Cocaine abuse epidemics come and go. Some of us remember the cocaine epidemic of the 1980s that peaked in 1985 and produced an estimated 2.5 million lifetime stimulant abusers (p 3). Some may assume cocaine abuse was a big problem but hopefully isn’t big any more. Unfortunately, it still is, and we are facing yet another epidemic.

There are approximately 1.4 million cocaine abusers and 350,000 methamphetamine abusers in the United States (p 3). The cocaine abusers are not just those remaining from the 1980s epidemic; there also has been a steady stream of new users (p 3). This edited volume brings us information that can help us face and fight this new, and in a way, larger and more dangerous epidemic. Why larger and more dangerous? Partially because methamphetamine was not a part of this equation during the previous epidemics. However, nowadays it is atypical to find a patient who abuses only cocaine or only methamphetamines (p 155). “Most stimulant users use these drugs in combination, often with the intent either to increase the effects produced by the primary stimulant or to ‘take the edge off’ a high when they want to control the cardiovascular and subjective effects” (p 155).

In addition, the epidemiology and geography of stimulant abuse is different in the present epidemic, as the distribution of cocaine and methamphetamine is different. Cocaine is being supplied from South America, while amphetamines and methamphetamines are coming from more “home-grown” resources (illegal labs; methamphetamine imported from Mexico is replacing the locally produced methamphetamine) (p 1). Cocaine remains primarily an urban problem. Methamphetamine distribution was predominating in the rural, western, and southern regions of the United States and has moved to rural Midwestern states.

Cocaine and methamphetamine abuse is not a problem limited to North America. Cocaine abuse has recently spread to Europe, starting in Spain. Methamphetamine abuse also is an international problem, “with two-thirds of the world’s 33 million methamphetamine abusers living in Asia” (p 4). The Philippines have the world’s highest rates of methamphetamine abusers: 2.9% of its population (p 4). These are staggering numbers, underscoring the fact that stimulant abuse has become a serious worldwide problem.

This small volume consists of a Foreword (a useful summary of the book) by Herbert Kleber and 8 chapters written by 11 contributors. The first chapter, “Epidemiology and psychiatric comorbidity,” provides a wealth of information (some of it previously mentioned). The epidemiology part also points out some changes in patterns—a shift from inhaled to smoked methamphetamine, or increase of stimulant abuse in the form of pharmaceutical abuse (increasing number of prescriptions led to greater availability, easy access to stimulants through family and friends makes it cheap and attractive) (p 7). The authors also point out that “drug use is more common among patients with mental illnesses than among the general population” (p 9) and that methamphetamine users appear to be at higher risk for developing psychotic symptoms (p 8).

The second chapter, “History, use, and basic pharmacology of stimulants,” includes a great and detailed, yet a bit boring, explanation of stimulants’ pharmacology. The history part includes many interesting pieces of information—Coca-Cola and Red Bull companies use “de-cocainized” extracts from coca leaves in their drinks;
until 1900, Coca-Cola drinks contained some cocaine, and Bolivia now produces a drink called Coca Cola that uses the coca leaf as its base ingredient (p 3-4). Another more important piece of information: most cocaine seized in the United States is adulterated with the agranulocytosis-inducing anthelmintic drug levamisole, which is responsible for numerous hospitalizations and deaths (p 26). The author explains what “crank, ice and crystal meth” means—there is even a photo of crystal meth. The chapter also mentions an interesting clinical fact: cognitive enhancers and anti-inflammatory agents have shown some promise for treating methamphetamine/amphetamine dependence.

The third chapter, “Diagnoses, symptoms, and assessment,” starts with a good discussion of clinical aspects of stimulant abuse. The text emphasizes that the subjective and behavioral responses to stimulants are complex and depend on many variables—dose, route of administration, previous experience with the drug, the environment in which the drug is taken, and patients’ unique response patterns. Other interesting areas discussed are stimulant delirium, serious cardiovascular side effects, and the controversy over the persistence of antidepressant effect of stimulants in depressive states. This chapter also addresses the frequently asked clinical question: “Is use of addictive medications flatly contraindicated in patients with substance dependence in remission, or is such medication prohibited only in instances of use of drugs of the same class (eg, methylphenidate and methamphetamine or cocaine)?” The authors respond that, “In general, a psychiatrist should never rule out the use of any addictive drug if there are good symptom-based reasons for prescribing it. Nor should the psychiatrist assume that an addicting drug of one class (eg, opiates) will be safe for an individual who abused another class, such as stimulants” (p 98). These are wise and cautionary pieces of advice.

