Antidepressants are an important—and probably, the most widely used—part of today’s psychiatrist’s armamentarium. Many are frequently used by other specialists; some antidepressants, such as amitriptyline, are used by other specialists even more often than by psychiatrists. Because there has been a continuous shift toward the use of selective serotonin reuptake inhibitors (SSRIs) and other newer antidepressants, a text summarizing the literature on antidepressants, including the old ones, could be quite useful to clinicians in practice, residents, and educators.

Anthony J. Rothschild, MD, an experienced researcher and clinician in the areas of depression and antidepressants, put together a group consisting of mostly psychopharmacologists to write an up-to-date, evidence-based text summarizing the literature on antidepressants. In addition to the Introduction summarizing the content of the book, the following 10 chapters address the use of antidepressants in unipolar and bipolar depression; anxiety disorders; schizophrenia and schizoaffective disorder; personality disorders; substance-related disorders; in children and adolescents; in geriatric patients; in medically ill patients; during pregnancy and lactation; and in patients receiving nursing care. Each chapter follows a similar format and ends with a summary of key clinical concepts in bullet points. Most chapters, with a couple of exceptions, provide a solid—although a bit dry—review of a specific topic. The exceptions are the chapter on unipolar and bipolar depression written by Dr. Rothschild and the chapter on treatment of patients receiving nursing care written by Judith Shindul-Rothschild, PhD, RNPC. These 2 chapters seem to have a bit more “meat” and their writings seem to include more personal experience that, at times, makes it a better read.

The chapter on unipolar and bipolar depression serves partially as a sad reminder that lately, many patients have not had a trial of a tricyclic antidepressant (TCA) or monoamine oxidase inhibitor (MAOI). Psychiatrists are either not experienced in prescribing these medications, are afraid to prescribe them, or both. Dr. Rothschild relates this to his impression that “it seems as if many more patients have TRD [treatment-resistant depression] now than 30 years ago when fewer antidepressants were in the therapeutic armamentarium” (p 29). In addressing prescribing antidepressants in bipolar disorder, Dr. Rothschild makes some useful suggestions, such as that, “The belief that antidepressants (even in combination with mood stabilizers) induce switches, rapid cycling, or both in patients with bipolar disorder is not sufficiently justified by the scientific evidence in the medical literature and may, unfortunately, create unnecessary anxiety among clinicians, patients, and their relatives. The available evidence does suggest, however, that antidepressant medications have little efficacy in the acute treatment of the depressed phase of bipolar disorder...Furthermore, despite the lack of systematic studies, almost all experts would agree that the prescription of antidepressants in the absence of a mood stabilizer is not recommended for patients with bipolar I disorder” (p 40). This is a well-written, informative chapter. Unfortunately, since its publication, 2 antidepressants, vortioxetine and levomilnacipran, have been released and therefore are not included in the chapter. The chapter on anxiety disorders and antidepressants suggests that the debate about whether cognitive-behavioral therapy (CBT) or antidepressants are superior for treating anxiety disorders is dying down: “Many comparative studies show that antidepressants and CBT have roughly comparable efficacy, at least in the short term. The exception is in treating OCD [obsessive-
compulsive disorder], for which CBT appears to have a distinct advantage" (p 58). We do not know whether the combination of both modalities provides any advantage, whether there is any differential treatment modality efficacy in the longer term, and how best to accommodate patient preferences for a specific modality (p 58). Otherwise, this chapter is a standard review of the topic.

