Diagnosis and Treatment

American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2000, *Washington, D.C., APA, 2000, 738 pp., $74.95 (paper).*

Surveys conducted by APA suggest that psychiatrists in clinical practice spend most of their time diagnosing and treating patients with anxiety and mood disorders, psychosis, dementia, and chemical dependence. These broad groups encompass a lot of patients and represent multiple diagnostic strategies, treatment modalities, and nuances of the doctor-patient relationship.

Research on psychiatric diagnoses will continue to sharpen our focus on the patient's symptoms and suffering. Research on psychiatric treatments will continue to provide excellence in patient management. Total patient care will be improved only if we can determine what is known today about the best ways to help our patients. This is the focus of the guidelines contained in this new edition of the *American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders,* required reading for every mental health clinician.

Decisions made at the beginning of the Practice Guidelines project permitted APA to present guidelines covering the disorders that are most common, most often lead to disability, are most lethal, and are most amenable to treatment.

A unique characteristic of the Practice Guidelines series is the presentation, under the rubric of psychiatric management, of a broad array of interventions and activities that should be instituted by psychiatrists for all patients, regardless of the specific treatment modalities selected, and continued throughout all phases of treatment. Psychiatric management includes a complete diagnostic evaluation, consideration of the safety of the patient and others, evaluation of impairment, determination of treatment setting, establishment and maintenance of a therapeutic alliance, and monitoring all these variables in an ongoing fashion throughout treatment.

At a time when psychiatry is challenged by those who would focus on cost containment, psychiatrists can use these guidelines to prove that quality can be provided at a cost that enhances the value of treatment for the patients and all those around them. Knowledge of the guidelines is paramount to APA's effort to maintain the clinical excellence that has characterized the best strategies in timely, appropriate, and effective psychiatric care.

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The Psychiatric Interview: A Guide to History Taking and the Mental State Examination, *by Saxby Pridmore. Amsterdam, Harwood Academic Publishers, 2000, 146 pp., $38.00; $22.00 (paper).*

Modern psychiatric practice and research rely heavily on structured pencil-and-paper instruments for diagnosis and for following symptom severity and change. The move to standardized assessment, which gathered momentum in the 1960s, has been enormously important to progress across all facets of our field, from epidemiologic and treatment research, to biological psychiatry, to the training of students and residents. It has also had its maddening aspects, such as the rote application of checklists to determine the need for treatment in managed care settings. This grim example, all too commonly encountered, serves as a reminder that first-rate psychiatric assessment is a complex craft requiring the observation and integration of multiple signs and symptoms with well-honed clinical judgment and that this should not become a lost art.

Enter Saxby Pridmore's *The Psychiatric Interview*. The title is something of a misnomer in that the book is not a guide to diagnostic interviewing and DSM-IV diagnosis per se. Rather, it is a thorough treatment of the mental status examination that is clinically sound, understandable, and enlightening. For each domain—appearance, speech, mood, affect, thought, perception, intelligence, cognition, rapport, and insight—a chapter is devoted to description of the many more common as well as less common signs and symptoms that are germane to psychiatric assessment. The signs and symptoms are carefully described, along with suggestions about how to elicit them during the interview. Numerous examples are provided in the form of photographs, sketches, and writing samples of patients, drawn from the author's wealth of clinical experience. These serve to illustrate several phenomena, particularly disorders of thought and mood, that are difficult to appreciate through text alone. A closing chapter on office assessment of frontal lobe function is brief but highlights an important domain not often considered in the routine clinical examination.

In summary, this is an excellent text for advanced trainees in psychiatry and related fields, as well as for experienced practitioners and teachers who wish to bone up on the fundamentals of the mental status examination. One does sometimes wish that the discussion were more rooted in the contemporary research literature in addition to the author's rich clinical experience. However, this would surely lengthen the text and maybe dampen its impact as a concise training tool. The text may be too detailed for beginning medical students, but it certainly will be useful in the training of psychiatric residents, neurologists, and primary care physicians with an interest in disturbances of mental status, as well as psychologists and psychiatric nurse practitioners and social workers.

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Hitler: Diagnosis of a Destructive Prophet, *by Fritz Redlich, M.D. New York, Oxford University Press, 1999, 448 pp., $35.00.*

Adolf Hitler was 11 years old 92 years ago, when Fritz Redlich was born. They lived in Vienna at the same time: Redlich a psychiatrist with a medical degree from the University of Vienna and Hitler a failed art student and draft dodger. Redlich, a Jew and a socialist, left Austria when it became part of Germany. Six of his relatives who did not leave perished in the concentration camps. The two men never met, but as a

psychoanalyst, Redlich was moved to attempt to understand what kind of man could rise from humble origins, without an education, to become a mass murderer and the most influential figure of the 20th century. The final impetus for this book was the emergence of Holocaust deniers and the movement that attempted to excuse Hitler's actions as the result of mental illness, "the insanity defense." As Redlich says, "One of the largely unresolved questions is whether physical illness or mental disorder could contribute to an understanding of his behavior. That is the topic of this book, the only topic to which I—not a historian by profession—could make a contribution."

By separating "physical illness" from "mental disorder," Redlich betrays a bias of his psychoanalytic background, that mental illnesses are not physical but are the result of intrapsychic processes resulting largely from early childhood experiences and parental abuse. Redlich regrets that we know nothing of Hitler's toilet training or the content of his dreams, but he is quick to formulate the unsupported opinion that Hitler had a congenital malformation of the penis (hypospadias) and spina bifida. At autopsy (by the Russians, not necessarily a reliable source), Hitler was found to have had only one testicle, but this was never reported by any physician who examined him while he was alive.

From hypothetical genital malformations to the invasion of Poland is a giant leap, even for a psychoanalyst. Others have suggested that Hitler had the "encapsulated eldest son syndrome" (1), a "Messiah complex" (2), "borderline personality" (3), or the most well-documented and reasonable psychiatric explanation by Hershman and Lieb (4), who suggested that he was "a paranoid, manic depressive megalomaniac whose illness made him capable of the most monstrous crimes—indeed made him eager to commit them."

There were 802 books listed on the web site of a major publisher when the search term "Hitler" was entered. Do we really need another one? If there were new information, perhaps a previously undiscovered diary or the deathbed testimony of an associate (Hitler had no friends), it would be worthwhile. At least Redlich discloses his motivation. Unfortunately, he does not keep his promise; he does not make a diagnosis. He cannot be blamed, however; even Freud refused to make a diagnosis of Hitler's pathology because he had never examined him.