Chapter 4, “Behavioral interventions,” provides an introduction to common behavioral-based interventions for stimulant dependence: contingency management, cognitive-behavioral therapy, and group counseling. The chapter also discusses the use of motivational interviewing at length. Motivational interviewing generally is not used as a stand-alone intervention; it is, however, an integral component of the community reinforcement approach (p 139).

The fifth chapter, “Pharmacotherapy,” is fairly brief because there is not much available in this area. An interesting note—disulfiram treatment reduced cocaine use in some studies, and this effect was independent of concomitant alcohol use (p 147). Disulfiram also inhibits, in addition to aldehyde dehydrogenase, other enzymes, such as dopamine β-hydroxylase responsible for the synthesis of norepinephrine from dopamine (but also inhibits the enzyme responsible for cocaine degradation). The chapter also reminds us that studies testing antidepressant use in stimulant abuse largely have been negative with the exception of bupropion (it decreases methamphetamine use in light but not heavy users) (p 149). Reading these 2 chapters, I missed some mention of combining behavioral therapies with pharmacotherapy.

Chapter 6, “Polydrug abuse,” emphasizes finding a patient who abuses only cocaine or only methamphetamines is not typical (p 155). As mentioned, “most stimulant users use these drugs in combination…” (p 155). It seems that medications used for other substance abuse treatment may be useful for treating stimulant abuse or dependence (eg, varenicline and bupropion used for nicotine dependence; modafinil). Another important piece of information about polydrug abuse: cannabis enhances cocaine’s subjective and physiological effects and may trigger a psychosis in vulnerable individuals (p 167).

Chapter 7, “HIV and other medical comorbidity,” reviews the effects of cocaine and methamphetamine on the body (overdose, cardiovascular and cerebrovascular systems, lungs [eg, asthma exacerbation], oral health [periodontal disease and tooth decay and loss], skin, and injuries), effects on fetal development, and effects on infectious diseases, including increased HIV disease progression. The last chapter briefly summarizes the text and provides some future directions.

This is a solid, useful, well-written volume. It is fairly well edited and thus there is not much overlap among chapters. Useful features include the summary of key clinical concepts and resources at the end of each chapter. The book is packed with new information that many clinicians will find interesting and useful. Even at $65 for a paperback, it is a good buy.
Understanding suicide is one of the Holy Grails of psychiatry. As the editors of this volume write, “suicide accounts for more deaths each year than all wars and other forms of interpersonal violence combined—meaning that we each are more likely to die by our own hand than by someone else’s. More alarming is the fact that suicide is projected to be an even greater contributor to the global burden of disease in the coming decades” (p 1). Yet we understand little about suicide and our efforts to prevent it are unsatisfactory. In efforts to understand and elucidate it, suicide has been studied, within the framework of what is possible and ethical, from many angles and views. One such approach is the epidemiological one. The epidemiological approach allows researchers to study some aspects of suicide in large population samples and hopefully find some common features of people who attempt and/or commit suicide.

In the past, most epidemiological studies of suicidal behavior have been done in smaller areas or individual countries. The World Health Organization (WHO) has expanded this approach to study suicidal behavior around the globe. This book provides “previously unavailable information about the occurrence of suicidal behavior around the globe—from a broad array of countries and cultures including those in the Americas, Europe, Africa, Asia and the Pacific; and the Middle East—in an effort to answer fundamental, and previously unaddressed questions about this devastating problem” (p 1). The information has been obtained from the WHO World Mental Health Surveys. The book’s 16 chapters, written by an international team of 50 authors, is divided into 4 sections and a large, 153-page Appendix.

