folds as these young professionals seek a bolder, more inclusive truth.

The reader is provided the opportunity to see the space around the questions these doctors ask as they pose research questions. Each new question creates a new context for finding the truth. Initially they are not working together and are unaware of each others' work. Yet they are breathing the same air. The impact of the intellectual and political culture of the 1970s, the push for greater freedoms, and the understanding and respect for individuals begins to filter directly into the work of Gilligan, Miller, and Herman.

Robb describes the impact of the scholars' work and the contributions of their colleagues, students, and patients. The contributions made to the knowledge base in clinical psychology, psychiatry, and education are clearly detailed. The author credits each of the scholars and reveals the magnitude of their findings. The paradigm in clinical care, theory building, and psychiatry is shifted. Being in relationship becomes the new model. Truth finding reveals that interaction and relationships are the states of health and the conditions that human beings seek. Health is no longer viewed as the lone individuated self. The lone genius who builds theory in isolation is also brought to question.

Robb takes the time to contextualize the theoretical giants Freud and Erikson, to see the environments from which they grew and the forces that drove them to see health from a context of interpersonal separation versus connection. Robb describes how Freud and Erikson's work could never be separated from their cultures. Both men received positive support from their colleagues, and both stirred up controversy. They worked in intellectual and academic environments and learned through interactions with others.

The reach of the new paradigm enabled the scholars to explore uncharted areas of research. Before the 1970s, rape was an unspoken event, thought to be experienced by a rare few. It was believed that trauma itself occurred mainly to soldiers and was poorly understood. The incidence of incest was sited in clinical literature as approximately one person per one million population. Often incest was considered a reflection of the victim's fantasized desire for the alleged perpetrator and was not taken seriously. Domestic violence was class based and not especially a mental health concern.

Mental health services in general were focused on individuals who could articulate conflict and demonstrate insight. Health was achieved when individuals separated and achieved states of increased independence from others. Male psychology was dominated by theories of male health as a chronic state of disconnection from others—dissociation and being emotionally cut off were states of wellness. Male wellness was the model for all individuals independent of sex, age, or culture. Listening to patients was considered valuable only to the extent that one could help them to conform to existing theories or at least to get them to verbally accommodate the therapist with agreement.

Gilligan, Miller, Herman, and their colleagues opened all these therapeutic locked doors. They allowed the spaces between people to exist in relationship. They allowed patients to breathe new fresh air and to receive sunlight. They allowed new ideas to enter the rooms of academia and healing. Over time, male colleagues joined them in reexamining doctrinaire theories and examining clinical taboos.

This Changes Everything is a most valuable contribution to the history of clinical psychology and psychiatry. For the classically trained researcher it will offer a summary of the evolution of the caregiver's relationship to the patient and to practice. For the newly trained it will fill in the gaps in the history of care, from the attitude of "we know better" to "we will work together to understand this." We are repeatedly reminded in this book to listen, to not know, and to care. The context, the relationship is the center of healing and learning.

This is a book that contains great wisdom. It is well written and extremely accessible. Carol Gilligan, Jean Baker Miller, and Judith Lewis Herman demonstrate great courage in their clinical and academic work. The benefits we have received from them, their colleagues, students, and patients are immense. ♦

Loss, Trauma, and Resilience: Therapeutic Work With Ambiguous Loss

by Pauline Boss; New York, W. W. Norton, 2006, 251 pages, $27.50

Sandra L. Bloom, M.D.

I was driving in the car with two friends of mine, who are both psychiatrists, last weekend. One of my friends was discussing a particularly challenging problem she was confronting, and what came to my mind was Pauline Boss's book, *Loss, Trauma, and Resilience*, which I had just finished reading.

Dr. Boss has covered important territory, because she has focused on the neglected subject of loss, particularly as it applies to situations in which the person is physically gone but not dead. Into this category fall experiences as traumatic as having a family member who is kidnapped or a prisoner of war or whose body is never found after a disaster. Other circumstances are so unfortunately common that they are not generally classified as "traumatic," such as being a part of a family in which someone suffers from Alzheimer's disease, chronic mental illness, or addiction.