The chapter on schizophrenia and schizoaffective disorder reminds us of the main reason for using antidepressants in these disorders: the high comorbidity with depression (as high as 50%), posttraumatic stress disorder, OCD, and panic disorder (p 89). The reader also is cautioned to differentiate negative symptoms of schizophrenia from depressive symptoms by examining “for the presence of clinical features of low mood, guilt, poor self-esteem, and appetitive symptoms such as insomnia and anorexia, all of which are more characteristic of depressive symptoms than negative symptoms” (p 91). The authors point out that there is no compelling evidence that antidepressants work for negative symptoms. Another interesting notion is that trimipramine may be useful in acute schizophrenia as a monotherapy. Surprisingly, nothing is said about amoxapine, which is mentioned in the chapter on depression as a possible treatment of psychotic depression. Last but not least, one of the key clinical points emphasizes that there is no compelling evidence that antidepressant use is associated with exacerbation of psychosis in schizophrenia. The main focus of the chapter on antidepressant use in personality disorders is, what else other than, borderline personality disorder (BPD). Interestingly, the authors state that antidepressants appear to be less effective for dysphoric or depressive symptoms in patients with personality disorders than in patients who do not have personality disorders comorbidity (p 139). The authors remind us that the use of antidepressants in personality disorders is no different from their use in psychiatric patients in general (p 146). The medications that have shown some effectiveness are the SSRIs fluoxetine and fluvoxamine, the MAOIs phenelzine and tranylcypromine, and the TCA amitriptyline in BPD, and all SSRIs and venlafaxine in avoidant personality disorder/social phobia (p 148). The use of antidepressants in substance-use disorders is widespread because of frequent comorbidity, however, as the authors of the chapter on this topic state, there has to be a firm diagnostic clarity of comorbid condition(s). Antidepressants are used for nicotine dependence (bupropion), cocaine dependence (dopaminergic agents), and at times, methamphetamine dependence (limited evidence).

The chapter on using antidepressants in children and adolescents reviews the developmental considerations and indications of antidepressants in this population. Only fluoxetine is approved for use in preadolescent children as young as age 8, and escitalopram is approved for depression in children age 12 to 17. Four SSRIs (fluoxetine, fluvoxamine, paroxetine, sertraline) and 1 TCA (clomipramine) are approved for various ages of children with OCD. The text also discusses suicide risk and antidepressants (although suicidal ideation and behavior are common features of depression in youth). The chapter on antidepressant use in geriatric patients nicely outlines the physiological changes in older patients associated with altered pharmacokinetics and drug response, and includes a good table on the principles of drug prescribing. It also includes a page on treatment of depression in patients with Parkinson’s disease. A fairly good, comprehensive, and clinically oriented chapter is “Use of antidepressants in medically ill patients.” It starts with medical considerations (drug-drug interactions, pharmacokinetics, sexual side effects, akathisia, hyponatremia, serotonin syndrome), and then turns to general considerations (cardiovascular disease, pulmonary disease, GI disease [TCAs in irritable bowel syndrome], renal disease, endocrine disease, cancer, neurologic illness, chronic pain, HIV, steroid-induced psychiatric symptoms, and burn- and hospital-based trauma). The chapter on using antidepressants during pregnancy and lactation is another thorough overview. It provides a good discussion of the FDA’s teratogenic risk classification; it also points out the shortcomings of this system: the risk categories do not specify the dosage and/or duration of gestational exposure associated with teratogenic risk. The key clinical concepts of this chapter contain some important messages including 1) two-thirds of pregnant women undergoing antidepressant monotherapy may require a dose increase, especially after 20 weeks of gestation to treat depressive symptoms or to maintain euthymia; 2) women who discontinue successful antidepressant...
treatment to avoid the risk to the fetus have a higher risk of depression than women who stay on antidepressants; and 3) there are no reports of adverse effects in breast-fed infants of mothers treated with various TCAs. The last chapter on using antidepressants in patients receiving nursing care would be especially useful for advanced practice psychiatric nurses. It contains a good list of suggested reading and Web resources.

This is a solid, yet a bit uneven book. Some chapters, as noted, are a bit dry. Clinically relevant comments and suggestions make several chapters (eg, the one on unipolar and bipolar depression) much more readable and enjoyable. Clinicians, especially younger ones not familiar with TCAs and MAOIs may find parts of the books especially useful, hopefully encouraging them to expand their armamentarium.

Richard Balon, MD
Wayne State University
Detroit, Michigan, USA

Handbook of Good Psychiatric Management for Borderline Personality Disorder

By John G. Gunderson and Paul Links.

