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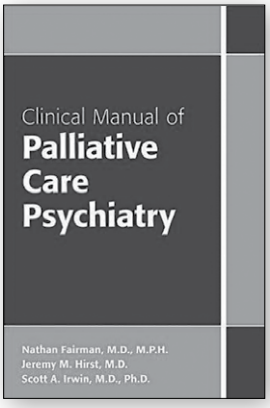
Clinical Manual of Palliative Care Psychiatry



By Nathan Fairman, Jeremy M. Hirst, and Scott A. Irwin; American Psychiatric Association Publishing; Arlington, Virginia; 2016; ISBN: 978-1-5856-2476-8; pp 279; $59.00 (paperback).

The Clinical Manual of Palliative Care Psychiatry is a concise and practical textbook written by 3 experts in this emerging field. The aim of this book, stated in the introduction, is "to address the needs of both front-line palliative care providers who lack formal mental health training yet are eager to improve their ability to address psychiatric symptoms, and mental health specialists who lack familiarity with palliative care yet are eager to improve their effectiveness in participating with palliative care physicians in the care of seriously ill and dying" (p xix-xx).

Part 1 contains 2 chapters: "Palliative care 101" and "Psychiatry in palliative care." The former lays the framework for the book, providing a broad definition of palliative care, describing its basic tenets (total pain, person-centered, goal-driven care), and overall benefits of providing palliative services. The latter discusses how psychology and psychiatry fit into the palliative care movement both historically and in the present day, sources of suffering that may benefit from psychiatric services, and how psychiatrists fit into palliative care services. As an educator, I found trends in the education of psychiatrists in palliative care quite interesting; few psychiatrists have received hospice and palliative care certification (only 61 as of 2014); there is a high degree of interest among trainees, yet inadequate learning opportunities during residency.

Parts II and III, "Core clinical applications" and "Other common psychiatric conditions," are quite similar in structure and contain the bulk of the material in this text. Included are chapters on depression, anxiety, delirium, dementia, insomnia, and substance use disorders. In my opinion, these chapters are more appropriate for non-psychiatric providers because they include detailed explanations of psychiatric diagnostic criteria, differential diagnoses, and approaches to treatment, including excellent tables listing drugs by class, suggested dosing, and clinical pearls. For psychiatrists, this portion of the text may be too simplistic, although not entirely unbeneficial. The authors do pay careful attention to how these conditions specifically present in palliative care populations. For example, in the chapter on depression, the authors focus on the concept of demoralization and, when discussing dementia, they touch on prognostication and point of eligibility for hospice care.

Part IV, "Interventions," contains 2 chapters: "Psychotherapy" and "Pain management and psychopharmacology." Psychotherapy covers techniques that many psychiatrists likely are unfamiliar with because they are specific to palliative care settings: Meaning-Centered Psychotherapy (MCP), Dignity Therapy (DT), and Managing Cancer and Living Meaningfully (CALM). "Pain management and psychopharmacology" discusses the assessment of pain, and differentiates between acute, chronic, nociceptive, and neuropathic pain. Given the aim of the text, the treatment of pain focuses on the use of antidepressant and antiepileptic medications, and does not discuss use of opioids.

This small textbook ends with a section focusing on pediatric and adolescent populations. The authors cover the psychiatrist's role in caring for seriously ill children and their families, communication techniques, conceptions of death during different developmental periods, psychiatric symptomatology (depression, anxiety, and insomnia), and pharmacological, behavioral, and environmental treatments.

The Clinical Manual of Palliative Care Psychiatry is well organized and easy to read. Each chapter begins with a brief overview and concludes with a bulleted section containing conclusions, key points, references, and additional resources. The extensive tables are excellent and can be referred to

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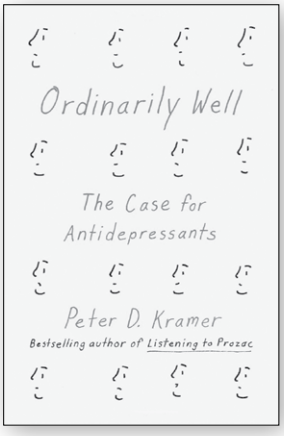
in clinical settings. Those concerning pharmacological treatments contain suggested dosing and titration schedules, as well as clinical pearls. This short text is weighted toward addressing the needs of palliative care providers who lack mental health training. Despite this, it still contains information that provides valuable information to those psychiatrists who are interested in the interface between their field and palliative care but do not have formal training, which may be a large number of us.