The book begins with a chronological account of Hitler's life and the course of Germany's rise from the fires of World War I to a powerful world empire. There are many other books that tell the same story, and Redlich refers to many of them. If the reader wants to see what the latest scholarship reveals, the best of the new crop of history books are the two-volume work by Ian Kershaw (5, 6) and *The Third Reich* by Michael Burleigh (7).

Redlich's book is scholarly, has a huge bibliography, and is thoroughly researched, but he fails to connect Hitler's words and acts to the known facts of his medical history. For instance, Hitler missed several months of grade school with a serious pulmonary illness, but it is not clear whether Redlich considers that the simple fact of falling behind can discourage a student. Instead, he argues that the illness was not tuberculosis. Hitler's brother, Edmund, died of measles encephalitis when Adolf was 11 years old. Redlich dismisses out of hand the possibility that an infection of the same encephalitis may have influenced Adolf's future life (although he refers to that hypothesis by Johann Recktenwald on page 234). He does not mention that measles regularly produces EEG changes in children when acute. Since Still's classic descriptions in the 1902 Coulstonian Lectures (8), we have known that encephalitis produces subtle changes in "moral control." According to Still, "The child with only slight intellectual impairment may show far greater moral defect than a child with more impaired intellect." Encephalitis in early life can lead to Parkinson's disease in middle life, and we know that Hitler had Parkinson's disease. It would be amazing if this degenerative brain disorder did not affect Hitler's judgment in the light of the frontal lobe defects and major depression that often accompany it.

This is not to excuse Hitler his anti-Semitism, which was both endemic in Europe and a ticket to his appeal to the masses, but it may serve to explain his violent mood swings, paranoia, and lack of a moral compass. His well-documented amphetamine abuse could have increased his paranoia and impaired his judgment, particularly in the presence of a preexisting organic brain syndrome.

Hitler may have been a product of his times, but he was a great orator, the inventor of the multimedia political campaign, and a man of prodigious memory for detail. He wrote, "I know that men are won over less by the written than by the spoken word, that every great movement on this earth owes its growth to our great orators and not to great writers" (9).

Redlich labels Hitler a "destructive prophet," and Hitler considered himself to be the Messiah. He wrote his manifesto, *Mein Kampf* (9), while in Landsberg prison. He shares his literary use of prison time with other writers such as Saint Paul, Seneca, Cervantes, Bunyon, Voltaire, Dostoevsky, Solzhenitsyn, Martin Luther King, and Iceberg Slim (Robert Beck). Prison has a way of focusing the mind and allowing the lost to find their way. Little is made of this book, in which Hitler set forth his anti-Semitic and anti-Communist paranoia and his plan for racial "purification" through eugenics.

Hitler won the Iron Cross in World War I. He was not a coward, nor was he a leader in that war. Having Germany's highest military honor certainly helped his political career. He had an attack of hysterical blindness several weeks after being wounded by poison gas in the trenches. The "miraculous" recovery of his sight and some auditory hallucinations contributed to Hitler's delusions. Redlich does not connect the episode of psychophysiological reaction to further developments in Hitler's life except to show how he took steps to cover up the episode. Whether you call this book "psychohistory" or Redlich's term "pathography," it is an example of the case history method pioneered by Adolf Meyer, Professor at Johns Hopkins, and his wife Mary, the first psychiatric social worker.

Unfortunately, a psychiatric evaluation requires not only a detailed history but also a medical-physical examination, a mental status inventory, laboratory tests, and sometimes brain imaging. Some of this information may be gleaned from historical sources and the medical records that exist, but Redlich, in the end, does not provide the promised diagnosis that the title leads the reader to expect. After 448 pages we learn, "*Er war ein schlechter mensch*" [He was an evil man].

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To Redeem One Person Is to Redeem the World: The Life of Frieda Fromm-Reichmann, *by Gail A. Hornstein, Ph.D. New York, Free Press (Simon & Schuster), 2000, 480 pp., $35.00.*

As a young resident I absolutely idealized Frieda Fromm-Reichmann. I studied her two wonderful books (1, 2), which had just been published. I spent many hours, days, and months struggling in intensive psychotherapy with patients with schizophrenia at a time before we had the aid of the neuroleptics. Her approach, developed along with that of Harry Stack Sullivan, has influenced my work with all patients to the present day, and I am still writing and teaching about her (3, 4). I met Dr. Fromm-Reichmann (1889–1957) only once at a meeting of APA and was enormously impressed by the sensitivity of this little woman, who with a gesture could convey more than a lecture. I was never privileged to observe her actually performing psychotherapy with patients with schizophrenia, and, although I am not a movie aficionado, it is my intuitive feeling that the middle-aged male therapist portrayed in the wonderful classic *David and Lisa* used a technique and had a personality quite similar to hers. She of course was also the therapist in the best-selling book *I Never Promised You a Rose Garden* (5).

The book under review here is a biography written by a professor of psychology at Mt. Holyoke College who is also listed as the director of the Five College Women's Studies Research Center in Pioneer Valley, Mass. Anyone interested in the practice of psychoanalytically oriented psychotherapy needs to be familiar with Fromm-Reichmann's work, which has a contemporary value quite unusual for publications written half a century ago, so readers can imagine my delight when greeted by the appearance of a full-scale biography of Frieda Fromm-Reichmann. The reader can also imagine my disappointment, then, when I found that from the beginning it is extremely hostile to psychiatrists. We are told, for example, that psychiatrists are "the people fighting hardest against this idea" (p. xiv), i.e., the idea that relationship can heal severe mental illness, and that "most psychiatrists, accustomed to treating 'the worried well,' find the unbearably slow pace of therapy with psychotics intolerable" (p. xv). The author claims that "psychiatry's despair is so profound the field can scarcely be imagined without it" (p. xix) and that "the very idea of psychotherapy with schizophrenics had been made to seem preposterous by a mental health establishment addicted to drug treatment" (p. xxii). Since the author was born in 1951, she is perhaps unaware that in the 1950s the entire psychiatric establishment was working furiously to establish the principles of psychoanalytically oriented psychotherapy for schizophrenia and that working intensively with such patients was part of the training in every reputable residency program in psychiatry in the United States. The prodigious cost of such therapy over many years of time was borne by the insurance industry.