Patients suffering from borderline personality disorder (BPD) usually are the most challenging ones in everybody’s clinical practice. They are difficult to manage, trigger a lot of countertransference feelings (rarely positive ones), definitely will not allow us to ignore them, we dislike them, and actively avoid them (p vii). John Gunderson, MD, also points out in the Preface to this small volume that most mental health professionals do not feel comfortable and are insufficiently trained to manage BPD patients. “Regrettably, the training of most professionals is provided solely by their individual supervisors, who themselves have had no BPD-specific training. Training programs typically include little didactic information about BPD’s psychopathology, let alone about evidence-based practice” (p vii).

One of the foremost experts in the management of BPD, Dr. Gunderson, together with his colleague Paul Links, MD, MSc, FRPC, put together a small handbook of Good Psychiatric Management (GPM) of BPD. Dr. Gunderson explains that, “The basic principles of Good Psychiatric Management (GPM) developed primarily from clinical experience and the personal growth that was required. Treaters who practice GPM are encouraged to be active agents in helping borderline patients understand their inner experience, in reshaping their behavioral adaptations, and in establishing a good life. This treatment comfortably utilizes cognitive, behavioral, and psychodynamic interventions...GPM borrows heavily from concepts introduced earlier by Winnicott (1953) such as ‘holding environment’ and ‘good enough parenting.’ These concepts decry too much specificity or perfectionism; they fit comfortably with GPM’s emphasis on the patient’s interpersonal sensitivity and with a dyadic model of the therapy relationships” (p viii-ix).

Make no mistake, this is not your usual handbook. The text is very instructive, provides detailed guidelines, and most importantly, is accompanied by 7 case illustrations and 9 videos demonstrating the basic therapeutic approach of GPM. The videos can be viewed at www.appi.org/Gunderson. The text refers to the videos fairly frequently and therefore one learns best by reading and watching simul-
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taneously. The book has 4 sections: Section I. Background (Introduction to Good Psychiatric Management); Section II. GPM Manual. Treatment guidelines (6 brief chapters addressing “Overall principles,” “Making the diagnosis,” “Getting started,” “Managing suicidality and nonsuicidal self-harm,” “Pharmacotherapy and comorbidity,” and “Split treatments”); Section III. GMP Workbook (includes “Case illustrations”); and Section IV. GPM Video Guide (briefly describes each of the 9 videos). The book also includes 4 Appendices: A. Relation of GPM to other evidence-based treatments for BPD; B. Common features of evidence-based treatments for borderline personality disorder; C. Safety planning: An example; and D. Guidelines for families.

In the first chapter the authors discuss GPM’s place in treatment planning, GPM’s precedents and foundations, and GPM’s empirical validation. The authors explain that “GPM is a pragmatic, therapeutically effective approach emphasizing case management” (p 4). It should not be considered another individual therapy and “More than most psychotherapies, it embraces neurobiological (genetic and pharmacotherapeutic) and social situational (stressors, family environment, and vocational) perspectives. It also embraces the perspectives of positive psychology: GPM encourages patients to pursue satisfactory and meaningful lives” (p 4). It also is not meant to replace or compete with evidence-based therapies such as dialectical behavior therapy, mentalization-based treatment, and others. The distinctive characteristics/elements of GPM include case management; psychoeducation; goals; multimodality; duration and intensity (no specific length and intensity prescribed); and interpersonal hypersensitivity (an explicit and consistent effort to connect the patient’s emotions and behaviors to interpersonal stressors).