Mary Morreale, MD
Wayne State University
Detroit, Michigan, USA

Ordinarily Well: The Case for Antidepressants



By Peter D. Kramer; Farrar, Straus and Giroux; New York, New York; 2016; ISBN 978-0-3742-8067-3; pp 336; $27 (hardcover).

Peter Kramer starts his new book with the following quote from Javier Marias book, *Your Face Tomorrow*[1]: "No one dares any more to say or to acknowledge that he sees what he sees, what is quite simply there, perhaps unspoken or almost unsaid, but readily apparent."

In a way, this quote aptly expresses the ethos of Kramer's book, a passionate "defense" of antidepressants and their efficacy and usefulness. Defense of what is to clinicians obvious, but frequently unspoken. Antidepressants have been with us, fortunately, for more than half a century. They have helped millions of patients to improve their lives and saved many lives. However, antidepressants also have been maligned—their efficacy doubted or denied. Some may remember the debate on the pages of *The New York Review of Books*[2] in 2011 (discussed in the preface of Kramer's book) in which Marcia Angell (former interim editor of the *New England Journal of Medicine*) called psychoactive drugs useless or worse than useless. An authoritative voice (of a pathologist, not a clinician), to which Peter Kramer responded with the article "In defense of antidepressants."[3] That was probably the starting point and the kernel of this volume.

As Kramer writes, "This book is about two influences on medical practice: rigorous trials and clinical encounters. In an attempt to keep the strands separate, I will use the title 'Interlude' for chapters that, more than others, discuss time spent with patients. But the distinction holds up poorly. Observations from my own experience intrude on scientific sections, and case vignettes introduce technical points" (p xx). The book starts with a chapter "The birth of the modern." It is a well-known story of the discovery of imipramine by the Swiss psychiatrist Roland Kuhn. This discovery usually is a cited footnote of textbooks or chapters on the history of psychiatry. However, Kramer's narrative makes the reader realize the scope and significance of Kuhn's discovery. Kramer notes that Kuhn "... invented the modern antidepressant. He didn't synthesize a chemical. He created the concept" (p 3). Kuhn was an astute observer, a great clinician, "... bridged the old and the new in psychiatry: psychoanalysis and psychopharmacology" (p 3). As Kramer says, "Kuhn's assessment of imipramine had virtues that formal drug trials rarely duplicate. He knew his patients well and interviewed them extensively.... Kuhn tested imipramine for eighteen months, without deviating from his customary administration of care" (p 3-4). Kramer adds, "Kuhn tested imipramine at a moment that can arrive only once, when an antidepressant is available but no one has been treated with one. Today, trials of new drugs attract people who have failed on readily available medications or people outside the medical system, not diagnosed in the ordinary course of practice—an

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unrepresentative sample.... He had witnessed the full power of an antidepressant" (p 4). This is an important observation reminding us how much the landscape of clinical trials and clinical practice has changed, yet how important good clinical observation is.

Kramer continues with chapters that describe the introduction of randomized trials and the development of scales (Max Hamilton's creation of the famous Hamilton Rating Scale for Depression). The following interlude reminds us again, how the landscape of depression care has changed in a positive, yet difficult to document way. Kramer observes—and confirms this in a discussion with Anthony J. Rothschild, MD—that we see much less of the classic, immobilizing melancholy. "People used to move from depression to severe depression to that paralyzing state. Since the 1980s, with the advent of easier-to-use antidepressants, often the downward progress is interrupted" (p 38). The book continues to meander through the history of antidepressants viewed through the scope of Kramer's observations and clinical experience. In the next interlude, Kramer reminisces about another important event that changed our clinical practice—the case of Raphael Osheroff. Osheroff was a physician who became severely depressed and was hospitalized at a well known psychoanalytically oriented hospital, Chestnut Lodge, in 1979. His medication was withheld, and he was treated with psychotherapy for 7 months. Afterwards he was moved to another hospital, treated with antidepressants and antipsychotics, improved in 3 weeks, discharged in 3 months, and returned to his practice. As his life had profoundly changed (lost marriage, business), Osheroff brought a malpractice suit against Chestnut Lodge. Osheroff won, which was appealed and later settled largely in Osheroff's favor. As Kramer writes, "If not in its content, in its political effects Osheroff was like Roe vs. Wade. A legal process gave a victory to one side in a dispute turning on deeply held, principled views" (p 46). Remembering the case and its reverberations, I agree wholeheartedly.

