

Countertransference Issues in Psychiatric Treatment (Review of Psychiatry Series, Vol. 18)

edited by Glen O. Gabbard, M.D. Washington, D.C.,
American Psychiatric Press, 1999, 127 pages,
\$26.50 (paperback).

In an era during which medication management of patients based on a descriptive diagnosis derived from DSM-IV has in some circles become the clinical foundation of psychiatry, Gabbard's brief book on issues in countertransference is a welcome and essential addition to contemporary clinical psychiatry.

Freud first introduced the concept of countertransference in 1910, noting, "We have become aware of the 'countertransference,' which arises in him [the physician] as a result of the patient's influence on his unconscious feelings. . . .¹ Issues of the psychiatrist's countertransferences to patients can and do occur whether the treatment focuses on medication management, psychotherapy, or a combination of both treatment modalities. We today share Freud's view ". . . that he [the therapist] shall recognize this countertransference in himself and overcome it."

Gabbard and his contributors first offer an expanded theoretical basis for understanding countertransference. After accomplishing this task, they develop models as to how practitioners can observe their countertransference reactions and then use their self-knowledge to minimize such countertransferences from interfering with treating their patients.

It should be noted that in their contributions, Glen Gabbard, John Maltsberger, Francis Varghese, and Brian Kelly all base a substantial element of their theoretical understanding of the complex unconscious elements that may create countertransferences on the original contributions of Melanie Klein. Not all contributors to this difficult subject matter would explain countertransference on a Kleinian model.

Independent of the theoretical views presented, the authors present a clearly written view of the varied clinical problems psychiatrists face in varied settings that can create countertransferences. Marcia Goin, in her chapter "Countertransference Is General Psychiatry," gives the reader an informative yet easy-to-read guide to using awareness of one's countertransferences to assist treatment. All too frequently, psychiatrists become defensive when discussing countertransferences, forgetting its inevitability in our work. Understanding our countertransferences informs us about ourselves and our patients.

The final chapter of this volume focuses not on the general issues we face in psychiatric practice but on a major social question—physician-assisted suicide. The authors argue that any physicians assisting in the suicides of their patients are likely to be dealing with countertransference issues or enactment with their patients and not functioning in the best interest of their patients. Although the authors provide a literature review and theoretical support for their contentions that

physician-assisted suicide is a grossly inappropriate act for a physician, an issue of this magnitude needs a much broader review. The authors are, however, correct in articulating the view that one cannot discuss physician-assisted suicide without comprehending the role of countertransference in the physician's behavior.

In sum, this volume is useful in keeping us focused on the doctor-patient relationship wherever the site of treatment or whatever the modalities utilized.

REFERENCE

1. Freud S. The future prospects of psycho-analytic therapy (1910). In: Strachey J, ed. The Standard Edition of the Complete Works of Sigmund Freud, vol. 11. London, England: Hogarth Press; 1957: 144–145

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The Chemical Dependence Treatment Documentation Sourcebook

by James R. Finley, M.A., and Brenda S. Lenz, M.S. New York,
N.Y., John Wiley & Sons, Inc., 1999, 278 pages, \$49.95.

This book is a "how-to" manual for developing and structuring a substance abuse treatment program (SATP). It is written by 2 master's degree-level addiction therapists (who also do education and SATP program management) and includes a comprehensive collection of clinical, educational, and program-management material.

The text is divided into 3 basic sections. The first section (chapters 1 and 2) addresses the basic issues of evaluating the need for a SATP, as well as local resources, goals, costs, and referral sources. It also explains the initial steps in beginning a SATP. The second section (chapters 3–7) provides numerous administrative aids for establishing a SATP such as reference forms, assessment procedures, consent and release forms, and various other administrative forms (attendance sheets, behavioral contracts, and so on). It is particularly helpful that the forms have also been provided on a computer disk (which comes with the book) so that readers can create their own copies. The third section (chapters 8–11) is primarily concerned with enhancing SATP programs. Chapter 8 includes a few ideas for outcome measurements, but this potentially very important chapter is unfortunately quite limited in content. Other chapters in this section contain information for conducting groups and teaching on issues such as substances of abuse, stress, anger, codependency, comorbidity, loss, domestic violence, and family depression.

Overall, this book will be extremely useful to addiction therapists and hospital administrators who are trying to create and/or enhance a SATP. However, some information that might have been useful to addiction psychiatrists, such as detoxification protocols, pharmacologic treatments for relapse prevention, clinical outcome measurements, and comorbidity issues, is weak or not included.

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The Recognition and Management of Early Psychosis: A Preventive Approach

*edited by Patrick D. McGorry and Henry J. Jackson.
New York, N.Y., Cambridge University Press, 1999,
495 pages, \$90.00.*

Growing evidence suggests that early recognition and treatment of the schizophrenic psychoses may be of critical importance in the reduction of subsequent morbidity. The present volume, edited by McGorry and Jackson, presents a comprehensive review of the psychosocial literature relevant to detection and treatment of the schizophrenias, together with a description of a rehabilitation program designed to reduce subsequent schizophrenic morbidity.

