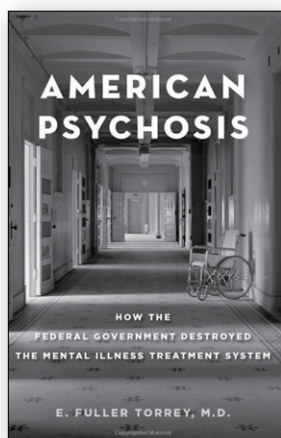


## BOOK REVIEWS

# American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System



By E. Fuller Torrey; New York, New York: Oxford University Press; 2013; ISBN 978-0-19-998871-6; pp 204; \$31.95 (hardcover).

**E**dwin Fuller Torrey, MD, has been a tireless, eloquent, and efficient advocate of patients with serious mental illness. He also is an excellent writer who has published several great, thought-provoking books. In his latest book, Torrey focuses on the disastrous state of our health care system for the seriously mentally ill, on the origin and unfolding of the failure of the federal mental health system, on the mistake of emptying the state hospitals, and on the dysfunctional community mental health system. He also tries to answer the question about the creators of this system that has been

bothering him: “How could so many well-meaning professionals have been so wrong and been complicit in creating such a disaster?” (p ix).

Each of the 8 chapter titles of this volume are illustrative and self-explanatory: 1. “Joe Kennedy: A Man with Problems”; 2. “Robert Felix: A Man with Plans”; “The Birth of the Federal Mental Health Program: 1960-1963”; 4. “The Short, Unhappy Life of the Federal Mental Health Program: 1964-1970”; 5. “The Death of the Federal Mental Health Program: 1971-1980”; 6. “The Perfect Storm: 1981-1999”; 7. “Dimensions of the Present Disaster: 2000-2013”; and 8. “Solutions: What Have We Learned and What Should We Do?”

The first chapter summarizes the story of Rosemary Kennedy, the younger sister of President John F. Kennedy who had mild intellectual disability that later developed to what appeared to be a psychotic illness. In 1941, her father, Joseph Kennedy, decided (after careful consideration) to have her lobotomized. Unfortunately, the lobotomy was an unmitigated disaster, because it “made her go from mildly retarded to very retarded” (p 12). She was hospitalized for several years, and then placed in an institution managed by Franciscan

nuns in Wisconsin, far away from Boston. Her illness had a profound impact on Kennedy’s family (especially her brother, the president) and their interest in the seriously mentally ill and their treatment. That also influenced President Kennedy’s support and signing of the Mental Retardation and Community Mental Health Centers Construction Act of 1963, the last piece of a major legislation he signed.

The next several chapters describe the development of the now-dead federal mental health system. The plan “to fix the nation’s mental illness treatment system by replacing overcrowded state mental hospitals with ‘properly staffed outpatient clinics’ that would ‘eventually be available throughout the length and breadth of the land’” (p 17) began in the 1940s. It included the creation of the National Mental Health Plan and the National Institute of Mental Health (NIMH). The plan started with Robert Felix, the first director of the NIMH. Interestingly, the proposed name for the NIMH was National Neuropsychiatric Institute, a name more fitting to its mission. However, “neuropsychiatric” was considered too medical, and because the prevalent psychoanalytic emphasis of the psychiatric establishment was on *health*, mental health would take precedent over mental *illness*. Although the NIMH was established in 1949, the plan to essentially nationalize mental health was delayed during the Eisenhower era, because the mental health lobby surmised that Republicans would not support it.

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Renewed efforts started with the election of President Kennedy. In his efforts to establish national policies, Felix was assisted by Stanley Yolles and Bertram Brown (who both later became directors of the NIMH). All 3 men “viewed intended targets of their policies as entire populations, not just individual patients, as public health officials are inclined to do” (p 43). At that time, state hospitals were considered “bankrupt beyond remedy” (p 44) and their demise was just a matter of time. Thus, the Interagency Committee rejected them and subsequently, the system of community mental health centers (CMHC) was created. As Torrey points out, nobody on the committee understood the role of state hospitals and explained to the members that these hospitals played a role “in protecting the public, and in protecting mentally ill individuals from being victimized or becoming homeless,” (p 45) or their function “as asylums in the original sense of the term” (p 45). No study examined what would happen after emptying state hospitals.