Throughout the text, Kramer makes many other important observations and points. He notes that in his observation, "the early antidepressants could be restorative, making patients more available emotionally and then more engaged as parents and workers" (p 51).

Later in the book, Kramer gets to another famous point in the ongoing debate about antidepressants—the articles by psychologist Irvin Kirsch. Kirsch concluded that, based on his meta-analysis of antidepressant studies, much of the benefit of antidepressants derives from placebo response. In several chapters, Kramer carefully and methodically debunks Kirsch' conclusions. He muses over the modern medicine magical spell, evidence-based practice: "Standard definitions of evidence-based practice are innocuous. One in wide use refers to 'the integration of best research evidence with clinical expertise and patient values.' The devil is in the application. Notwithstanding the lip service given to expertise and values, from the start devotees emphasized randomized trial results to the exclusion of all else. Too often, EBM entailed an uncritical embrace of meta-analyses. The practical effect was to disqualify most evidence, from biological plausibility to less formal experiments to clinical experience and observation. As a result, clinicians had mixed feelings—I did—about evidence-based medicine" (p 116). He also reminds us that "the research submitted to the FDA is not designed to demonstrate new drugs' optimum efficacy. It is designed to produce two successful trials quickly in settings that retain patients and avert disastrous outcomes" (p 126). Only in clinical practice, with all its complications and over time we can fully appreciate the value of a new antidepressant. Kramer feels that "the FDA studies allow the agency to identify useful medicines, ones that patients can live with, ones that transformed the face of depression. Beyond that, the trials are a lousy source of information about antidepressant efficacy, and it's shocking that an important medical question, about the proper treatment of mood disorder, has been debated using them as a reflection of reality" (p 136).

Next is a masterful description of for-profit clinical research centers and how they work. It includes all their positive aspects but also all the negative aspects and artificiality. These centers work perfectly to get the data needed for FDA approval. Nothing else. Yet the care they provide, temporarily, is almost perfect. One wishes we could provide such care to all our patients, all the time. Kramer advocates for turning away from these for-profit mills back to

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either non-profit or academic centers to examine the clinical effectiveness of medications. However, he recognizes that "… even academic studies tend to be selective. They may exclude people with suicidal thoughts, drug-abuse histories, or ongoing depressive episodes that have been too prolonged or too brief" (p 166).

In another chapter, Kramer debates the notion that antidepressants do not work well in mild to moderate depression. Based on his analysis of the literature and his experience, he shows that they do work in mild to moderate depression and work well. He also adds a discussion demonstrating that antidepressants work in maintenance therapy of depression. Here he gets back to the false notion of Kirsch and other critics of antidepressants who ascribe most of their effect to placebo: "In the maintenance literature, the notion of medicine as glorified placebo loses meaning. There's nothing to glorify. Placebos don't prevent depression, and antidepressants do" (p 206).

At the end of the book, Kramer returns to his doubts about evidence-based medicine, "It's not just that EBM can get questions wrong and then make the answers into a rule. Like medications, EBM may have side effects. Will training young physicians to follow a guideline lead to better medicine than training them to read critically, observe closely, choose strong mentors, and aim to adapt treatments to cases? I would respect EBM more if its guidance included this requirement for trainees: *Make note of what you see*" (p 237). One cannot agree more.

After reminding the reader that antidepressants help and bring patients to life, Kramer writes, "Antidepressants can assume the role of partisans in an old struggle, about mind and brain, meaning and symptoms. Must that contest persist? Antidepressants and psychotherapy mesh so well. Still, it's true: we discount the miracle because sometimes antidepressants fail; and then sometimes we discount it because they succeed" (p 239-240).

In his last words of defense of antidepressants, Kramer writes, "In ways large and small, depression burdens lives. Combating it, psychiatry has been in stasis. But it would be shameful not to show gratitude for our imperfect tools. We're lucky to have them. Progress in mental health care may be slow, but make no mistake: for clinicians, for depressed patients, ours are still extraordinary times" (p 241). Perfectly stated!

This is an interesting book, full of food for thought. At times, it is difficult to read, but it conveys a great message, and even experienced clinicians will learn a lot. It is an enjoyable reading about important and complex issues, which Kramer explains fairly well. It is a great defense of antidepressants, but it is also a great defense of good clinical practice and clinical observations.