In the second half of the 20th century there was a dramatic breakthrough in psychopharmacology. At that time the profession was engaged in "schizophrenogenic mother"-bashing, which finally came to an end, not under the influence of increased understanding of the psychodynamics of schizophrenia but because of the dramatic improvement shown after pharmacotherapy by many patients with schizophrenia, especially with the latest wave of neuroleptics. It does not follow from this that psychotherapy for schizophrenia is to be abandoned, but since the use of psychopharmacological agents in the psychoses has been demonstrated by the strictest scientific standards to produce improvement in many cases, every patient deserves a trial of such agents by experienced practitioners. There is no need for a polarization between psychopharmacological treatment and the use of intensive psychotherapy in psychiatry; such a polarization is simply a mark of narrow-mindedness.

The author of this book sets up a dramatic controversy that I do not think Frieda Fromm-Reichmann would approve of because, as the author herself correctly states, "She was willing to try practically anything that might help them, which was a great deal more than most other psychiatrists were willing to do" (p. xv). Furthermore, it is simply not true, as the author claims, that Fromm-Reichmann's approach "had been repudiated and then literally expunged from the history books" (p. xxiii). There has been no secret plot and no conspiracy, only the search for cost-effectiveness.

I do not think that Fromm-Reichmann would care for such a grandiose title as *To Redeem One Person Is to Redeem the World*. The proper title of the book should be *A Biography of Frieda Fromm-Reichmann and a History of Chestnut Lodge.* In the early chapters we are acquainted with standard biographical information about Fromm-Reichmann. There is a curious emphasis on the influence of her background of orthodox Judaism on her thought and theoretical approach, and I am not qualified to judge whether this is accurate or overdone. Her first and only husband, Erich Fromm, was originally her patient and had an affair with her during the analysis. They "later married to preserve appearances" (p. 60). The author tells us that Fromm-Reichmann treated her husband (and men in general) like an amusing child and indulged his whims; eventually they divorced, and Erich Fromm began an affair with Karen Horney. We are treated to such psychoanalytic interpretations as, "Unconsciously, in other words, Frieda had been pregnant with Erich's child" (p. 69). We are told that in Königsberg she was raped but "she always blamed herself for everything bad that ever happened" (p. 70). The author feels that this explains to some extent why she "downplayed the role of sexual factors in pathology" (p. 71) and had "buried sadism in her attitude toward men" (p. 72).

The author reports that in 1935, as a refugee to the United States, Fromm-Reichmann was lucky to find a 2-month assignment at Chestnut Lodge, where she remained for about 20 years. This launches the book into a complete history of the famous Chestnut Lodge, which, under the influence of Fromm-Reichmann and Harry Stack Sullivan, became internationally famous for the treatment of schizophrenia. The author claims that "in warning against the danger of a 'schizophrenogenic mother,' Frieda was unconsciously praising her own mother for a sense of balance as much as she was lashing out at her for being controlling" (p. 135).

Although the book vilifies psychiatrists on many pages, the author explains at the same time that Fromm-Reichmann's work "inspired a whole generation of young psychiatrists to try to create truly therapeutic environments for people assumed to be beyond reach" (p. 172). As a member of that generation, I can attest this is true. Her life was essentially uneventful from the time she came to Chestnut Lodge, where she was immersed in the intensive psychotherapy of patients with schizophrenia and some with manic-depressive disorder. The author claims that "by the mid-1950's, the Lodge had become a place of last resort, where mainstream psychiatry dumped its failures and forgot about them" (p. 292).

We are given many instances of Fromm-Reichmann's patience and intuitive skill, a skill that cannot for the most part be taught, only improved with one's personal psychoanalysis. The author claims that the gradual abandonment of efforts to do psychotherapy for schizophrenia by the psychiatric profession was attributable to the fear psychiatrists have of psychotic patients; she does seem to understand that most people did not and do not have the kind of unique capacities that Fromm-Reichmann possessed. So when authorities complained that her approach could not be universally applied, the author attributes this hard-headed demand for empirical reality testing to malevolent motives. She has no patience with those who dare to question Fromm-Reichmann's work. Criticism came from "orthodox analysts, irritated by Frieda's deviations from party doctrine, and from experimental psychologists, irked at her omission of their empirical findings" (p. 301).

Fromm-Reichmann's sad and lonely death is poignantly described, and a long chapter on the bestseller *I Never Promised You a Rose Garden* is appended, in my judgment for the purpose of encouraging attempts to do intensive psychotherapy with patients with schizophrenia. The famous lawsuit brought by Osheroff against Chestnut Lodge because he had not received appropriate psychopharmacological treatment there is explained as follows:

> By embracing only those disorders that defy understanding or can't be treated, psychiatrists have allowed impotence to replace failure and made abdication their creed. They cover their hopelessness with a veil of verbiage about experimental treatments and breakthroughs in the limitless worlds of genetics and brain research.… Having colluded with legislatures bent on saving money in emptying the state hospitals, sending most seriously ill patients off to nonexistent "community care," psychiatrists can't allow themselves to consider alternatives to biological models of mental illness that open them to charges of moral negligence. (pp. 387–388)

In summary, this book presents the carefully researched life of Frieda Fromm-Reichmann but is spoiled by the author's psychiatrist-bashing and her attempt to set up a polar opposition between psychiatrists who are oriented to the intensive psychotherapy of schizophrenia and those who are oriented to biological treatment: "Warfare in psychiatry, endemic for a hundred years, is finally dying out only because insurance companies have starved both sides into submission by refusing to pay for treatment of any kind" (p. 389). It does not seem to occur to the author, although she is right about insurance companies, who are the true enemies of psychiatry, that warfare in psychiatry is dying out because there is an increasing body of evidence indicating the best approach to the treatment of schizophrenia and many other mental disorders is a combination of intelligently applied psychopharmacological and psychotherapeutic techniques.

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Health and Disease in Human History: A Journal of Interdisciplinary History Reader, *edited by Robert I. Rotberg. Cambridge, Mass., MIT Press, 2000, 345 pp., $60.00; $25.00 (paper).*

Medicine has long had a love affair with history. Psychiatrists, relying almost exclusively as we do on the personal histories of our patients, may be the physicians most vulnerable to this romantic affliction. It is hard for even the strongest willed of us to resist the temptation of revisiting the past, of diagnosing away and fancying on the possible outcomes that the tools of our day would have allowed. As a telling example, I learned as an impressionable young medical student that Beethoven had been afflicted with otosclerosis. Fair enough. His disease, alas, progressed to osteopetroses by the time of my internship and aggressively morphed into chronic lead toxicity and then into late-onset paranoid psychosis by the time I became a card-carrying psychiatrist. As armchair historians, psychiatrists have tended to be long in theory but short in (or oblivious to) actual data.