One of the major roles of CMHCs was the prevention of mental illness, although there was no evidence that these centers had prevented mental illness in the past. The federal mental health center legislation was fatally flawed. “It encouraged the closing of state mental hospitals without any realistic plan regarding what would happen to the discharged patients, especially those who refused to take medication they needed to remain well. It included no plan for the future funding of mental health centers.

It focused resources on prevention when nobody understood enough about mental illnesses to know how to prevent them. And by bypassing the states, it guaranteed that future services would not be coordinated” (p 58-59). In addition, there was no way to criticize the new system for various reasons (eg, a connection to President Kennedy).

The further problematic issue was that the CMHC system was, in a way, isolated and not connected to state systems and to state hospitals (that was intentional). Focusing on prevention over the treatment of the seriously mentally ill was unsustainable, yet “by 1969 NIMH had virtually abandoned the treatment of mental illness as its primary mission in favor of promoting mental health” (p 68). There was an implication of unlimited expansion of the boundaries of psychiatry to encompass all social ills, which, in my opinion, remains among some psychiatrists and others. Finally, there was no accountability, and the NIMH was not interested much in how the CMHC were doing.

Later, politics entered the stage in the fight for funding of federal programs. During the era of President Nixon, assuring funding was difficult. There was a temporary funding reprieve during the Carter presidency, but “a quiet death and burial” (p 87) came during the Reagan presidency. This led to what Torrey calls the perfect storm of 1981 to 1999. A huge number of patients with serious mental illness were deinstitutionalized. As Torrey writes, “... deinstitutionalization per se was not the mistake. The

mistake, rather, was our failure to provide continuing treatment and rehabilitation for these individuals once they left the hospitals” (p 93). There was “no master plan, no coordination, no corrective mechanism, no authority, no one in charge” (p 93-94). The lives of the majority of those discharged from the state hospitals “were little different than they had had while hospitalized, and a significant number were considered worse off” (p 95).

We finally get to the chapter on the dimensions of the present disaster as we know it. Jails and prisons as the new psychiatric inpatient system; sheriffs, police, and courts as the new psychiatric outpatient system. For-profit, poorly inspected nursing and after-care homes. Victimization of the seriously mentally ill. Victimization of community residents such as the many places where they do not feel comfortable “going downtown to shop or using community parks and playgrounds. Homeless individuals, especially those who are mentally ill, have expropriated spaces in many American communities” (p 128). Emergency rooms flooded with the seriously mentally ill. Violent behavior and homicides—if 10% of the nation’s homicides are committed by the seriously mentally ill who are not adequately treated, how many could have been prevented? And the huge cost! As Torrey writes, “... it would appear that the direct costs of supporting and treating individuals with serious mental illnesses in the United States are presently at least \$140 billion per year” (p 138). That does not include

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indirect costs such as income lost by the mentally ill or social cost of violent crimes committed by the mentally ill. As Torrey muses, “the fact that the \$140 billion spent on public mental health services in the United States is merely buying the grossly inadequate and disjointed services described in this book is mind boggling. It suggests that something is profoundly wrong” (p 138).

The final chapter of this book reviews the impediments to change in our system and what should be done. In Torrey’s opinion, the impediments are lack of understanding of serious mental illnesses; lack of understanding of the magnitude of the mental illness problem; lack of understanding of the civil rights of people with severe mental illnesses; public mistrust of psychiatry; economic interest to maintain the status quo; political interest to maintain the status quo; the federal government; and lack of leadership.

The 10 recommendations are: (1) Public psychiatric hospitals cannot be completely abolished, and

a certain number of beds will be needed. (2) Lack of awareness of illness among patients must be considered when planning the mental illness treatment system, and provisions have to be made for the implementation of some form of involuntary treatment. (3) Community treatment of the mentally ill will only be successful if carried out by community mental *illness* centers, not community mental *health* centers. (4) Continuity of care and caregivers is essential. (5) In addition to medication, individuals with serious mental illness need access to decent housing, vocational opportunities, and opportunities for socialization (clubhouses). (6) The facilities, such as nursing homes and board-and-care houses, must be periodically inspected and the inspections must be unannounced. (7) For-profit funding of public mental illness services has been tried and does not work. (8) Service for mentally ill patients must be prioritized to ensure that those who are sickest, pose the greatest risk to themselves and others, and incur the greatest cost receive services as the first priority. (9) In

selected cases, psychiatric information on the mentally ill who have a history of dangerousness should be made available to law enforcement personnel, because they are now the frontline mental health workers. (10) It will be necessary to assign responsibility to a single level of government and to hold such individuals accountable.