Section 1, “Introduction,” includes 3 chapters. In the first chapter, the editors discuss the challenges to studying suicidal behavior—suicide and suicidal behavior occur at fairly low base-rates in the general population; suicidal behavior is the result of the combination of many factors and few studies of suicidal behavior are replicated (probably because of the difficulties with recruiting subjects). The rest of the chapter briefly describes the remaining chapters of the book. Chapter 2, “The epidemiology of suicide,” reviews the majority of what is already known about suicide and suicidal behavior—the data on the current rates and recent trends for suicide and suicidal behavior in the United States and cross-nationally, the data on the onset, course, and risk and protective factors for suicide and suicidal behavior, and the data on recent suicide prevention efforts (p 6). Suicide is the 11th leading cause of death in the United States (10.8/100,000) and accounts for 1.4% of all deaths in the United States (p 7). The earliest onset ever reported for suicidal behaviors is in children age 4 to 5 (p 17)! These are staggering pieces of information. Fortunately, it seems that restricting access to lethal means and training physicians to recognize and treat depression and suicidal behavior reduces suicide rates (p 20). Interestingly, the suicide rate in the United States has decreased approximately 11% since 1990. However, it seems that the rates have fluctuated over the past century between 10.0 and 19.0/100,000 (the current rate is the same as it was in the 1950s).

The rest of the book focuses on the WHO study and its results in the area of suicide. The third chapter describes the methodology of the WHO study. The data in this study were obtained by using the same standardized procedure as for sampling interviews. The WHO Composite International Diagnostic Interview

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(CIDI) was used to interview patients in 28 countries (the book’s data comes from 21 countries). Presenting the data from only some countries and the use of the CIDI are, in my mind, the main limiting factors of this study and of the data presented in this volume.

Section 2, “Prevalence and course of suicidal behavior,” includes 2 chapters. Chapter 4, “Prevalence, onset, and transitions among suicidal behaviors,” notes the wide ranges of prevalence of suicidal ideation (2.6% in Romania, 15.9% in New Zealand), suicidal plans (0.7% in Bulgaria, Romania, and Italy, and 6.2% in India), and suicide attempts (0.5% in Bulgaria and Italy, 5% in the United States). The authors also confirm that suicidal ideation rarely is reported before the early teen years and that in all countries, history of suicidal ideation is a key risk factor for future suicide plan. The results presented in chapter 5, “Persistence of suicidal behaviors over time,” show that persistence of suicidal behavior is complex. “A substantial proportion of suicidal behavior is short-lived, resolving within the year of onset and never recurring. But the remainder is often highly persistent” (p 85).

Seven chapters of the third section, “Lifetime risk factors for suicidal behavior,” present data on various risk factors for suicide, such as sociodemographic risk factors (chapter 6), parental psychopathology (chapter 7), childhood adversities (chapter 8), traumatic life events (chapter 9), mental disorders (chapter 10), and chronic physical conditions (chapter 11). The final chapter of this part, “Integrative models of suicidal behavior,” attempts to integrate all these risk factors into one model of suicidal behavior. The reader will find a lot of interesting information in this section. Some of it is well-known (eg, women are at a significantly increased risk for suicide ideation and attempts; those never married are at increased risk for suicide ideation and attempts), some information is less well-known (fewer years of education are associated with higher risk of suicide ideation and attempts). Interestingly, only parental generalized anxiety disorder (GAD) increases the chance of offspring developing a suicide plan, and only panic disorder, antisocial personality disorder, and GAD predict unplanned suicide attempt (p 110). It seems that the presence of mood disorders in parents is more likely to predict the onset of suicidal thoughts while anxiety and poor impulse-control behaviors, such as panic disorder, intermittent explosive disorder, and substance abuse disorders are stronger predictors of suicide attempts (p 110). The results of this large study also noted that a broad range of childhood adversities (bodily injury-related adversities, eg, sexual and physical abuse) are strong predictors of subsequent onset of suicide ideation and attempts. There also is a strong association between sexual and interpersonal violence and suicide ideation and attempt, with sexual violence also predicting the persistence of suicide ideation (p 143). What I found most interesting and clinically relevant with regard to a person’s psychiatric disorder was that “although depression is among the strongest risk factors for suicide ideation, it does not predict which people with suicide ideation go on to make a suicide plan and/or attempt. Instead, disorders characterized by anxiety and poor impulse-control (eg, bipolar disorder, alcohol use disorder, PTSD [posttraumatic stress disorder], panic disorder) predict this transition” (p 160). Another important finding is the fact that epilepsy was the physical condition most strongly associated with suicidal behavior (p 175).