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

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

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1. Marias J. Your face tomorrow: fever and spear. New York, NY: New Directions Books; 2002:241.
2. Angell M. the epidemic of mental illness: why? http://www.nybooks.com/articles/2011/06/23/epidemic-mental-illness-why. Published June 23, 2011. Accessed August 29, 2016.
3. Kramer PD. In defense of antidepressants. http://www.nytimes.com/2011/07/10/opinion/sunday/10antidepressants.html. Published July 29, 2011. Accessed August 29, 2016.

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Pocket Guide to Addiction Assessment and Treatment

Edited by Petros Levounis, Erin Zerbo, and Rashi Aggarwal; American Psychiatric Association Publishing; Arlington, Virginia; 2016; ISBN 978-1-5856-2512-3; pp 379; $65 (paperback).

As the editors of this pocket guide write, "This is not a textbook. It is not even a handbook or manual. It's a pocket guide, a compact helper for the enthusiastic, yet not necessarily experienced, traveler in the world of addictions" (p xiii). The reader may still ask, why a pocket guide and for whom? Well, the world of addiction is expanding and changing. We are facing an opioid epidemic, marijuana, unfortunately, is being legalized; new drugs of abuse are appearing; and alcohol abuse is still a big problem (although not as big as in Russia). We do not have enough addiction specialists to face all these problems, and thus we all have to deal with substance use disorder patients (only 10% of patients with these disorders receive specialized addiction treatment). Clinicians, especially those who are starting in this area, would like to have reliable, quick to access information on how to assess and treat patients afflicted with addiction(s). The editors of this pocket guide ask, "When textbooks feel overwhelming, the Internet is not consistently trustworthy, and helpful colleagues seem overextended, where do I turn? What information does a clinician need to have to optimally serve her or his patients in today's health care environment?" (p xiii) Thus, they put together a group of addiction specialists to create this pocket guide which should serve "a wide range of clinicians—general psychiatrists, internists, family practitioners, pediatricians, emergency medicine physicians, residents and fellows from all specialties, medical students, allied professionals," (p xiii) and everyone interested in helping patients with addiction(s).

The guide is divided into 3 parts: I. "Fundamentals of addiction"; II. "Substances and behaviors"; and III. "Treatment." Part I consists of 3 chapters. The first chapter, "Neurobiology of addiction," is a brief summary of neurobiology by the National Institute on Drug Abuse. It emphasizes that the diminished sensitivity of reward circuitry that occurs in addicted individuals "… is now known to be accompanied by greater recruitment of the stress or 'anti-reward' systems that naturally act in opposition to reward, striving to maintain the motivational system in a state of balance (homeostasis).… Thus, addicted individuals, for whom this motivational system is dysregulated, are driven to escape intolerable stress as much as by the need to experience reward" (p 4). Chapter 2, "Addiction assessment across settings of care," is a useful and practical text for all specialties dealing with addicted individuals. It provides examples of common clinical scenarios that should trigger screening for substance use disorder in: pediatrics and adolescent medicine; primary care and medical subspecialties; emergency and hospital medicine; anesthesiology and surgical specialties; obstetrics and gynecology; and geriatrics. It also summarizes the clues for substance use disorder during general examination (eg, ear, nose, and throat: signs of "meth mouth," signs of inhalant use—rash around the nose and mouth); principles of how to approach the patient; barriers to care such as time-pressured visits, delayed treatment rewards; common relapses; psychosocial and financial issues; and how to overcome them. Chapter 3, "DSM-5 diagnosis and toxicology," provides a great overview of drug testing, starting with a discussion of drug testing settings (clinical, work place and criminal justice system, at home) and continuing with drug testing types (immunoassay, gas chromatography/mass spectroscopy); masking of drug use (eg, switching to "designer drugs," which are close to the original drug but not detectable on routine screening; substituting another person's urine; using a fake penis; taking

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diuretics; ingesting a large amount of sodium bicarbonate [baking soda]); selecting specimens for testing (pros and cons of urine, blood, oral fluid, sweat, hair); and detecting commonly used substances (levels, how long they are detectable).