Health and Disease in Human History is an edited volume that brings together the best papers published in the *Journal of Interdisciplinary History* over the last 20 years. The book is a demanding read that covers a wide range of medical topics. Even if none of its 13 chapters deals directly with a psychiatric disorder, its overall tone and full-immersion approach to history make this book relevant. Whether the topic be fertility and pellagra in turn-of-the-century rural Italy or the tracking of an isolated community afflicted with intermittent porphyria in 19th-century Oregon, the bottom line is clear: a return

to the original sources is inevitable, indeed mandatory, in order to do justice to the past.

In their detective work, the chapter authors go to sources as detailed as they are geographically spread out. Daily prices of bread between 1550 and 1750 are meticulously recorded in order to reexamine whether adulterated bread could have contributed to excess infant mortality in London—plausibly so, we learn. Mountains of newly available sources in both Spanish and Nahuatl are translated in painstaking detail by one author to revisit the decimation of Meso-America through the introduction of smallpox from Europe—corroborating the long-suspected importance of this disease.

Medical history is sobering and serious at times, as in a chapter on the mortality associated with the slave trade, but, as the volume reflects, it can be amusing as well. In "Urban Sanitation in Preindustrial Japan" we learn that the rights to human fecal matter and waste (top-line fertilizers of the day) were so important as to lead to outright battles and aggressive legislation. More importantly, the value placed on fecal matter contributed to cities in Japan becoming more hygienic than their American and European counterparts, such as 1850s Paris and the "shockingly direct connection" between its sewage disposal and water supply).

Psychiatrists have not always been at fault when venturing into history; nor have they always failed to follow the rigors exemplified in this volume. In a recent essay on Emily Dickinson's work, for example, John McDermott (1) rolled up his sleeves by returning to the source—to the exact text and dating of each of her poems—in order to draw conclusions regarding the cycling of Dickinson's creativity and her possible underlying psychopathology. *Health and Disease in Human History* provides a useful guide to those who venture to revisit the past and epitomizes what can be accomplished by applying responsible and accurate historical methods. "Spare my past," pleads Stephen Dedalus in *Ulysses*. The nature of our calling makes us unlikely to spare *any* past. On that same account, we should show utmost diligence and respect when proceeding along.

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CHILD/ADOLESCENT PSYCHIATRY

Handbook of Neurodevelopmental and Genetic Disorders in Children, *edited by Sam Goldstein and Cecil R. Reynolds. New York, Guilford Publications, 1999, 602 pp., $70.00.*

Contemporary neurobehavioral assessment of children calls on clinicians to have a sophisticated knowledge base that spans the ever-widening biopsychosocial framework. Rapid advancements in behavioral genetics, neuropsychology, and developmental neuropsychiatry present a challenge for clinicians in their attempts to keep current with the state of the art and science in the field. The primary objective of the *Handbook of Neurodevelopmental and Genetic Disorders in Children* is to provide a stand-alone compendium of the impact of genetics on neurodevelopment in children. As such, the text brings together leading experts in genetics, neurodevelopment, developmental psychopathology, and neuropsychology to provide a magnum opus resource manual for clinicians.

The text is divided logically into three sections. Section 1, Basic Principles and Applications, is an overview of the role of neuropsychology in assessment, treatment, and management of children with neurodevelopmental and genetic disorders. This section contains excellent, detailed, and reasonably up-to-date information on comprehensive neuropsychological assessment instruments and assessment strategies as well as a contemporary primer on current models for understanding genetics and its importance in child neurobehavioral development. Topics including structural and biochemical differences in children with genetic disorders and the use of neuroimaging in diagnostic assessment are covered comprehensively, yet in a readable and easily understandable fashion. Psychosocial issues related to emotional, family, educational, and behavioral problems are covered with sophistication and nuanced insights that complement the more technical chapters. Section 1 provides a cohesive framework for understanding the complexities of neuropsychological assessment and medical genetics from which the remainder of the text flows.

Section 2 covers common disorders with presumed genetic etiologies: learning disabilities, attention deficit hyperactivity disorder (ADHD), Tourette's syndrome, anxiety disorders, autism, and pervasive developmental disorders. Each chapter presents a vast amount of information and relevant data in comprehensive reviews presented from a neuropsychological perspective. The chapters are well organized, detailed in terms of their presentations of assessment and treatment methodologies, and strongly buttressed by extensive references. A minor but forgivable criticism is that the medication treatment sections tend to be rather sparse and not up-to-date, although it is not a primary aim of the text to be a psychopharmacology manual. For example, there is no mention of the use of atypical neuroleptics in the treatment of Tourette's syndrome, nor does the ADHD chapter present data from the important multimodal treatment of ADHD study.

Where the chapters excel is in providing excellent historical overviews as well as specific and practical frameworks for assessment and treatment that are detailed and comprehensively biopsychosocial. Particularly strong is the chapter on learning disabilities, which presents a functional paradigm for intervention in tandem with a highly detailed account of the assessment process. One will not find a great deal of speculation; the authors stick close to empirical evidence in the writing of their chapters. In the chapter on learning disabilities, for example, one will find a balanced and proportional account of nonverbal learning disabilities in the context of general learning disabilities. The chapters are uniformly well written and cohesive; treatment recommendations follow nicely from the neuropsychological assessment strategies that are presented.

Section 3 of the text, the longest, contains 14 chapters overviewing less common genetically based disorders that are seen in academic and general practice settings. Examination of these relatively less common disorders is instructive regarding

the relationships between genetics and behavior. Syndromes covered in this section include Turner's, Tourette's, fragile X, Noonan's, phenylketonuria, Rett's, Prader-Willi, Klinefelter's, Down's, neurofibromatosis, and seizure disorders, among others. This section is particularly valuable for the updated information the chapters provide on genetic advances in the diagnosis and neurobiology of these disorders. Sensitive, detailed, and highly illustrative case vignettes are presented outlining the convergence of genetics and the neuropsychological and neurobehavioral phenotypes of the disorders. Clinicians who strive to understand the connection between genetics, brain function, and brain structure on the one hand and behavioral/psychological phenomena on the other will find these chapters highly satisfying and thought provoking. The chapters in section 3 are well referenced, and many include contacts, addresses, web sites, and online support/news groups for the respective syndromes. This is particularly useful for clinicians seeking to keep abreast of new developments and for providing information to parents and families.