The centerpiece of the argument is that the schizophrenia process is most active, and schizophrenia is most amenable to successful intervention, within a relatively short period that extends from the beginning of the prodromal period to 5 years after the emergence of frank psychotic symptoms. The contributing authors bewail the common failure of early diagnosis, with psychotic symptoms often present years before the individual comes to the attention of mental health professionals. They also note the often extended prodromal period, with evidence of deteriorating psychosocial interests and skills. These are the optimum times for intervention to arrest or partially arrest the process that subsequently tends to become relatively fixed, with permanent damage to both the biological and psychosocial substrates.

The Melbourne program (Early Psychosis Prevention and Intervention Center [EPPIC] and its Early Psychosis Assessment and Community Treatment Team [EPACT]) attempts to optimize initial management of the patient's first psychotic episode, both maximizing chances for full recovery and minimizing the potential for future relapses and morbidity. The protocol first attempts to provide the patient with *immediate* access to mental health evaluation (rather than weeks or months of shuffling from one professional to another), prompt use of low-dose neuroleptics (2–4 mg/day equivalents of haloperidol) preferably in a community, home-based setting, together with cognitive and family interventions aimed at rapid and sustained recovery from the episode. Recovery is further enhanced by the use of the EPPIC day programs, with social, recreational, vocational, creative expression, health promotion, and personal skills development streams.

As readily acknowledged by the authors, a paucity of *controlled* studies documents the efficacy of such interventions. The extensive literature reviews and the EPPIC program itself are largely descriptive. Intuitively, this is an empathic program that should provide almost every available chance for recovery from first-episode psychosis. Yet the skeptics, including state and local legislatures, might not be convinced in the absence of hard, controlled efficacy data.

It is striking that the concept of identifying those at risk and intervening prior to the emergence of frank psychosis is paid limited attention here. That much of the biological and psychosocial damage in schizophrenia is turned on and results in permanent destructive effects even during the prodromal period is increasingly accepted. The advent of new atypical antipsychotics with low drug-induced morbidity now permits experimental pharmacologic treatment interventions in high-risk populations during early-to-mid prodromal periods, although the results of such pharmacologic trials may not be known for some time. Similarly, serious strategies need to be attempted in the sphere of psychosocial intervention early in the prodromal periods with at-risk populations. It is likely that, within the next few years, genomic scans will aid the identification of such at-risk individuals, leading to an opportunity for truly preventive rather than restorative treatments.

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Personality-Guided Therapy

*by Theodore Millon. New York, N.Y., John Wiley & Sons, 1999,
776 pages, \$65.00.*

Theodore Millon's *Personality-Guided Therapy* will probably be viewed as somewhat of an opus of this singular and prodigious contributor to our understanding of personality and systematic attempts to influence human behavior. With 713 pages of text, expanding to 776 pages including references and index, and a \$65.00 quoted cost, the book is hefty in size but moderately priced by contemporary standards.

The book begins with a section on "Foundations" that gives a brief overview of treatment modalities, including contemporary trends and 2 chapters focusing on Millon's personal contributions to integrating psychotherapeutic strategies in a systematic manner to plan treatment for humans as opposed to disease states. The review is strong in its treatment of individual therapies but expectably weaker in handling of group psychotherapy. (Specifically, there was no mention of David Spiegel's work with expressive supportive group psychotherapy or the group analytic contributions of Bion.) I also wish that he would have spent more time on the admittedly less developed but extraordinarily promising contributions of Kandel and Cloninger. The "Foundations" section does best what the author can do best. The chapters on personality-guided synergism and planning personality-guided treatment provide a succinct and highly useful summary of the author's singular contributions to organized efforts to help heal peculiarly human suffering.

For the reader already immersed in Millon's work, this book will largely be a helpful review. For the reader who is an established clinician but unfamiliar with psychological aspects of psychopathology, the book provides a systematic, thorough orientation to move beyond conceptualizing psychopathology as only a neurobiological event. It will help such readers to gain a framework upon which to organize comprehensive treatment. Millon's work is systematic enough that even the most committed biological reductionist will have to (grudgingly perhaps) acknowledge that there is a systematic approach toward understanding and responding to the psychological aspects of psychopathology.