Part II includes 11 chapters on main addictions: "Alcohol"; "Anabolic-androgenic steroids"; "Benzodiazepines"; "Caffeine"; "Cannabis"; "Hallucinogens and dissociative drugs"; "Inhalants"; "Opioids"; "Stimulants"; "Tobacco"; and "Behavioral addictions" (mostly gambling). All these chapters follow a general format: (1) Pharmacology; (2) How to recognize intoxication; (3) What to do about intoxication; (4) How to recognize withdrawal; (5) What to do about withdrawal; (6) How to recognize addiction; (7) What to do about addiction; (8) Special issues with psychiatric comorbidities; (9) Special issues with medical comorbidities; and (10) Special issues with specific populations. The chapters include DSM-5 diagnostic criteria for substance-specific intoxication, withdrawal, and use disorders (including gambling disorder). The chapters are succinct, informative, and useful. I was a bit disappointed by the chapter on benzodiazepines. Some of the "facts" were a bit puzzling, such as the frequency of benzodiazepine dosing in one table. Why would anyone dose clonazepam 3 times a day? The Key Points of this chapter (a feature of all chapters) also recommend that benzodiazepines should not be considered first-line treatment for anxiety and insomnia. This statement should be more grounded in clinical practice; it depends on the patients, whether he (she) abuses substances, etc. The chapter also should have emphasized that benzodiazepine abuse alone is rare. The chapter on caffeine provides some interesting recommendations and facts, such as that pregnant women should not consume more than 200 mg/d of caffeine (one 12-ounce cup of brewed coffee) and that a full tablespoon of caffeine powder contains 3,200 mg of caffeine, the equivalent of sixteen 12-ounce cups of brewed or drip coffee! The solid chapter on *Cannabis* mentions that *Cannabis* smoke contains a higher density of tar and a greater number of carcinogens than tobacco smoke (it is just smoked less frequently).

The chapter on hallucinogens and dissociative drugs divides these drugs into classic (serotonergic) hallucinogens (LSD, psilocybin, mescaline, N,N-dimethyltryptamine); atypical hallucinogens (MDMA, substituted phenethylamines [designer drugs]; and Salvinorin A [*Salvia*]), and dissociative drugs (PCP, ketamine, dextromethorphan). The chapter also emphasizes that what occurs during the use of hallucinogens are not hallucinations but perceptual alterations of genuine sensory input, more correctly called "illusions." The chapter on inhalants presents an amazing array of inhalants' adverse effects physicians rarely consider/recognize. The chapter on opioids contains a number of useful tips, including how to manage acute pain in patients receiving methadone maintenance treatment. The chapter on stimulants discusses not only the use of cocaine and amphetamines but the use of "bath salts" (synthetic cathinones), piperazines (benzylpiperazine, originally an antihelminthic compound), and Ephedra.

Five chapters of Part III cover "Cognitive-behavioral therapy"; "Relapse prevention"; "Motivational interviewing"; "Twelve-step programs and spirituality"; "Mindfulness and mentalization"; and "Diet and exercise." These chapters cover the basic principles of each therapeutic approach and its effectiveness, and will be appreciated especially by novices in therapy, as they are very instructive, yet written in a simple, understandable language. I was intrigued by the chapter on diet and exercise, because these areas have not been emphasized enough in the comprehensive management of addictions. The discussion on diet suggests tailoring nutritional counseling to stages of use and recovery and encourages the use of multivitamins. It also encourages exploring with the patient how cessation or moderation of substance use affects food choices, appetite, sleep, and weight. The discussion on exercise recommends starting with simple activity, such as walking for active substance users.

This little book is really what it promises to be: a solid guide that one can use easily in various clinical situations by pulling it out of his (her) pocket. Although it is "just a pocket guide," one learns a lot by reading it. It will serve well all those the authors intended it to serve—all clinicians involved in assessing and treating patients with substance use disorders. It's definitely a good buy.

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

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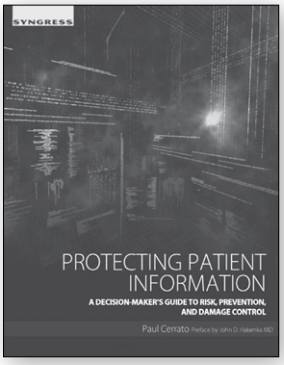
Protecting Patient Information: A Decision-Maker's Guide to Risk, Prevention, and Damage Control



By Paul Cerrato; Elsevier; Cambridge, Massachusetts; 2016; ISBN 978-0-12-804392-9; pp 162; $49.95 (paperback).