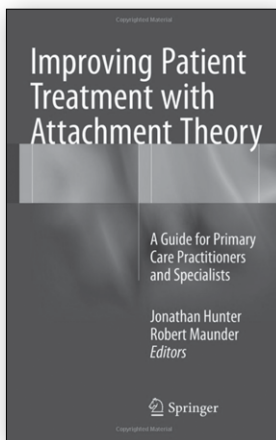
This is an important book that should be read by all policymakers in mental illness (I agree that the use of “mental health” is a misleading idea at best), as well as all of us who are involved in the public mental health (or illness) system. It also is a cautionary tale of unexperienced men implementing untested policies, of good intentions going wrong, and a great reminder of the saying that “the road to hell is paved with good intentions.”

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**DISCLOSURE:** Dr. Balon is a member of the American Psychiatric Association Publishing editorial board.

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# Improving Patient Treatment with Attachment Theory: A Guide for Primary Care Practitioners and Specialists



Edited by Jonathan Hunter and Robert Maunder; New York, New York: Springer; 2016; ISBN 978-3-319-23299-7; pp 196; \$98 (hardcover).

The importance of attachment theory in explaining certain aspects of human development has been appreciated for many years. As the authors of one chapter of this volume write, “Attachment theory provides a biopsychosocial model to explain how individual differences in experience and behavior are related to interpersonal proximity and distance, as well as to the regulation of affect and stress” (p 39). However, it has not always been clear how attachment theory applies to medicine in general and to adult clinical practice. Jonathan Hunter and Robert Maunder put

together this edited volume to help us understand how to incorporate this theory into the everyday general practice of primary care practitioners and specialists. As “health care is inevitably and inescapably relational, understanding how relationships develop and how that development sets a precedent for later relationships, including those between a patient and a health-care professional, illuminates many of our health-care dilemmas and holds a promise of improving care” (p 5). They feel that the perspective of attachment theory could be used to understand illness and health care, and provide new ways to meet the challenges of providing care in the increasingly complicated system.

The book consists of 4 parts: I. Foundations; II. Specific populations; III. Interventions; and IV. Future. The 4 chapters of the first part outline the fundamentals of attachment theory, review advanced concepts of this theory and their application to health care, and discuss the relevance of attachment theory in medical practice. There are 4 basic attachment functions, including secure base, safe haven, ability to seek and maintain proximity, and separation protest. Exploration of these functions could be used when

illness requires investigation and treatment. Interestingly, there “is a surprising degree of consistency in patterns of attachment behaviour as children grow into adolescents and then adults. As we mature, we turn to new people to serve our attachment needs, first peers and then usually romantic partners” (p 11). The patterns of adult attachment, according to chapter 2, can be understood in different ways, as “states of mind” about attachment phenomena or as clusters of attitudes, behavior and emotional expression in close relationships. Based on 2 dimensions of attachment insecurity—attachment anxiety and attachment avoidance—the authors describe 5 basic types of attachment style: secure, preoccupied, dismissing, fearful, and disorganized. To explain a bit more, the *secure* individual has had sufficiently reliable, sensitive, and responsive parenting relative to his (her) needs, which leads to expectations that others will be consistent, respectful, responsive, and supportive. In contrast, a *preoccupied* person has an internal working model that was formed in the context of inconsistent interactions with the attachment figure, who may have been depressed, anxious, or preoccupied himself (herself); thus, a person with this attachment style may readily signal vulnerability and need to keep an unreliable attachment figure close by. The *dismissing* person has learned in his interactions with attachment figures not to show vulnerability or neediness, although he is not unattached. A *fearful* person may have experienced intrusive or hurtful parenting, expects that needed

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support will not be forthcoming, and thus tends to endure anxiety and other distressing emotions in isolation. A person with *disorganized* attachment is likely to have grown up in an environment of unresolved fear. As adults, persons with *disorganized* attachment are likely to use both *dismissing* and *preoccupied* strategies inconsistently and are unlikely to communicate their needs and preferences coherently.

These 5 types of attachment styles are discussed throughout the book in context of various issues, including pain management, cancer treatment, and end-of-life experience. It also is assumed that patterns of attachment behavior are triggered by illness and injury and manifest in a reliable pattern each time they are triggered. The authors of the chapter on the fundamentals of attachment theory also point out that attachment insecurity is consistently elevated among people with mental illness, and that “most significant psychiatric syndromes that co-occur with insecure attachment in a consultation-liaison setting are depression and personality disorders” (p 19).