The second chapter reviews the overall principles of GPM (GMP management theory: interpersonal hypersensitivity; basic therapeutic approaches; and how change occurs). All of these principles are illustrated by the videos or case illustrations (references to specific ones are made). In discussing interpersonal hypersensitivity the authors emphasize that, “Clinicians who respond supportively will calm their patients, whereas those who respond with anger or withdrawal will activate more distressed and potentially dangerous responses” (p 13). The 8 GPM basic principles (explained in text and illustrated by videos) are 1) Offer psychoeducation; 2) Be active, not reactive; 3) Be thoughtful; 4) The therapy relationship is real (dyadic) as well as professional; 5) Change is expected; 6) Accountability; 7) Focus on life outside of treatment; and 8) Be flexible, pragmatic, and eclectic. In the discussion on accountability, the authors write that one should “Hold patients responsible for what they say while retaining the leavening attitudes that your patient’s mistakes, intolerance, hostility, or offensive behavior are understandable and can change” (p 17). The third chapter on “Making the diagnosis” discusses the importance of disclosing the diagnosis because the diagnosis anchors the patient’s and the clinician’s expectations about course. The authors also outline the basic elements of psychoeducation every patient with BPD and their families should know. Also useful is a paragraph (illustrated) on how to disclose diagnosis and on situations such as when your patient refuses the borderline diagnosis or does not meet the DSM threshold.

Chapter 4 on starting treatment reviews setting the framework, intersession availability (with a video illustration and algorithm), building alliance, and some common problems such as changing therapists or not liking your patient. The good and important fifth chapter focuses on managing suicidality and non-suicidal self-harm. One should realize that the risk of suicide in patients with BPD is significant, 3% to 10%, particularly high in young females. Approximately 75% self-harm, among these 90% do so repeatedly, self-harm increases the risk of suicide 15 to 30 times; suicidal acts are ambivalent, often precipitated by interpersonal stress, substance abuse, and increasing depression. For all these reasons, “clinicians should always respond to even indirect communication of self-endangering behaviors with concern, but assessing the patient’s actual dangerousness is essential” (p 38). The chapter also discusses one’s limitations, the aftermath of self-endangering behavior, and problems such as if your patient’s suicidality is not diminishing. The following chapter is a useful discussion of pharmacotherapy and comorbidity. The last chapter of this section reviews the framework, complementary functions of different modalities (individual therapy, case management, medication, group therapy, family interventions, self-help groups), and common problems of split treatment for patients with BPD.
As noted before, Section III, chapter 8 consists of 7 case illustrations, highlighting the application of the GPM treatment model, as well as common problems that clinicians confront. The cases are interrupted by “Decision Points” where the reader may consider how to respond to the clinical situation, followed by a section with possible “Alternative Responses to the Decision Points” where the reader rates various responses. Finally, in the “Discussion” of each case, one finds the merits of proposed alternative responses. This is all quite practical and educational.

The last chapter briefly describes the 9 included videos: Psychoeducation; Diagnostic disclosure; Establishing an alliance; Managing intersession availability; Managing safety; Managing Anger; Managing medications; Managing safety and medications; and Managing family involvement. Although I have not managed a patient with BPD using this unique handbook yet, I have to say, I learned a lot just by reading it. It is quite practical. The videos and cases are invaluable. It is really a “handbook” in the true sense. Every clinician managing patients with BPD will find this book useful. It also will be quite useful for those who teach residents and other mental health professionals how to manage patients with BPD.

Richard Balon, MD
Wayne State University
Detroit, Michigan, USA

Mental Health and Deafness (Professional Perspectives on Deafness: Evidence and Applications)

Taking care of Deaf people with mental illness is a complex affair that clinicians without a hearing impairment know fairly little about. There likely are several reasons for the lack of knowledge and necessary skills; one being the lack of a good text addressing the issues of mental illness and its management in Deaf people. Two clinicians with a vast professional and personal experience with Deaf people and deafness, Margaret du Feu (a UK psychiatrist deafened by cochlear otosclerosis) and Cathy Chovaz (clinical psychologist from Canada profoundly deafened as a young adult), put together a book that should fill this void. Both authors draw from their clinical experience of taking care of Deaf people and a large body of literature.

The book consists of 21 chapters that cover 4 areas: general information about deafness and Deaf people; Deaf children and adolescents issues; mental health of Deaf adults; and special areas such as deafened people, deaf-blind people, mental health of older adults, legal and forensic issues, and service development.