What these situations have in common, according to Dr. Boss, is the condition of ambiguous loss—situations in which it is not known if a

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loved one is dead or alive, is absent or present, or is in or out of your family or relationship. In some cases, the ambiguously lost person is physically absent but remains uncomfortably psychologically present. In other cases the lost person is physically present, but the person he or she once was is gone in some fundamental ways. In such cases, the classical notion of "closure" becomes impossible. The actual experience of ambiguous loss is so universal that Dr. Boss questions the viability of closure as a useful concept. She asserts that in fact "closure is a myth" and that "perhaps the reason we talk so much about closure is that we can't stand the pain."

Although Boss spends a great deal of time in the book discussing her theoretical premises and the therapeutic frameworks that inform her work, she is obviously an experienced family therapist, and the meat of this book for clinicians comes from the therapeutic guidelines that clearly derive from a wealth of practical, hands-on experience with suffering individuals and families. She does not deny the traumatic losses she has encountered, but her experiences have taught her about the resilience that often lies in the background of families who brush up against, or are hit with the full force of, tragedy.

The book has some redundancy, which can be forgiven in service of the value of repetition. The chapter on trauma and stress is weakened by the lack of reference to other people in the field of traumatic stress studies who have been carefully enumerating the connections between trauma and loss.

This decidedly is a book worth reading, especially for new therapists in the field, because it reminds us all that both psychodynamic and family systems principles are as relevant today as they were in previous decades. For human beings, attachment and loss remain central to our existence on this planet. ♦

Mood and Anxiety Disorders During Pregnancy and Postpartum

edited by Lee S. Cohen, M.D., and Ruta M. Nonacs, M.D., Ph.D.; Arlington, Virginia, American Psychiatric Publishing, Inc., 2005, 164 pages, $41.95

Nafisa Ghadiali, M.D., F.R.C.P.C.

Should women with mood and anxiety disorders be treated with medication while they are pregnant or postpartum? Are nonpharmacologic interventions viable alternatives to medications during pregnancy or lactation? These crucial questions have no simple answers, yet patients frequently need evidence-based information about the course and treatment of psychiatric illness during pregnancy, the postpartum period, and lactation. Clinicians who provide care and advice to these women also need evidence-based information in order to weigh the risks and benefits of treatment and the risks of deferring treatment. *Mood and Anxiety Disorders During Pregnancy and Postpartum* offers clinicians practical, evidence-based information and guidelines for caring for their patients.

Edited by Lee Cohen and Ruta Nonacs, this book covers critical areas in the clinical care of women during pregnancy and the postpartum period. Its primary objective is to help the clinician collaborate with patients who have experienced or are currently experiencing psychiatric illness but who wish to conceive, who are pregnant, or who are in the postpartum period and plan to breastfeed.

The first chapter is an excellent review of the course of psychiatric illness during pregnancy and the postpartum period. It covers depression, bipolar disorder, anxiety disorders, and psychotic disorders. It emphasizes the risks of discontinuation of treatment and the risks of untreated illness for the mother and the neonate. The chapter substantiates the authors' contention that pregnancy is not "protective" with regard to risk for new onset or relapse of a psychiatric illness.

Subsequent chapters address the diagnosis and treatment of mood and anxiety disorders in pregnancy and postpartum. Nonacs' chapter on postpartum mood disorders is especially informative, with clear explanations of data about the detrimental effects of maternal depression on child development and well-being. This chapter also highlights the importance of health care professionals' awareness of postpartum depression, screening, early identification, appropriate treatment, and the fact that postpartum depression is not recognized frequently enough.

Another highlight of the book is a comprehensive, carefully researched section on psychopharmacologic treatment. The discussion of risks and benefits of pharmacologic treatment for pregnant psychiatric patients is very well written and meets the authors' central objective of helping clinician readers to be able to weigh the risks and benefits of medications. The authors point out that decisions regarding the use of psychotropic medications during pregnancy are ideally made before conception, and they discuss clinical approaches for doing so. The role of nonpharmacologic interventions is also rightfully highlighted. A subsequent chapter reviews the use of antidepressants and mood-stabilizing agents during breastfeeding, including a comprehensive summary of relevant published data. The authors correctly explain the limitations of standard sources of information about psychotropic medications during lactation, such as the *Physician's Desk Reference* and the American Academy of Pediatrics' periodically issued statements on the transfer of drugs into human breast milk.

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