Annals of Clinical Psychiatry, 17[2]:99–105, 2005

ISSN: 1040–1237 print / 1547–3325 online
DOI: 10.1080/10401230590946286

Taylor & Francis

Book Reviews

Psychological Treatment of Bipolar Disorder, edited by Sheri L. Johnson and Robert L. Leahy, The Guilford Press, New York, New York; 2004; ISBN: 1-57230-924-5; $ 40 (hardcover), 340 pp.

Bipolar disorder, or as many, including me, prefer to say, manic-depressive disorder, is notoriously difficult to treat. Various psychotropic medications have been the cornerstone of treatment of manic-depressive disorder. As Jan Scott pointed out in chapter six of *Psychological Treatment of Bipolar Disorder*, historically, psychological therapies were not offered to bipolar disorder patients for three main reasons. First, etiological models emphasized genetic and biological factors and largely dictated that medication was not just the primary, but the only appropriate treatment for manic-depressive disorder. Second, there was a misconception that virtually all patients with manic-depressive disorder made a full interepisode recovery and return to their premorbid level of functioning. Third, psychoanalysts have been historically ambivalent about the suitability of psychotherapy for patients with this disorder.

However, over the last two decades our views have changed. It has become more obvious and accepted that psychological and social factors play a role in the course of manic-depressive disorder. The role of vulnerability to stress, long acknowledged in conceptualizing the course and treatment of other major mental disorders, has been acknowledged in manic-depressive disorder, too. It has also been established that manic-depressive disorder can have severe psychosocial consequences. In addition, there is also substantial evidence that psychosocial variables predict the course of manic-depressive disorder. Finally, it is well known that the rates of nonadherence, a phenomenon modifiable by psychosocial treatments, are quite high in manic-depressive disorder. Once all these factors are recognized and accepted, one begins to see the role for psychological treatments as an adjunct to medication in manic-depressive disorder. As Sheri Johnson in the introductory chapter to this book points out, psychosocial approaches to manic-depressive disorder may actually 1) provide psychoeducation regarding symptoms, 2) promote adherence with medication regimes, 3) address comorbid conditions, 4) ameliorate the stigma and self-esteem consequences of the diagnosis, 5) promote greater social and occupational adjustment, 6) help reduce the risk of suicide, and 7) identify and reduce psychosocial triggers that may intensify the risk for relapse, including family conflicts and life stressors.

The editors of this book, together with a team of authors well-versed in psychosocial treatments of manic-depressive disorder, put together a volume summarizing the area of psychological treatment(s) of this disorder. The book is divided into three parts, I. Overview of bipolar disorder, II. Therapy and treatment issues, III. Special issues in treatment, and five appendices.

Part I consists of five chapters, addressing general issues such as defining bipolar disorder; psychosocial functioning; differential diagnosis and assessment of adult bipolar disorder; assessment of bipolar spectrum disorders in children and adolescents; and psychosocial predictors of symptoms. The overview of functional impairment focuses on occupational, marital, parental and social functioning impairment. The authors emphasize that while the impairment may be significant, it varies enormously from person to person and is not readily explained simply by clinical features of the disorder. The chapter on assessment of adult bipolar disorder provides a good discussion of various instruments and mania scales, their advantages and limitations. The overview of bipolar spectrum disorders in children and adolescents includes an interesting discussion of developmental constraints on the expression of many manic symptoms (e.g., children usually cannot bounce checks or squander savings on risky investments). The review of psychosocial predictors of symptoms, such as expressed emotions, negative life events, or poor social support points out that these variables seem to exert a stronger influence on depression than on mania. This part serves as a solid introduction to the problem of bipolar disorder and to the rest of the book.

Part II contains six chapters, reviewing various treatment options of bipolar disorder. It starts with a chapter on psychopharmacology of this disorder. The following three chapters review specific psychological treatments—cognitive therapy, interpersonal and social rhythm therapy, and family therapy. I found the chapter on interpersonal and social rhythm therapy (IPSRT) especially useful. This modality focuses on "helping patients optimize the regularity of daily routines, resolve social and interpersonal problems, and understand their illness."(p 165) The chapter on family therapy reviewed a specific family-focused treatment program developed at the University of Colorado in Boulder and its five phases—assessing the family, psychoeducation, communication enhancement training, problem-solving skills training, and termination. The following chapter describes the Life Goals Program, a group-based psychoeducational program designed to assist patients with manic-depressive disorder to become better collaborators in their own illness management. The last chapter of this part focuses on key psychosocial treatment outcome studies.