The first thing, among many others, that one learns is that the word “deaf” in Deaf people should be capitalized—which I admit I did not know and probably many hearing people don’t know. The introductory chapters on deafness and Deaf people present a lot of important and interesting information, such as that partial hearing loss affects 360 million people globally (5% of the world’s population), the existence of various sign languages including an international one called Gestuno (unfortunately, similar to Esperanto, it is not used much), types and causes of deafness,
technology to enhance hearing and communication with Deaf people, CoDAs (hearing children of Deaf adults), and other.

The chapters on Deaf children and adolescents present passionate treatises on psychological development of Deaf children, their education, assessment, mental disorders (the chapter speaks of mental health disorders which is a bit of a paradoxical term), and their treatment. The discussion of education of Deaf children and adolescents points out the benefits of residential schools—access to accessible and visual language; access to Deaf role models and mentors; camaraderie with Deaf friends; Deaf sports and social clubs; and the transmission of Deaf heritage, traditions, and identities. These benefits may be helpful in advising parents about placement of their children in these schools. Another important “developmental” note is that Deaf children of Deaf parents tend to fare better in terms of literacy skills than Deaf children of hearing parents. The book also points out that the mastery of developmental milestones is different between Deaf teenagers and hearing adolescents, influenced by factors such as language acquisition, educational practices, and family relationships. The chapter on assessment of children and adolescent emphasizes that the foremost consideration in the assessment of a Deaf child is that the assessment’s language match the child’s preferred language (sign or spoken, the same holds for adult assessment) (p 86). When treating children with limited language skills, one may use certified Deaf interpreters, who should be regulated under local jurisdiction and work within the code of ethics to ensure confidentiality and professionalism. Actually, the chapter on mental health and deafness provides specific guideline for using an interpreter (eg, details such as that one person speaks at a time, there should be a neutral backdrop, and the light should be on speaker’s face and on the interpreter, not behind them). The chapter on treating children and adolescents discusses various types of intervention (family education, inpatient setting, outpatient resources, therapeutic foster homes and foster placement, technology) and points out frequent mistakes made by hearing physicians while treating Deaf children and adolescents.

The chapters on mental health of Deaf adults cover the assessment, physical and organic disorders and intellectual disability, schizophrenia, mood disorders, posttraumatic stress disorder, substance abuse, and personality disorders, and later on, treatment. The authors emphasize the need for specific questions by the physician and interpreter during assessment (eg, there is no general term for “medication” in British Sign Language). The assessment may encounter some complex issues—at times Deaf people have been thought to have a psychopathic personality disorder when in fact they have behavior and relationship difficulties that resulted in aggressive behavior. The chapter on organic disorders mentions that Deaf people have increased incidence of epilepsy and discusses some rare organic syndromes (Schilder disease, mitochondrial encephalomyopathy), which effect hearing.

The chapter of deafened people (acquired deafness or hearing impairment) points out that >70% of people age >70 may have some degree of acquired deafness, and that even profoundly deafened people can benefit from many of the technological and environmental aids for people with more moderate forms of deafness. The discussion of deaf-blind people reviews some rare syndromes again (eg, Usher syndrome and neurofibromatosis type 2). I found the chapter on legal and forensic issues important, because it reviews issues such as capacity/competence, informed consent, legal transactions, a deaf defendant at a police station (however, it did not mention the Miranda Warning), fitness to plead, sentencing options for Deaf people, Deaf people in prisons, and others. The authors again emphasize the use of appropriate language in these settings.

The chapters include a number of case vignettes illustrating various issues and situations. The book is written in an easy-to-read style. It is basically all you need to know about deafness, Deaf people, mental illness, and more. The only relative weaknesses are the focus on international audience (mainly North America and the United Kingdom, though) and the effort to cover too much, if not everything. Both these factors then preclude the authors from writing in specific detail in some areas. Nevertheless, this is a useful book for anyone clinically dealing with hearing-impaired or Deaf people. It also could be used as a teaching text in specialized facilities for Deaf people or in training programs.

Richard Balon, MD
Wayne State University
Detroit, Michigan, USA
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.


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