In the following chapter on advanced concepts, the authors discuss how to use attachment theory in a clinical interview or any similar interaction between the health care provider and the patient. They propose that the most important aspects of attachment style in this interaction are narrative coherence, mentalizing, affect regulation (particularly the expression of anger), and interpersonal pulls. Based on these and on previous constructs, the authors construct prototypes of how patients

with each of the 5 attachment styles will appear in the health care context. The last chapter of this part includes several tables that outline the relevance of attachment theory to medical illness (eg, coping, self-management, adherence, forming a doctor-patient relationship); examples of patient characteristics as a function of secure attachment style; examples of patient characteristics as a function of dismissing attachment style; and examples of patient characteristics as a function of preoccupied attachment style. This chapter also discusses the influence of attachment on the doctor-patient relationship, not only on the patient but also on the physician. It seems that “physicians who focus on a holistic treatment of patients often have characteristics of secure attachment and that medical students with more secure attachment often opt for primary care medicine and medical disciplines allowing more stable and long-lasting doctor-patient relationships” (p 47) (ie, psychiatry!).

Part II reviews 3 areas: attachment theory and pain; adaptation to cancer from the perspective of attachment theory; and attachment and the end-of-life experience. As noted, these areas are discussed with respect to attachment styles and prototypical patients outlined before Part II. The chapter on pain includes a good table on characteristic responses to pain in people with different attachment styles. The authors of this chapter point out that “an attachment-informed approach in the management of pain has implications for what information we gather about people in pain, how we view the

person with pain, the emphasis on the therapeutic relationship, and associated outcomes” (p 67). The chapter on cancer suggests that “attachment classifications could also identify who is in the need of support and how to offer support to optimally address different need and abilities” (p 84). The chapter on end-of-life experience emphasizes the distress and the threats associated with this experience, and highlights that this phase can provide opportunities for growth and psychological development.

Part III covers areas such as “on the floor with C and L”; an integrative, attachment-based approach to managing and treating patients with persistent somatic complaints; and attachment style in bariatric surgery care. Again, these chapters use the previously discussed concepts and prototypes in specific clinical situations. The chapter on functional somatic disorder (or persistent somatic complaints) is important in the entire context of the book, but it also is a bit esoteric.

The last part of the book deals with the future. This is, in my opinion, usually the most boring and useless part of many books. It seemed that this would be the case here, too, but surprisingly, there is an interesting and useful chapter in this section on applying attachment principles to medical education. This chapter points out that fear and anxiety reduce learning, and provides a solution in discussing a secure supervisory base and safe haven for the student.

This is an interesting book written by experts in attachment theory and its application to clinical practice. It should be read carefully,



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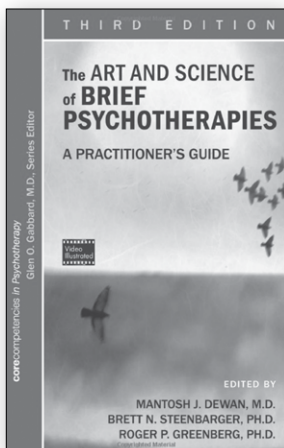
because the writing is complex and esoteric at times. The clinical examples could have been more developed and instructional. However, the book addresses an important area of health care—interpersonal

relationships—from one important point of view, the attachment theory. The book should be viewed as a good beginning of hopefully increasing interest in the neglected area of interpersonal relationships. Hopefully,

we will see more books addressing this area from other points of view and other theories.

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## The Art and Science of Brief Psychotherapies: A Practitioner's Guide. Third Edition.



Edited by Mantosh J. Dewan, Brett N. Steenbarger, and Roger P. Greenberg; Arlington, Virginia; American Psychiatric Association Publishing; 2018; ISBN 978-1-61537-079-5; pp 381; \$87 (paperback).

**B**rief psychotherapies are part of everyday clinical practice for many reasons, such as limited resources, limited patient time, and the fact that, at times, the efforts and time needed for a desired change could be relatively short. We have

witnessed a substantial development of new brief psychotherapy modalities over the last decade or two. Thus, an update on the development and expansion of these therapies is needed. The third edition of *The Art and Science of Brief Psychotherapies* edited by Dewan, Steenbarger, and Greenberg is exactly such a timely update.