The third part of the book deals with special issues such as treatment compliance, suicidality, and consumer advocacy and self-help. The discussion of compliance emphasizes that non-compliance is as much the norm as the exception, that compliance is not an all-or-nothing phenomenon, that compliance is more difficult than it looks, and that the best predictor of future compliance is the past. This chapter also reviews some useful remedies, such as pillboxes, pairing medication with an existing activity, cues to recall, and family support. The chapter on suicidality provides some useful tips on suicide risk assessment and management of suicidality in bipolar disorder. Though one of the elements of the management of suicidality involves the anti-suicide contract, the authors acknowledge that these contracts are not sufficient safeguards. I would add that they also do not help much in the court of law. The review of advocacy and self-help provides a number of useful addresses and websites for patients.

The five appendices include The Altman Self-Rating Scale for mania (ASMR); mood chart; evaluation of suicide risk table (useful, but unfortunately including an anti-suicide contract formula); recommended resources for consumers and their families; and an outline of collaborative disease management strategies.

This is an interesting and useful book for all clinicians managing patients with bipolar disorder. It advocates a comprehensive management of this disorder, which includes various psychosocial therapeutic modalities as adjunct to medication. It is a good source for anyone looking for information about psychosocial management strategies for bipolar disorder. Most chapters are well written and informative. I would recommend this book to psychiatrists, psychologists, psychiatry residents and all practitioners providing care to patients with this difficult to treat disorder.

Richard Balon, M.D.
Wayne State University
Detroit, Michigan

Marijuana and Madness. Psychiatry and Neurobiology, edited by David Castle and Robin Murray, Cambridge University Press, Cambridge, United Kingdom; 2004; ISBN: 0-521-81940-7; $ 80 (hardcover), 218 pp.

In spite of the widespread use and abuse of marijuana (*Cannabis sativa*) among persons with mental illness, the relationship between marijuana and mental illness remains unclear and controversial. For many, experts and laymen, marijuana is just a gateway drug to the use of more "serious" substances of abuse. For others, the use of marijuana is a serious problem on its own. And for some, marijuana is occasionally associated with the onset of mental illness, specifically psychosis. Actually, people who suffer from psychotic illness are far more likely to consume marijuana than the general population. However, we do not fully understand why they consume marijuana more frequently, whether they use it to help them feel better, whether the use of marijuana increases the risk of onset of mental illness, and whether some individuals are more vulnerable to the effects of marijuana on mental health than others.

The possible link between marijuana and mental illness has been increasingly discussed in the scientific literature. It seems that a summary of this discussion would be desirable and timely. The editors of the book *Marijuana and Madness*, David Castle and Robin Murray, brought together an international team of experts to provide the readership with such a summary of evidence of the relationship between the use of marijuana and onset/worsening/outcome of mental illness. I would like to point out to the reader of this review and possibly of the book—the authors and the reviewer use the term marijuana and cannabis interchangeably.

The book consists of thirteen chapters. It starts with the discussion of the cannabinoid system from the point of view of a chemist. This discussion emphasizes that the active compounds of marijuana, chemically closely related terpeno-phenols, are very difficult to separate and purify. It also reviews the so far identified endocannabinoids and raises the question whether dysfunctions of endocannabinoid system contribute to the biological basis of mental disorders. The second chapter follows with exploring how cannabis works in the brain. It reviews what is known about the interaction of marijuana with the cannabinoid system in the brain and how it affects psychomotor, cognitive, perceptual and appetitive functions. For instance, is known that dronabinol (tetrahydrocannabinol) counteracts the loss of appetite and weight in AIDS patients. Interestingly, rimonabant, a substance blocking CB_1cannabinoid receptor, suppresses appetite and reduces weight (it was introduced for treatment of obesity in Europe, and is studied in the United States at present). This chapter also emphasizes that several studies demonstrated a significant withdrawal syndrome in human marijuana users after the drug was withdrawn. Chapter three discusses the acute and subacute psychomimetic effects of cannabis in humans. As the authors point out, it is important to realize that cognition and psychomotor functioning are impaired in a dose-dependent fashion during acute intoxication with marijuana. This chapter also reviews a controversial entity—the amotivational syndrome presumably associated with marijuana use.

Chapter four reviews the evidence on the association between cannabis use and depression. The authors of this chapter conclude that there is an increasing evidence that regular cannabis use and depression occur together more often than might be expected by chance, and that there is an increased risk of depression among persons who report heavy cannabis use (but not in those who use it infrequently). The reasons for this association are not clear (does cannabis use cause depression or does depression cause cannabis use, or are there common factors increasing the risk for both?).

The following two chapters deal with cannabis and psychosis-proneness and pose the question of whether there is a specific "cannabis psychosis." Cannabis use may be an independent risk factor for psychosis, at least in subjects with a preexisting