Section 4, “Twelve-month risk factors and treatment,” includes 2 chapters: chapter 13, “Prevalence and identification of groups at risk for twelve-month suicidal behavior in the WHO World Mental Health Surveys” and chapter 14, “Treatment of suicidal behaviors around the world.” The results on treating suicide around the world are quite disappointing: only 39% of suicidal respondents received treatment in the past year, with consistently lower proportions having received treatment in low- (17%) and middle-income (28%) countries than in high-income (56%) countries. Low perceived need for care was the most common reason for not seeking help, followed by attitudinal and structural barriers; stigma or financial concerns were not major barriers (p 208). On another interesting note, up to 17% of respondents received treatment from complementary or alternative medicine (p 209)!

The final section, “Conclusion and future directions,” consists of chapters focused on “Research, clinical, and policy implications of the World Mental Health Survey findings on suicidal behavior,” and on “Conclusion and future directions.” These are chapters that are included in almost every volume of this kind and could be omitted in almost any volume. The Appendices include numer-
Over the last several decades there has been a continuous effort to make psychiatric diagnosis and evaluation more and more simple or, as many would say, more simplistic. The DSM approach to psychiatric diagnosis has, rightly or not, been criticized from many angles. One of the main criticisms has been the disappearance of individual aspects and experience of our patients from their diagnosis and of what underlies their presentations. As Paul R. McHugh and Phillip R. Slavney write in their Foreword, “…psychiatric practice has devolved from a thoughtful professional art to a technical, instrumentalist routine where, with what exists being officially presumed, what is done both diagnostically and therapeutically is mechanical and generic rather than devised, individuated, challenging and progressive” (p x). They also warn of the fact that today’s psychiatrists “…display a complacent satisfaction in refusing to go beyond the securities of diagnostic consistency given to them by the DSM diagnostic categories—a complacency often expressed in discussion-ending statements such as ‘he meets criteria’” (p x).

There have been some attempts to address these concerns within the world of even American psychiatry. One of the attempts or approaches addressing these concerns has been McHugh and Slavney’s book, The Perspectives of Psychiatry. They introduced a conceptual framework using 4 perspectives: disease, dimensional, behavior, and life story, for understanding patients who present with psychiatric condition. As they state, “With The Perspectives of Psychiatry we did not offer some new theory to psychiatrists but rather drew attention to causal ideas long implicit within the discipline and in need of re-emphasis at this time and place in the discipline’s history: specifically ideas that provide psychiatrists power to ‘know about’ the disorders that they ‘know of’ by name. The Perspectives of Psychiatry strives to offer a view of what psychiatry today ought to become” (p xi). Some of McHugh and Slavney’s satisfaction in refusing to go beyond the securities of diagnostic consistency given to them by the DSM diagnostic categories—a complacency often expressed in discussion-ending statements such as ‘he meets criteria’” (p x).

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Systematic Psychiatric Evaluation: A Step-by-Step Guide to Applying The Perspectives of Psychiatry


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students and colleagues have expanded the ideas of “perspectives of psychiatry” into further volumes. This book is another contribution to this list sparked by McHugh and Slavney's work. It attempts to “distill that book’s [The Perspectives of Psychiatry] concepts into an easier-to-digest and easier-to-use format”... “to distill the detailed instructions of The Perspectives of Psychiatry into a practical ‘recipe’ for trainees” (p xiii) and apply it into a systematic psychiatric evaluation.