In sum, Goldstein and Reynold's text succeeds marvelously in providing a comprehensive resource on genetic disorders and neurodevelopment in childhood. The book is to be recommended to clinicians, including child psychiatrists, pediatric neurologists, general and behavioral pediatricians, child psychologists and neuropsychologists, and especially those who may be several years out of training and wish to update their knowledge of the relationship between genetics and neuropsychology. For the practicing clinician involved in the day-to-day assessment and treatment of children, this text is a required resource on the bookshelf. The child clinician of the 21st century needs a working knowledge of genetics, neurodevelopment, and neuropsychology, even if these are not primary areas of interest or expertise. A working knowledge of these areas is essential for contemporary clinicians to be fully competent in assessing the range and complexity of children seen in clinical practice and to offer the most up-to-date treatment and management interventions.

The text has both great practical utility, e.g., providing discrete frameworks for assessment and detailed recommendations for interventions in learning-disabled children, as well as a cohesive wide-angle perspective on the vast, exciting, and promising area of the impact of genetics on neurodevelopment.

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What Works With Children and Adolescents? A Critical Review of Psychological Interventions With Children, Adolescents and Their Families, *edited by Alan Carr. New York, Routledge, 2001, 364 pp., $34.95 (paper).*

This attractively printed and bound volume is a compilation of 11 reviews of child psychiatric disorders by mental health professionals with bachelor's and master's degrees, supervised by the editor. The reviewers took all English-language publications in the psychological literature from 1977 to 1997, reportedly "the most methodologically robust investigations that could be located through computer and visual literature search methods." They subjected the material to tabulations of data and statistical analysis; this presentation of data takes up roughly half of the book.

The narrative text presents the methods and substantive findings of the psychological literature reviewed and offers the authors' conclusions as to what are effective treatment approaches at the end of the chapters on each disorder as well as at the end of the book, where all of the conclusions are presented once more. Most chapters present the findings under headings of Method and Methodologic Features, Substantive Findings, and main treatment approaches, such as Parent Training (of several types), Child-Focused Training (again, of several types), and Self-Instructional Training. Finally, each chapter ends with a Conclusions section. Although the emphasis is on behavioral approaches, some psychodynamic treatments are evaluated as well. The Conclusions sections address each disorder under the headings of "What Works?" and "What Does Not Work?"—the latter being invariably shorter. The authors also offer discussions of the implications of their conclusions for treatment and for the development of treatment delivery systems.

The editor has approached the entire project with the expanded question, "What works for that specific problem under which circumstances?" This question is pragmatic and, as the editor points out, counteracts the simplistic therapeutic nihilism of some of the older studies of psychotherapies.

In keeping with the editor's way of addressing this entire topic, we may ask ourselves, "What does this book offer to which reader?" It depends on what the reader's work in mental health consists of. The large amount of statistical minutiae will be welcomed by those doing research on purely psychological treatments. The practicing clinician will likely skip the tabulations and find plenty of interest in the narrative. It is my impression that the book is of greatest use to the experienced clinician, who will either find confirmation of his or her clinical wisdom or learn new treatment approaches. Examples of these are resilient peer therapy in child abuse, the "chronic care" model with "increased service contact at transitional points" in attention deficit hyperactivity disorder, and the use of family therapy in drug abuse. There are many more examples of treatments that are novel and helpful.

A very small weak spot is the coverage of psychopharmacology, which, fortunately, is extremely limited, occurring only in the context of attention deficit disorder and obsessive-compulsive disorder. The authors' coverage of pharmacotherapy shows their total lack of expertise in that field and, in the case of attention deficit disorder, had best been left out completely because it is quite misleading. One area that I wish were covered is that of pervasive developmental disorder and autism, where this team's critical review would be welcome.

Overall, this book can be recommended to a wide spectrum of readers because most readers can find either something new or a reaffirmation of their current treatment approaches. Moreover, administration and organizational impetus is often given by the authors under the heading of "Service Development," providing agency administration with data to implement treatment programs or changes in those programs.

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ADHD With Comorbid Disorders: Clinical Assessment and Management, *by Steven R. Pliszka, Caryn L. Carlson, and Jim M. Swanson. New York, Guilford Publications, 1999, 325 pp., $42.00; $22.00 (paper).*

Comorbidity in psychiatric disorders has been a major concern because it influences clinical management and course and may have etiological implications. This text reviews the literature on comorbidity in attention deficit hyperactivity disorder (ADHD) and how it affects clinical decisions. It identifies problems of differential diagnosis and systematically reviews the evidence for specific patterns of psychopharmacological treatment, as well as family history, for ADHD that is comorbid with various disorders. It also identifies the current controversies and disagreements in the field. On all these counts, the book does a superb job. The overviews are lucid and make for easy, enjoyable reading. The discussions of differential diagnosis and medication management are sensible, provide useful clinical suggestions, and will be of use to any clinician who deals with children who have ADHD.

The title does the book a disservice because the book not only discusses comorbidity but also guides clinicians on the value of different assessments in order to differentiate ADHD from other childhood disorders. As an example, the authors discuss the value (or lack thereof) of cognitive testing for differentiating ADHD from conduct disorder. They also provide comprehensive overviews of drug action and treatment guidelines for ADHD in general. All this is done in a reader-friendly fashion. One senses that the authors not only are scholarly but have much hands-on clinical experience enabling them to walk the reader through thorny clinical problems of differential diagnosis and pharmacotherapy. Pointed clinical case histories bring the issues to life.

In addition to reviewing psychiatric comorbidity in ADHD, which includes important coverage of mental retardation and pervasive developmental disorders, the book also summarizes current knowledge about the role of medical disorders in ADHD. The authors do not hesitate to take a stand, such as noting the weak evidence linking allergies to ADHD, but they do so in a dispassionate, thoughtful manner that promotes an appreciation of uncertainties in the field. Although the diagnostic and psychopharmacological evidence reviewed is data based, it is not dry and can be translated easily into clinical practice. The authors are to be commended for their contribution.

The same cannot be said of the book's sections on behavioral interventions. These are tacked on to the end of the text and not integrated into the issue of comorbidity. However, behavior management procedures are well described and informative. Unfortunately, the nonspecialist will be misled by the book's claims of efficacy. The authors report that there is ample evidence that behavioral intervention is effective in ADHD, but they do not substantiate this claim and provide no relevant references. This section stands in marked contrast to the rest of the book, which is meticulous in this regard. The book was published at a time when the results of the large multisite study of medication alone, behavior treatment alone, and medication and behavior treatment in combination with medication (1) were known. This study failed to document an advantage for the combination treatment over medication alone and did not support the efficacy of extended, intense, systematic multimodal behavioral treatment in children with ADHD. There is no mention of the trial in the book. It is unfortunate that standards for scholarship and clinical relevance that were applied to the sections on diagnosis, pharmacotherapy, and family history were not applied to the coverage of behavioral management. In every other respect, the book is a wonderful resource to anyone interested in what is known about ADHD.