Compared with the previous editions of their book, in this edition, the editors added chapters on mentalizing, cultural formulation, and mindfulness-based dialectical behavior therapy, and expanded the presentation on motivational interviewing. They also “cover fresh approaches to intervention, such as Internet-based therapies and telepsychiatry; document new developments within existing models; and summarize the growing body of evidence that tracks outcomes among the models” (p 1-2). They also updated the video illustrations to reflect new practice trends and

replaced the video illustrations DVD with streaming video.

Thus, this edition consists of the Introduction (chapter 1) and 4 parts that include 15 chapters. Part I, “Building a foundation for successful therapies,” includes 4 chapters addressing issues such as essential ingredients for successful psychotherapy; mentalizing as a common factor in psychotherapy; integration of culture and psychotherapy through the DSM-5 cultural formulation interview; and combining brief psychotherapy and medication. Part II, “Seven key brief psychotherapies,” includes chapters on motivational interviewing; cognitive therapy; exposure therapy for anxiety disorders, obsessive-compulsive disorder, and posttraumatic stress disorder; application and techniques of dialectical behavior therapy; solution-focused brief therapy; interpersonal psychotherapy; and time-limited dynamic psychotherapy. Part III, “Special topics,” deals with telepsychiatry; Internet-based brief therapies; and evaluating competence in brief psychotherapy. Lastly, the sole chapter in Part IV, “Putting it all together,” provides an overview and synthesis of doing therapy briefly. The chapters are well written, filled with facts and good advice, and include 49 video illustrations (almost entirely provided for the chapters in Part II).

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The bulk of the introduction discusses issues such as what is brief therapy, when it is appropriate to conduct brief therapy, and how brief therapy could be learned. The authors argue that, at a broad level, "brief therapies are treatment approaches in which time and time-effectiveness are explicit aspects of treatment planning and in which the common factors that account for change across therapies are distilled and intensified" (p 5). The authors also outline factors that determine the indication or contraindication of brief therapies, including duration of the presenting problem, interpersonal history, severity of the presenting problem, complexity, understanding, and social support. They also point out that brief therapy is not suitable for some patients. "Individuals at risk for regression and decompensation in the face of stress may not tolerate the elicitation of symptoms that is key to brevity. They may require supportive interventions that build defenses, not challenges to defense already present. A careful history at the outset of therapy is essential to discriminate between those patients who can benefit from an afflicting of their comfort and those who require comfort from their afflictions" (p 9-10).

The chapter on the essential ingredients of successful brief therapy outlines important common determinants of outcome in psychotherapies, such as relationship factors, patient variables and extra-therapeutic events, and placebo, hope, and expectancy effects. "In addition, evidence continues

to mount showing that differences in therapists' personalities, interpersonal sensitivity, and skills, are more important for achieving a successful outcome than the particular therapeutic method they embrace" (p 19-20). The authors also point out that psychotherapy could be for better or for worse. They write that "Investigations indicate that negative outcomes are more likely when the therapist does not listen well, is non-empathic, and is judgmental. In addition, deterioration is most likely when the therapist's needs supersede those of the patient and too much emphasis is placed on analyzing the nature of the treatment relationship" (p 27). The chapter on mentalizing emphasizes that "mentalizing is a guiding construct and common factor uniting a range of therapeutic approaches" (p 29).

The 7 chapters reviewing key brief psychotherapies are masterful summaries of these therapies written by experts in these areas. As noted, they include a substantial number of video illustrations. The videos on cognitive therapy and dialectical behavior therapy are especially instructive.

The 3 chapters of Part III are a bit uneven. The chapter on telepsychiatry is disappointingly short. On the other hand, the chapter on Internet-based brief therapies is informative and comprehensive. The authors write that there are various Internet-based approaches to treatment that depend on the target population (eg, prevention vs treatment) and service delivery models (eg, open access Web sites, Internet clinics). "One form of Internet treatment is

chat based and is conducted in real time. This is close to real-life therapy and also can be delivered via video conferencing.... For most research studies and clinical implementations, however, treatment programs have been text and screen based (with the possibility of printing) supplemented by streamed video and audio files" (p 316). Internet-based therapy differs from traditional face-to-face work in the following 5 aspects: mode of treatment delivery, content of treatment, the presence of a deadline for treatment, reduced therapist drift (this therapy is highly standardized), and flexibility of service delivery (24/7). The chapter also addresses issues such as for whom does Internet-based therapy work, and the pitfalls associated with Internet-based therapies and how to deal with them. The mandatory chapter on evaluating competence in brief psychotherapy is overly complex.