The book is divided into 2 parts: “I. The concept behind the approach” and “II. The approach in action.” The purpose of the 6 chapters of Part I: “An introduction”; “The psychiatric evaluation”; “The life-story perspective”; “The dimensional perspective”; “The behavior perspective”; and “The disease perspective,” is to explain and illustrate the key concepts of “perspectives of psychiatry.” In the Introduction that the authors point out that “The central tenet of The Perspectives is that one single method cannot explain all psychiatric conditions” (p 5). According to this tenet, clinicians should consider every psychiatric patient from 4 points of view: disease, dimensional, behavior, and life story—each with a unique way of understanding the emergence of various psychiatric conditions” (p 5). The authors add that The Perspectives introduce “perspectival” thinking and are “less concerned with the differentiation and classification of psychiatric conditions (nosology) than with helping clinicians become aware how they think about each patient presentation” (p 6). The rest of the Introduction explains each perspective in more detail. The disease perspective focuses on disease (what one has) and reasoning, with key features being clinical syndrome, pathology, and etiology. The dimensional perspective “considers whether a patient’s psychiatric condition is arising from aspects of personality that make her vulnerable to developing distress in specific situations,” (p 8) as personality is composed of enduring cognitive and temperament dimensions (what one is). The key concepts of this perspective are potentials, provocations, and responses. According to the authors, “understanding a patient’s dimensional characteristics help the clinician guide the patient in psychotherapy” (p 9). The behavior perspective focuses on what a patient is doing, with key concepts being choice, physiological drive, and conditioned learning (what one does). Finally, the life-story perspective deals with what one encounters, as “Every individual goes through life as an agent with needs, desires, goals, and hopes. When someone encounters life circumstances that disrupt these, distress and demoralization may arise” (p 11). The conclusion of this chapter suggests that the entire approach could be summarized in what a patient has, is, does, and/or encounters, in mnemonic: HIDE (Has, Is, Does, Encounters).

The discussion of “The psychiatric evaluation” presents 2 versions of the same case evaluation; the first illustrating a typical approach to a psychiatric history and the second presenting a more comprehensive evaluation embedded in The Perspectives (this usually takes >1 hour and should be done in 1 session). The chapter summary emphasizes that the essential features of the systematic psychiatric evaluation are a detailed history; a history obtained and presented in a specific sequence; a history obtained from multiple sources; a systematic mental status examination; and a careful differentiation between observations and interpretations.

The following 4 chapters present cases illustrating in more detail the life-story perspective, the dimensional perspective, the behavior perspective, and the disease perspective. Each chapter is written in a dialogue format between the clinician and the patient, followed by a structured discussion and key summary points. The authors explain that they changed the order and started with the life-story perspective “because the life story is the most natural, and personal, way of explaining someone’s thoughts, feelings, and behaviors” (p 35). Although these chapters generally explain the concepts, they are not always clearly written (eg, the chapter on dimensional perspective written on the background of an intellectual disability case).

The second part consists of 9 cases: bipolar disorder (maintaining personhood in the face of a disease); a young man with psychosis (the role of life story and behavior in disease); a mother’s overdose (life story and dimension); a man with depression amidst multiple life stressors (life story or disease?); a matriarch with memory and mood problems (managing diagnostic dilemmas); an executive with health worries (dimension or disease); a young woman’s fear of fat (an aberration in feeding behavior); a lawyer who lies and cuts (synthesis of a complex case); and a case of bereavement (why psychotherapy
matters). Cases (again in a dialogue format) are followed with discussion that applies a step-wise approach to psychiatric evaluation (step 1: role induction; step 2: history; step 3: mental status examination; step 4: collateral information; step 5: consideration from each perspective in sequence: life story, dimensional, behavior, disease; step 6: collaborative formulation; step 7: collaborative treatment plan). In my opinion, these cases are interesting not only in the way they are presented, but also in what they present (e.g., the case of the executive with health worries considers both dimension and disease). They may make an interested clinician think.

Appendices A, “The psychiatric evaluation” (table format to be used), and B, “The mental status examination” (discussion and table to be used) accompany this book.

This book left me with mixed feelings. Although I understand and agree we need to perform and teach more complex and refined psychiatric evaluation, I am not sure The Perspectives and this book will be able to accomplish that. This book is not clear in explaining some issues. I felt that I was able to understand the entire concept better when I read Peter Fagan’s book on applying the perspectives in the area of sexual disorders.2 The idea of the 4 perspectives is intriguing (although some may envision that the dimensional perspective presents something different in terms of psychopathology dimensions) and on the right track...maybe. However, I am not sure how practical this approach is, and how to teach it to clinicians. To spread this gospel would probably require a long-term combination of the passion of Johns Hopkins trainees with training seminars at meetings around the country. Nevertheless, an interested clinician disappointed with the current state of affairs of psychiatric diagnosis and/or a teacher interested in teaching more than just what is in the DSM and how to prescribe medications will find this book thought provoking and useful.

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REFERENCES

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.