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The Fate of Early Memories: Developmental Science and the Retention of Childhood Experiences, *by Mark L. Howe. Washington, D.C., American Psychological Association, 2000, 218 pp., $24.95.*

When mothers repeatedly read aloud a given story passage during the last trimester of their pregnancy, their newborn babies demonstrate recognition of that specific story passage during the first 33 hours after birth. Howe uses this well-documented research to show that long-term memory is operational even *before* birth. Howe goes on to provide a scholarly review of the broad topic of children's memory to assess the accuracy and durability of early childhood memories. The author, Professor of Psychology at Lakehead University, has done extensive research on this topic, and he reviews the work of other researchers in this field. His list of references runs to 36 pages. He offers subtle critiques of some of the studies that he reviews, calling for improved methodology that can clarify possible confounding variables, when numerous aspects of memory may be intertwined in what is being measured—i.e., initial storage, retention, revision over time, and, finally, later recall. He offers a plausible thesis that autobiographical memory can develop only once the 18–24-month-old child has attained a cognitive sense of the self who has experienced the events of the child's life. Readers who are looking for a review of ordinary childhood memory will find this book useful and illuminating. Howe persuasively describes the reality of memory revision and distortion (readers who doubt these phenomena need only think of their spouse's faulty memory for some of their shared experiences!).

The book has a further agenda: to forge a sort of Howe-itzer to fire salvos in the so-called memory wars concerning traumatic memories (1). Howe, who has served as an expert witness concerning memory in lawsuits, doubts that traumatic events could be recorded in memory, then repressed, and still later be recalled with substantial accuracy. As Lein (2) has noted, however, "Karon and Widener (1997) [3] found it 'astounding that so many authoritative statements…refer to repression and repressed memories as myth' when, in World War II, there were hundreds of documented cases of recovered traumatic combat experiences, usually with eyewitness observers of the event" (2, p. 483).

Howe does not examine the issue of traumatic memories in an unbiased way. He states in his introduction,

> It is this belief that early experiences can exert such a powerful influence over people's lives, and that these so-called formative events can be remembered, that served as the impetus for writing this book…there is a need to counteract these beliefs about early memories of experiences with the empirical facts. (p. xii).

Howe does not accept the currently widely held theory that memory includes several rather distinct systems, such as explicit memories and implicit memories (the latter are especially relevant to repressed or dissociated traumatic memories). He repeatedly cites the principle of parsimony, demanding one-sidedly that those who differ with him on this issue produce "incontrovertible evidence" for their position (p. 15), although the evidence he offers for his own views is considerably short of incontrovertible. To his credit, he calls for empirical investigations that might falsify his own "theoretical speculations" on memory (p. 149). But he then ignores much of the literature that, in my opinion, does just that (e.g., reference 4). He fails to mention a book that is perhaps the single most important contribution to the topic of traumatic memories. The winner of APA's 1998 Guttmacher Award, *Memory, Trauma, Treatment, and the Law* by Brown et al. (5), clearly demonstrates that traumatic events can be forgotten, then later remembered (e.g., pp. 390–394).

Also surprisingly, Howe downplays the neuroanatomy of memory (his references omit the work of LeDoux [reference 6, for example]). This is an exciting area of research that will offer a great deal to our conceptual models of memory, including emotionally charged memories of traumatic events. Howe does acknowledge that "both positive and negative experiences can have long-lasting neurobiological effects that, although not necessarily remembered declaratively, certainly must be considered a memory inasmuch as future behaviors are altered by these earlier experiences" (p. 70). He then asserts, however, that any progress in linking memory with neurobiology "in no way diminishes the theories advanced in this book" (p. 142). Howe also entirely omits the topic of dreams, despite the abundant evidence that dreams are crucially linked with memory processing (e.g., reference 7). He shortchanges the robust findings of attachment research, which offer intriguing evidence of the enduring consequences of the child's early experiences with caretakers (see issues 4 and 5 of the journal *Psychoanalytic Inquiry* in 1999, edited by D. Diamond and S.J. Blatt).

Howe's exploration of ordinary memory allows him to draw many plausible conclusions about its operation. His speculations about traumatic memory, however, are deeply flawed. Howe studied the memories of children who had emergency room treatment for accidents and posits that such research can "serve as analogs to 'real-life' abuse traumas" (p. 64). He does not adequately acknowledge the vastly different nature of memories of children who experience repeated physical, emotional, or sexual abuse by a parent or other primary caretaker. He erroneously concludes that children who have been abused will retain whatever memories for the abuse that they recorded in the first place— that the "gist of the event" will be preserved in readily accessible memory (p. 79). He even maintains that lack of memory of an experience of abuse, or of the birth of a sibling, could simply mean that these events "may not have been important at all" for the child, rather than reflect the child's use of repression (p. 129).

Howe's lack of attention to clinical data severely limits the relevance of his book. Clinical experience, for example, highlights the contrast between the neurotic defense mechanism of repression and the use of dissociation in the face of overwhelming psychological trauma. Howe seems to be unaware of the clinical observation that autobiographical memory may not include instances of severe trauma perpetrated by an abuser whom the child trusts, because the child resorts to dissociation to create a wishful fantasy that the trauma occurred to someone else, in an attempt to preserve the core sense of self from unbearable psychic pain. Neither "repression" nor "dissociation" appears in the book's index. Howe does not distinguish between the preconscious mind and the dynamic unconscious mind. He draws sweeping conclusions about severely traumatic memories that are not supported by his data, and he says nothing about the impact on a child's memory of abuse when the abuser threatens to harm the child if she or he ever discloses the abuse to anyone, although this is precisely the sort of condition that increases the likelihood that a child will dissociate traumatic memories.

Loewenstein (8) has reviewed the evidence that severe and repeated childhood trauma is likely to result in amnesia in explicit memory, whereas implicit memory records the events, which can lead to accurate behavioral reenactments of the trauma. Many of the articles that Loewenstein cites in support of this position are not mentioned by Howe.

Howe's book is a useful compendium of research on nontraumatic childhood memory, but as a weapon in the memory wars, it is shooting blanks.