The final chapter reviews, among other things, relationship skills, instrumental skills, and change agency skills needed for brief psychotherapies. At the end, the editors write that, "The goal of this book and accompanying videos has been to give readers a taste of different brief therapies and their underlying strengths and similarities. Although reading a text and watching videos cannot be expected to provide expertise on their own, they can start the process of applying new approaches and learning from this application. Ultimately, nothing substitutes for the observation and mentorship of experienced professionals. Learning short-term work is not unlike therapy

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itself: it is best learned by doing. Via workshops, tapes, and direct supervision, readers can examine their own patterns of practice and acquire new ways of assisting others” (p 356).

By my standards, the authors achieved this goal. The book is well-put together, well-written, informative, and useful. It is intended to be used primarily in education; however,

every clinician can learn from it. This book is a definite buy.

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## BOOKS RECEIVED

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

**Play Therapy: A Psychodynamic Primer for the Treatment of Young Children.**

By Pamela Meersand and Karen J. Gilmore; Arlington, Virginia; American Psychiatric Association Publishing; 2018; ISBN 978-1-61537-043-6; pp 468; \$78 (paperback).

**Co-occurring Mental Illness and Substance Use Disorders: A Guide to Diagnosis and Treatment.**

Edited by Jonathan D. Avery and John W. Barnhill; Arlington, Virginia; American Psychiatric Association Publishing; 2018; ISBN 978-1-61537-055-9; pp 304; \$65 (paperback).

**The American Psychiatric Association Publishing Textbook of Forensic Psychiatry. Third Edition.**

Edited by Liza H. Gold and Richard L. Frierson; Arlington, Virginia; American Psychiatric Association Publishing; 2018; ISBN 978-1-61537-067-2; pp 544; \$145 (hardcover).

**Mind the Gap. Generational Differences in Medical Education.**

Edited by Geoffrey A. Talmon and Gary L. Beck Dallaghan; North Syracuse, New York; Alliance for Clinical Education/Gegensatz Press; 2017; ISBN 978-1-62130-779-2; pp 162; \$29.95 (paperback).

**Admissions: Life as a Brain Surgeon.**

By Henry Marsh; New York, New York; Thomas Dunne Books, St. Martin's Press; 2017; ISBN 978-1-250-12726-6; pp 288; 26.99 (hardcover).

**Competency in Combining Pharmacotherapy and Psychotherapy: Integrated and Split Treatment. Second edition.**

By Michelle B. Riba, Richard Balon, and Laura Weiss Roberts; Arlington, Virginia; American Psychiatric Association Publishing; 2018; ISBN 978-1-61537-066-5; pp 163; \$65 (paperback).

**Transcranial Magnetic Stimulation: Clinical Applications for Psychiatric Practice.**

Edited by Richard A. Bermudes, Karl I. Lanocha, and Philip G. Janicak; Arlington, Virginia; American Psychiatric Association Publishing; 2018; ISBN 978-1-61537-105-1; pp 216; \$65 (paperback).

**Office-Based Buprenorphine Treatment for Opioid Use Disorder. Second Edition.**

Edited by John A. Renner Jr., Petros Levounis, and Anna T. LaRose; Arlington, Virginia; American Psychiatric Association Publishing; 2018; ISBN 978-1-61537-083-2; pp 375; \$79 (paperback).

**Study Guide to Child and Adolescent Psychiatry. A Companion to Dulcan's Textbook of Child and Adolescent Psychiatry. Second Edition.**

Edited by Philip R. Muskin, Anna L. Dickerman, and Oliver M. Stroeh; Arlington, Virginia; American Psychiatric Association Publishing; 2018; ISBN 978-1-61537-115-0; pp 359; \$64 (paperback).

**User's Guide for the SCID-5-AMPD. Structured Clinical Interview for the DSM-5 Alternative Model for Personality Disorders (SCID-5-AMPD).**

By Michael B. First, Andrew E. Skodol, Donna S. Bender, and John M. Oldham; Arlington, Virginia; American Psychiatric Association Publishing; 2018; ISBN 978-1-61537-050-4; pp 243 (with modules); \$85 (paperback).