Understanding computers and informatics is a bit difficult for most clinicians. It is a different world for most of us. Yet, we are becoming, or already are dependent on, computers, internet, and other technology. Most of medical information is stored in the form of electronic medical records and is transferred via the internet, in addition to a small portion being transferred via fax or telephone. As we know, most, if not all, medical or health information should be protected, as stipulated and outlined in various laws and regulations governing health care security, including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH). However, is all the protected health information (PHI) really protected and our computers and other devices secure? We all know that this is not always the case. As John Halamka notes in the Preface to this slim volume "… if you have an internet connected device, it will be compromised" (p xv).

Compromised device means that the PHI available on that device will be stolen, similar to a huge amount of other data stolen every day, or every minute (eg, identity theft, bank and retailer data, credit card numbers). Why is medical data being stolen? For numerous reasons similar to reasons for stealing other data. As Paul Cerrato, author of this book, writes in chapter 5, "Just how valuable is a patient's medical identity on the black market? Estimates vary between $6 and $50 per record, with some researchers suggesting it is far more valuable than credit card numbers. Thieves have been known to use medical identity information to submit fraudulent bills to Medicare, fill prescriptions for narcotics, buy medical equipment, and have expensive procedures done leaving others with the bill" (p 51). Thus, we all need to safeguard PHI.

It is clear that an airtight security system preventing PHI from being exposed does not exist. "No matter how much you invest, you cannot guarantee complete protection of your records. Fortunately, government regulators do not expect it. They expect organizations to take reasonable measures to prevent a breach, and to report data exposure should it occur" (p 14-15). That is the focus of this small book: reasonable protection of PHI, including risk assessment, prevention, and damage control.

The book consists of preface, 10 chapters, and an appendix. The first chapter introduces the topic in "dissecting a book title." The remaining chapters cover the following topics: "How well protected is your protected health information? "Perception versus reality"; "Regulations governing protected health information"; "Risk analysis"; "Reducing the risk of data breach"; "Mobile device security"; "Medical device security"; "Educating medical and administrative staff"; "HIPAA, HITECH, and the business associate"; and "Preparing and coping with a data breach." As Paul Cerrato explains, his primary objectives in writing this book were 2-fold: "First, to provide convincing evidence to show that the price of making your organization more secure is far less than the cost of not shoring up your defenses. And second, to describe *in plain English* the technological tools, policies, and procedures that will strengthen the digital walls built around your patient data" (p 1). He adds that his aim "… is also to address the issues that clinicians 'in trenches'

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have to deal with as they cope with the inconveniences, workflow disruption, production slowdowns, and general frustration that too often occur when an organization becomes more security conscious" (p 1).

The discussion on how well our PHI is protected brings numerous examples of security breaches from various health organizations and hospitals around the country. It emphasizes that the cost of insecurity is steep and warns about fines imposed by the government. However, government fines are only part of the problem; the costs rise with prices of forensic evaluation to determine how the breach happened, notification of patients, and possible legal defense. The chapter on regulations governing PHI provides a good explanation of HIPAA privacy vs security rules. It explains well which information can be released to patients and which information patients may be denied access to (eg, psychotherapy notes, information for use in legal proceedings). It also emphasizes one issue some of my colleagues are confused about: when to seek permission to share data. We should all note that, "The Private Rule requires your organization to seek the permission of patients to share their medical information with others, with some exceptions. Clinicians do not have to ask permission when they share medical data with other clinicians for the purpose of treating the patient—but they need to be especially careful that this information arrives at the correct destination, whether it is in written, oral, or electronic format" (p 23). The chapter also discusses the role of various federal agencies, such as the Federal Trade Commission, to which data breach has to be reported.

The data on risk analysis provides step-by-step guidance or action plan to risk analysis and security management. It includes a useful table with examples of potential information security risks with different types of electronic health records. Finally, it also guides the reader to some the U.S. Department of Human and Health Services (HHS) Office of Civil Rights and the HHS Office of General Counsel resources. The chapter on reducing the risk of a data breach tells the reader that the best mindset in the era of constant threat of data being stolen is "guilty until proven innocent." The author warns about phishing: "90% of cyberattacks begin with such spear phishing emails" (p 52). He emphasizes that the most important piece of advice one can give to staff is "Do not click on hyperlinks embedded in an email unless you are absolutely certain it is from a legitimate source" (p 53). Other very informative parts of this chapter discuss and explain (in plain English!) issues such as passwords, encryption, firewalls, and anti-malware/antivirus software. Addressing the use of e-mail, the author cites the Office of Civil Rights recommendation regarding the use of e-mails: "[W]hile the Privacy Rule does not prohibit the use of unencrypted e-mail for treatment-related communications between health care providers and patients, other safeguards should be applied to reasonably protect privacy, such as limiting the amount or type of information disclosed through the unencrypted e-mail" (p 66).