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Stranger in the Nest: Do Parents Really Shape Their Child's Personality, Intelligence, or Character?, *by David B. Cohen, Ph.D. New York, John Wiley & Sons, 1999, 312 pp., $27.95.*

For at least two decades, parents have been told that they are responsible for mental illness and emotional disorder in their children. Terms such as "refrigerator parent" or "schizo-

phrenogenic parent" have contributed to the guilt, dismay, and unhappiness that parents who have a challenged child feel. That guilt has led to a vicious circle in terms of how parents act and interact with their children. In the past few years a number of books primarily authored by psychologists and social workers have pointed their fingers at mental health professionals for inducing these parental guilts, suggesting that parenting is a negligible factor in the growth and development of children into mature, responsible adults.

Although Dr. Cohen does not totally absolve parents from their parenting responsibilities, he has attempted to mitigate such responsibilities by illustrating with a series of anecdotes and brief descriptions of current studies the importance of genetics in child development. Dr. Cohen's book is a quick, easy read. Most of the studies he cites are familiar to medical students, psychologists, psychiatrists, and other mental health personnel because they have been well publicized and are a part of the literature. Others are new, cutting-edge, and perhaps not so well-known. Dr. Cohen tries to be fair, but his central premise that "good parenting" cannot overcome "bad genes" is well known. He also repetitively makes the point that it is impossible to separate genetic background from environmental influence. No informed person would ever argue that one could. He illustrates his main points about the interaction of genetics and environment with a swimming pool analogy. I cite this anecdote in particular because it serves as an excellent example of the style and clarity of his writing and the points he wishes to make.

> Pool depth is analogous to environmental stress so the greater the overall depth—the more stressful the environment—the higher the overall rate of drowning. A swimmer's height is analogous to (genetic) vulnerability: the shorter the swimmers—the less able they are to stand at greater depths…the greater their risk of drowning. Because height is highly heritable with differences mostly genetic the potential for drowning must likewise be heritable. This is true even if at any given time no one drowns. If there were little water in the pool, differences in height would account for nothing. It is only when water levels are high that individual differences, in this case genetic differences, can be significant.
>
> Just as swimmers' height is analogous to (genetic) vulnerability, pool depth is analogous to stress from parents and siblings (family life), peers and politics (community life).

Cohen uses this example to illustrate why the suicide rate of American men increased from 1960 to 1990, suggesting that it was not only genes at work increasing the incidence of suicidality, because genes don't change in a 30-year period, but something different in the environment. He reports changes affecting the quality of parenting, including family instability, divorce rates, levels of violence, and decrease of traditional standards. Although he makes the point repetitively that genes are critical, he grudgingly admits that some therapies influence genetic determinism. He is not specific as to which therapies. Little or no mention is made of psychotherapy, behavioral therapy, psychopharmacology, or any of the therapies available to the traditional psychiatrist.

The central thesis of this book is made clear on the back cover of the jacket:

> The truth of the matter is that, if sufficiently strong, inborn potentials can trump parental influence, no matter how positive or negative. Some traits manifest themselves in such unexpected and uncontrollable ways that, for better or for worse, one's child may indeed seem like a perfect stranger.

Dr. Cohen is certainly most able to abstract and argue convincingly that new knowledge in genetics must be taken into account as we try to understand human vulnerabilities and frailties. It would be impossible and not sensible to try to refute that argument. However, in making as strong a case as he does for genetics, Dr. Cohen does not present a balanced argument. This book will be most helpful for parents as a psychoeducational tool. Professionals who treat parents and children cannot help but look on their own experience in the nature/nurture equation and realize how much influence genetics brings to the table. Mental health professionals will find the book entertaining but not that valuable as a resource for enhancing their knowledge or skills.

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Religion and Philosophy

Cults: Faith, Healing, and Coercion, 2nd ed., *by Marc Galanter. New York, Oxford University Press, 1999, 273 pp., $35.00.*

Cults was a good book when first published in 1989; the second edition is bigger and better despite the ugly cover and relatively small print. Marc Galanter, a professor at New York University, is *the* psychiatric expert on cults, and his is the best book on the topic. He neatly brings concepts to life with case histories, clear explanations of his research, and trenchant personal observations. His writing style is engaging, with just the right amount of informality.

Galanter describes cults as charismatic groups with as many as hundreds of thousands and as few as a dozen members. They are tightly cohesive, impute transcendent powers to their leaders or missions, strictly control members' behavior, and exert a powerful influence that overrides individuals' usual behavior. Examples of such zealous groups are the Divine Light Mission, the Unification Church, right-wing militias, Aum Shinrikyo, and, to a lesser extent, self-involvement groups such as Alcoholics Anonymous and est.

A major force operating in cults is a merging of identity and decision-making functions that results in feelings of relatedness among members, a decline in psychological distress (especially among new members), and an enhanced sense of well-being. The closer people feel to group members, the greater the relief from neurotic distress. Conversely, if they disaffiliate from the groups a bit, they are prodded to return by the increased distress they are likely to feel. Another major operating force is shared beliefs that are established by a

close-knit communications system in which acceptable views are encouraged and dissenting ones suppressed. Even an intense 2-day workshop exposure may result in surprisingly strong commitments by converts to the Unification Church.

Converts' affiliation and sense of emotional well-being reinforce compliance and continued ties to the group. The sight of bald Hare Krisha members singing and dancing in the streets may seem silly and incomprehensible to an onlooker, but the participants consider their behavior quite normal because it has been adopted in association with a system of cultic beliefs in a tightly controlled social network. These beliefs and behaviors can be intensified by alterations in consciousness induced by meditation, drugs, isolation, fasting, prayer, and rhythmic music. A psychiatrist attending his third Divine Light Mission (Hare Krisha) meeting described his perception of a bright halo that suddenly emanated from the body of a young woman who was speaking about the guru's mission: "She glowed as if she were a religious figure in a movie, and it gave her the appearance of holiness.…No one had told me to expect a light like this, and no one else seemed to see it.…I realized that something had happened to me that I couldn't dismiss. The experience would somehow have to become a part of my understanding of the world around me" (p. 61). He decided to join the group. Galanter could not make a diagnosis. He heard similar stories and concludes that the phenomena are difficult to integrate into psychiatric models.

Charismatic groups focus on making converts not only to become larger and stronger but also because the process, when successful, confers legitimacy to the group's ideology and consolidates the commitment of its long-standing members. Conversion demands a disruption of previous social ties and a change of world view. "The result may be psychiatric symptoms in people with no history of mental disorder or psychological instability" (p. 99). The groups carefully monitor members' behavior, foster identification with group leaders, suppress individual autonomy and divisive points of view, and manipulate feedback. They also establish boundaries to isolate members from outsiders. Thus, the glazed, withdrawn look and the trance-like state seen in members may appear pathological, but they serve to reduce direct exchanges with hostile persons. The behavior is usually not present when group members interact with each other or with friendly observers.

