Handbook of Medicine in Psychiatry

edited by Peter Manu, M.D.; Raymond E. Suarez, M.D.; and Barbara J. Barnett, M.D. American Psychiatric Publishing, Inc., Washington, D.C., 2006, 605 pages, $79.00 (paper).

The *Handbook of Medicine in Psychiatry* is directed toward psychiatrists who may not feel comfortable addressing medical conditions that often arise in psychiatric patients—especially lipid management, common infections, and electrolyte abnormalities. The book is well organized into a series of common medical conditions, and the chapters vary in content from directions on how to manage situations of less acuity to discussions of more complex differentials and needs for referral in higher acuity cases. Many chapters are further enhanced by the presence of flowcharts for quick reference and increased ease of use.

The book is well written at an appropriate level for psychiatrists who may not have an internal medicine background, and the table of contents and index provide for easy accessibility. The text will find a primary home in the offices of psychiatrists who wish to take a more active role in the management of their patients' medical conditions as well as those who may have suboptimal medical backup for routine complaints.

While the *Handbook of Medicine in Psychiatry* will not replace the value of consulting physicians, psychiatrists will gain in medical knowledge such that it will be less likely for medical comorbidities to be underrecognized or suboptimally treated. The authors should be commended for their effort.

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Cognitive Therapy for Obsessive-Compulsive Disorder: A Guide for Professionals

by Sabine Wilhelm, Ph.D., and Gail S. Steketee, Ph.D. New Harbinger Publications, Oakland, Calif., 2006, 245 pages, $39.95 (paperback).

Baseball players are known for superstitious behavior, activities that are irrationally tied to performance on the field. Some athletes have shown a flair for their superstitious behavior, attracting a lot of attention from fans and the media. For example, according to CBC Sports Online (http://www.cbc.ca/sports/columns/top10/superstition.html#1), Wade Boggs was among the most superstitious of players, with the following pregame rituals: fielding exactly 150 ground balls during infield practice; entering the batting cage at exactly 5:17 p.m.; running wind sprints at exactly 7:17 p.m.; and eating only chicken before games, earning him the nickname "Chicken Man." These are only a few of the rituals behind Boggs' pregame preparations. Do these rituals rise to the level of obsessive-compulsive disorder (OCD)? If Boggs entered treatment, where would you begin if you were only casually familiar with OCD?

Given the extremely high level of superstitious behavior among baseball players, as well as other athletes, it would be misguided to go so far as to begin diagnosing OCD among athletes who exhibit ritualistic pregame preparation. However, these rituals are an excellent laboratory for understanding the cognitive processes that underlie ritualistic behavior. In this particular illustration, disruption of pregame rituals might provoke thoughts related to perfectionism ("My game will be off just a bit, diminishing my competitive edge, which is unacceptable by my standards") or responsibility ("The team will suffer because of my less than exact preparation"). Thoughts such as these have been proposed as being central to the etiology and maintenance of OCD.

Individuals who have OCD may not be professional athletes, and their symptoms cause serious distress. Unlike professional athletes, who most likely view their pregame rituals as essential and would not be particularly interested in changing, persons with OCD find no joy in their symptoms and often desperately seek ways of changing their behavior. Clinicians face a myriad of problems in assisting clients in coping with their symptoms. Complicating the clinical care of those with OCD is that the prevalence of the condition is somewhat high (around 2% of the population) but there are relatively few experts in the treatment of the disorder.

Wilhelm and Steketee, in their clinicians' guide, *Cognitive Therapy for Obsessive-Compulsive Disorder: A Guide for Professionals*, present the essential components of cognitive therapy for OCD in a format that will be appealing to a wide range of practitioners. Even if you have only limited familiarity with OCD and a basic understanding of cognitive therapy, after reading Wilhelm and Steketee's book, you would most likely be prepared to treat individuals with OCD.

The first chapter provides an overview of the cognitive theory of OCD, as well as a review of available treatments for the disorder. This portion of the introduction, in which some discussion of behavioral treatment is covered, includes material that is sometimes difficult for clinicians who treat anxiety disorders less frequently. Behavioral components of treatment, such as exposure with response prevention, are difficult to conduct and to gain client compliance with and are less acceptable to many practitioners (for an example, see Richard and Gloster[1]). However, in the case of cognitive therapy, in which prolonged exposure is less essential, clinicians often find conducting such activities more palatable. Chapters 2 through 4 deal with assessment and psychoeducation and include a summary of cognitive therapy techniques. These chapters will be useful to all readers, as they include methods that, while familiar to many cognitive therapists, are sometimes overlooked as practitioners develop routines of practice.

Chapters 5 through 10 cover the central themes of treatment for OCD, namely, the major belief domains commonly seen among individuals with OCD. These include overimportance of thoughts, need for control of thoughts, overestimation of danger, desire for certainty (also known as intolerance of uncertainty), responsibility, and perfectionism. Each of these major areas deserves the attention given to it, as each poses significant barriers to treatment if left unexamined in therapy. Each chapter contains instructions for behavioral experiments, an important part of treatment that sets the occasion for directly challenging the target belief domain. Some have suggested that behavioral experiments are central when considering components of cognitive behavior therapy.[2] These chapters

will guide clinicians to providing real and lasting symptom relief to many clients.

The final 4 chapters are truly unique in texts of this sort, and deal with establishing mental health functioning above and beyond merely alleviating OCD symptoms. While many clinicians who regularly treat OCD will acknowledge that clients report concerns over the risk of experiencing anxiety, there is little written about it to guide treatment. Some of this material relates meaningfully back to earlier topics, such as need for control of thoughts, but it is nonetheless important to consider these beliefs associated with OCD separately. Another, even less understood phenomenon in treatment for OCD involves concerns over the experience of positive events. Many clients believe that if they let their guard down, they will be ill prepared to cope with future negative events. This is similar to difficulties sometimes reported by clients with other anxiety disorders (i.e., generalized anxiety disorder),[3] creating a serious barrier to treatment, as clients will justify their ongoing obsessive-compulsive behavior as a prophylaxis for mental health. The modification of core beliefs is covered in the penultimate chapter, in which cognitive biases that are unrelated to OCD, but nonetheless related to client distress, are challenged. Finally, the last chapter covers relapse prevention, an area that has received little attention in the literature but is nonetheless critical to effective outcome.

Wilhelm and Steketee have done a great service for individuals who have OCD by increasing the likelihood that clients can receive effective treatment for their condition. This clinicians' guide is an excellent resource for providers struggling to bring relief to their OCD clients. Of course, there are serious complicating factors associated with OCD, such as scrupulosity and overvalued ideation, which are discussed in this book, but for which there are limited directions for treatment. Many of these complications in treatment are still poorly understood, and so clinicians should recognize that although this text is an invaluable resource, relief may not come to all clients. In fact, it has been suggested that the demands of treatment for some who have OCD make compliance with therapy difficult or impossible, particularly for exposure-based interventions.[4] The problem with compliance with exposure therapy highlights the utility of cognitive therapy, but also points to the possibility that treatment gains in some cases may come more slowly. Nonetheless, a great many more clients will benefit with this book available to therapists.

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