorder, borderline personality disorder) and special therapy areas (trauma-centered group and couples and family psychotherapies; and adjunctive methods). Chapter 17 discusses the important topic of strains on the therapist, including not understanding the client: compassionate fatigue; not believing the client: false memory and credibility; hearing too much: vicarious traumatization; wanting to harm the perpetrator: retaliation and rage; wanting to rescue the client: advocacy, charity, and adoption; and having to be there: emergencies and phone calls. The *de facto*

BOOK REVIEWS

last chapter (there is the usual non-productive Conclusion chapter, too) presents what the authors see as limits to the trauma-centered approach: (1) the feeling that the therapist is not needed, because either other therapies are used or patients overcome trauma on their own; (2) the fact that trauma-centered approach is not for faint-hearted therapists, some may feel quite uncomfortable; (3) the lack of institutional support, the possible tension between the legal system

and psychotherapy (eg, when forensic evaluation is requested), and various limitations when working with children.

This book is a thoughtful, detailed manual to a new way of treating trauma victims. As the authors said, "This is a book on technique, not theory" (p xiii). Therefore it could be used by clinicians/therapists of various orientations. It should be added, that although this is a fine book on the technique of trauma-centered

psychotherapy, we do not know whether this therapy works and whether it works better than other therapies. That remains to be tested. Nevertheless, the book is a good reading for anybody interested in treating patients with psychological trauma. The case examples and the questions and answers are especially valuable.

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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.

Cruel Attachments: The Ritual Rehab of Child Molesters in Germany.

By John Borneman; Chicago, Illinois; The University of Chicago Press; 2015; ISBN 978-0-226-23391-8; pp 256; \$35 (paperback).

Practicing Psychodynamic

Psychotherapy: A Casebook. Edited by Richard F. Summers and Jacques P. Barber; New York, New York; The Guilford Press; 2015; ISBN 978-1-462-51718-3; pp 266; \$40 (hardcover).

The Bipolar Book: History, Neurobiology,

and Treatment. Edited by Aysegul Yildiz, Pedro Ruiz, and Charles Nemeroff; New York, New York; Oxford University Press; 2014; ISBN 978-0199300532; pp 686; \$175 (hardcover).

Do No Harm: Stories of Life, Death, and Brain Surgery.

By Henry Marsh; New York, New York; Thomas Dunne Books; 2015; ISBN 978-1-250-06581; pp 278; \$25.99 (hardcover).