The chapter on mobile devices warns about the use of various unchecked apps. Interestingly, it points out that Android devices are not safe, as 97% of mobile malware is located on Android devices, and "On the other hand, it is estimated that malware affects less than 1% of other mobile devices, including iPhones, Window phones, and Blackberries" (p 79).

For me, the most astonishing, and fear inducing, was the chapter discussing medical device security. Consider this quote from the book: "In 2011, Jay Radcliffe, a computer security researcher, demonstrated that he could hack into a Medtronic insulin pump and gain remote control of the device. Since then, Barnaby Jack, another security analyst, has shown he can cause some medical pumps to deliver fatal insulin doses from up to 300 feet away" (p 90). Paul Cerrato also emphasizes that it could, and does, take just a few seconds for the unprotected device to become infected and transmit data over the internet.

The remaining 3 chapters provide solid information on how to educate your staff, good discussion of business associate, and provide a plan to prepare and cope with a data breach.

This is an unusual, yet interesting and important small volume. I am not sure whether most clinicians would fully appreciate it. However, physician leaders, business executives of health care organizations, and those with smaller or

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bigger offices would find it useful. Considering the topic, it is highly readable. The author clearly fulfilled his objectives to provide evidence that it is cheaper to address the prevention of security breach than to pay for the breach, and to describe, in plain English, the technological tools, policies, and procedures involved in building digital walls around one's data. It is a brave, yet dangerous, digital world we live in.

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

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.

Foundations of Consultation-Liaison Psychiatry: The Bumpy Road to Specialization. By Don R. Lipsitt; Taylor and Francis Group; New York, New York; 2016; ISBN 978-1-1389-0625-9; pp 314; $61.95 (paperback).

Balanced Ethics Review: A Guide for Institutional Review Board Members. By Simon N. Whitney; Springer; New York, New York; 2016; ISBN 978-3-3192-0704-9; pp 131; $59.99 (paperback).

Ordinarily Well. The Case for Antidepressants. By Peter D. Kramer; Farrar, Straus and Giroux; New York, New York; 2016; pp 310; $ 27 (hardcover).

Pocket Guide to Addiction Assessment and Treatment. Edited by Petros Levounis, Erin Zerbo, and Rashi Aggarwal; American Psychiatric Association Publishing; Arlington, Virginia; 2016; pp 363; $65 (paperback).

The American Psychiatric Association Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patient with Dementia. By Guideline Writing Group (Chair Victor I. Reus); American Psychiatric Association Publishing; Arlington, Virginia; 2016; ISBN: 978-0-8904-2677-7; pp 218; $65 (paperback).

Study Guide To Geriatric Psychiatry. A Companion to the American Psychiatric Publishing Textbook of Geriatric Psychiatry, Fifth Edition. Edited by Philip R. Muskin and Anna L. Dickerman; American Psychiatric Association Publishing; Arlington, Virginia; 2017; ISBN 978-1-6153-7045-0; pp 352; $62 (paperback).

Study Guide for the Psychiatry Board Examination. Edited by Philip R. Muskin and Anna L. Dickerman; American Psychiatric Association Publishing; Arlington, Virginia; 2016; ISBN 978-1-6153-7033-7; pp 482; $89 (paperback).

People with Mental Illness in the Criminal Justice System: Answering a Cry for Help. Practice Manual for Psychiatrists and Other Practitioners. By The Group for the Advancement of Psychiatry Committee on Psychiatry and the Community; American Psychiatric Association Publishing; Arlington, Virginia; 2016; ISBN 978-0-8731-8219-5; pp 211; $29.95 (paperback).

A Clinical Guide to Psychiatric Ethics. Edited by Laura Weiss Roberts; American Psychiatric Association Publishing; Arlington, Virginia; 2016; ISBN 978-1-6153-7049-8; pp 382; $75 (paperback).

Psychodynamic Treatment of Depression. Second Edition. By Fredric N. Busch, Marie Rudden, and Theodore Shapiro; American Psychiatric Association Publishing; Arlington, Virginia; 2016; ISBN 978-1-6153-7035-1; pp 256; $65 (paperback).

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