The reader who is in the best position to benefit from this book is an experienced psychotherapist familiar with 2 or more different conceptual frameworks for structuring psychotherapeutic re-

relationships. This reader will easily grasp the ways in which Millon's efforts to integrate conceptual models and connect them to a developing treatment relationship can enhance therapeutic results. A reader with less sophistication will need a supervisory relationship to achieve maximum benefit from this book. For example, in psychiatric and psychology training situations, a seminar leader with previous experience utilizing Millon's conceptual framework will be helpful to produce a learning environment in which students, residents, or fellows can benefit from a clear but complicated scheme. As an alternative, a learning group with 2 or more respectful and competent faculty with different backgrounds would need to collaborate with each other and the learners to make the best use of this book. One approach would be for several sessions of a case conference in a mood disorder clinic to review the "Foundations" section and then present clinical material from the clinic while reading the chapter on mood-related syndromes. After a session or 2 of that focus, the faculty might identify where pharmacologic treatment is providing only partial response because of the confounding effects of a personality disorder. The group could then use a case conference to discuss a clinical presentation and the relevant chapter: for example, a schizoid patient whose mood improvement has not resulted in constructive social contacts.

In summary, this is a sophisticated and comprehensive book that urges us to recognize the limits of descriptive diagnosis-based treatment while not discarding the advances made by the DSM approach. Millon challenges us to provide treatments that "derive logically from the theory of that particular person." This book is a helpful tool in that worthy effort.

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The Selfish Brain: Learning From Addiction

by Robert L. DuPont, M.D. Washington, D.C.,
American Psychiatric Press, 1997, 553 pages, \$26.95.

This is a rather unusual book for the reader accustomed to most scientific books. It begins with 5 pages of endorsements and a foreword by Betty Ford. Then, after a brief, well-written preface that outlines the structure of the book, the author spends another 7 pages on his biography. Dr. DuPont states in the preface that this book is for therapists, counselors, and educators, which might explain the lack of references to support its many assertions, except for footnotes dealing with some of the statistical data.

The book comprises 3 sections. In the first section, "Thinking About Addiction," the author briefly touches on the genetics and character traits that predispose individuals to addiction. He stresses the disease concept of addiction, although later he seems to back off the traditional disease concept by extending the "disease" to family and even society. The chapters on history of drug abuse and the current "scene" of drug use are well written and provide a wealth of information for anyone concerned with addiction. However, the exact sources of some of the statistical data are difficult to ascertain.

In the section "The Brain and Addiction," the discussion of the neuropharmacology and neurophysiology of the brain is

rather superficial, but probably sufficient for the target audience. Chapters 5 and 6 do a reasonably good job in describing specific drugs, from nicotine and alcohol to the hallucinogens, and appropriately stress the highly addictive nature of cocaine and its central nervous system and peripheral deleterious effects. The section on marijuana lacks data to support many of the assertions. It reminds one of the "fried egg" commercials a few years ago designed to turn young people against drugs, which were totally rejected and ridiculed by the target audience. There are also some inaccurate statements in the section. For example, state-dependent learning is defined as "brain learning to function" with presence of alcohol, rather than the specific process in which an animal under the influence of a drug can learn but not recall the material when sober.

The last section, "Overcoming Addiction," consists of 7 chapters. The chapter on "The Addict's Career" clearly outlines the stages of addiction and has a good discussion of type I and type II addicts as well as an excellent discussion on "hitting bottom." However, the author's use of personality and personality disorders is problematic. Temperament traits like high novelty seeking and low harm avoidance are labeled character disorders, and antisocial personality, which has very clear criteria in the DSM-IV, is rather loosely used in the discussion.

The chapter on "Prevention of Addiction" has a useful guide to "drug-proofing your children" and for identifying high-risk youth. However, the terms *temperament* and *character disorder* are used interchangeably. The beneficial, well-documented effects of modest (up to 2 drinks per day) drinking on reducing coronary disease and stroke are rather quickly dismissed in favor of a focus on excessive drinking.

The chapters on intervention and on 12-step programs are well written and should provide useful data to therapists and counselors. Particularly significant is the author's stress of the importance of after care in any treatment process.

In the chapter on drug policy, the author admits up front that the ideas expressed are controversial. He extensively discusses the advantages and disadvantages of drug legalization, with most emphasis on the disadvantages. Harm reductions, including clean-needle programs, are dismissed by the author. Dr. DuPont's view on drug policy is probably best expressed in his concept of the "drug abuse chain," where drug production/cultivation and the drug user, i.e., the addict, are the main targets of sanctions. He recommends strict sanctions for users.

In the chapter on future of addiction, he admits that "crop substitution" does not work and that only eradication and destruction will work. He proposes that crop substitution on the supply side of the chain is analogous to education and treatment on the demand side and that without sanctions, treatment and education are ineffective.

This book may be useful to the stated target audience of therapists, counselors, and educators, but I do not find much to recommend it to psychiatrists or neuroscientists interested in addiction. It is unfortunate that Dr. DuPont sees no other options except for the U.S. government's quasi-military approach to the problems of drug abuse and addiction. If addiction is truly a disease, then treatment, not punishment, should be the ultimate goal to which most of our resources are dedicated.

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