Galanter examines alternative medicine and spiritual recovery movements, which often are embedded in an emotionally supportive structure that lends meaning to illness and recovery. "They are like charismatic groups in that they operate from a base of spiritual (or pseudoscientific) ideology, and may be fueled by the alterations in consciousness and sensations associated with pain, suffering, or addictive drugs" (p. 185). Although he admits that Melody Beattie's books on codependency have helped many people reshape their troubled relationships, Galanter also notes that "codependency" is a term that could characterize almost anyone who has ever had a close relationship. He provides an illustrative anecdote about Marianne Williamson, a popular author, motivational speaker, and guru of love. She described an event when she had a serious sore throat and ordered a drink at a bar to salve the pain. She spoke to a flirtatious man who said that he could get her some erythromycin because he was a physician. "This is a miracle," she wrote, "I had prayed for healing."

I heartily recommend *Cults* to all my colleagues. It's a nice respite from neuroreceptor binding charts and provides insights not only into group dynamics but also, by inference, into family functioning. The study of cults is not as exotic as it would seem. We all are enmeshed in social systems and confronted daily by demigods.

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Philosophy Practice: An Alternative to Counseling in Psychotherapy, *by Shlomit C. Shuster. Westport, Conn., Praeger (Greenwood Publishing Group), 1999, 200 pp., $59.95.*

Psychotherapy today is subjected to evaluation procedures for which almost identical criteria of efficacy and effectiveness are applied as for pharmaceutical studies if they are to be financed by health care systems. Counseling bodies like the Scientific Council to Psychotherapy Law in Germany discard therapies from their list of eligible "techniques" if they do not consider their efficacy as being evidence based, even if the therapies are highly appreciated by the public. A sizable number of these therapies, however, have formalized training programs and acknowledged institutionalized practice (systemic family therapy, for example). Some of the rebels against too-technical, evidence-based psychotherapy might rally around philosophy practice because one of its basic aspirations is to free the helping dialogue from methodological narrowness, uninterpreted aims, and the asymmetry between the patient and the professional caretaker.

In the introductory part of this book, the author criticizes "blind paternalism" in modern medicine, giving as examples case episodes for rational use of technical means against the patient's emotional demands. She instead declares the right of freedom from therapy, from medicalization of life problems in general, and from suicide prevention in particular. The "neutral" philosophical educator is proposed as an alternative to the therapist. At first glance this intention appears a sympathetic and promising attempt to find access to patients who shut themselves off from medical overcare or find themselves in a predicament with unbearable loss of autonomy. However, the author's reference to antipsychiatrists such as David Cooper, Ronald D. Laing, and Michel Foucault and to theologians like Paul Tillich or Martin Buber demonstrates that the ideas proposed here have a history of at least four decades or more and are in fact responsible for many changes that occurred in psychiatry in the 1950s to 1970s. Their renaissance sheds light on current shortcomings in the balance of our methodological canon and our ethics in psychiatry.

The history chapter goes through the different attitudes taught by philosophy in the past two millennia with regard to practical help for daily living. After elucidating statements of ancient Greek and the Renaissance philosophers on educational, ethical, and practical questions, the author concentrates on the work of the German philosopher Gerd Achenbach, who is considered the founder of philosophy practice in Germany. Achenbach does not hold a relationship to academic institutions, but there is a German-Austrian society for philosophy practice that can be approached through the Internet (www.philosophischepraxis.de).

One of the aims of philosophy practice, in general terms, is "distancing" by heaving the patient's personal problems up to

a general human aporia, a step that may cause relief from guilt, shame, and self-belittling. Above all, "distancing" conveys a notion of autonomy and bird's-eye view on a situation in which the patient has felt constrained. The author introduces Nelson's philosophy of antirelativism and resistance, exemplified for Nazi-time victims, without mentioning the ample psychiatric evidence-based research from the 1950s to today on trauma experience, which comes to very similar conclusions and recommendations as expressed in Nelson's philosophy.

The chapter on philosophical care or "transtherapeutic" techniques points out some details of philosophy practice, resuming the idea of "distancing" and elevating the patient's problems to a more general existential level as a feature of the condition humane. The author cites Paul Tillich's "courage to be" and the antique Greek stoic's "acceptance of the unavoidable" as well as the existential philosophers' "transcendence of the givens of life." Such reality-oriented attitudes are certainly helpful in or after intellectualizing therapies with their inherent difficulties for the transfer of their results to real life. In addition, the initial detachment of a patient from a problem by introducing philosophy, with a superindividual view on that problem as one of mankind over centuries, helps overcome narcissistic barriers against accepting the problem and looking at it closely. It also may soothe the patient by acknowledging the tragic element in his or her fate and the strain of coping under oppressive circumstances. This step seems similar to therapy by means of fairy tales practiced by Gaetano Benedetti (1), which was meant to help deluded patients deal with the topic entailed in the delusion by detachment. From a psychotherapeutic point of view, one would say that such an approach can be helpful, provided it is not a joint defense of client and philosopher to avoid personal involvement and hence change. From the philosophy practice point of view, the philosophical discourse would suffice as a purpose in its own right.

The characteristics the author outlines for the nature of the client-philosopher relationship come close to those of the vast psychotherapeutic debate in both psychodynamic and even recent behavioral literature. Shuster emphasizes "seeing the illness from inside," a facet of psychotherapy that empathy research has worked on. "Positive reciprocity," "dialogue," "intellectual love," and "critical wonder" are elements that go along with the recent trend in psychotherapy research to render the patient with more symmetry of the therapeutic situation and more joint methodological responsibility. Sartre's differential criteria of his psychoanalysis-derived therapy-like discourse summarize the intention of philosophers who offer a helping or clarifying dialogue—openness, beyond method, no prefixed aim, use of philosophical contents and means, and relating personal quests to philosophy.

About a third of the book is dedicated to narratives. In this chapter the author resumes the idea of the bird's-eye view on oneself by means of philosophy, explaining such famous narratives as those of Augustine, Thomas, Montaigne, and Rousseau as walking on high places to overlook and to find the eternal in the elapsing, the general in the particular, the Zeitgeist manifestation in the personal life history. This would be a necessary part of growing self-awareness, an aim of Jasper's "existential enlightenment," which acts against man's alienation.

The narratives illustrate the spirits and intentions of philosophy practice very well. The main impression is the gain of coherence, reconciliation with those features of the self, the life history, or the situation with which the individual has been cross, which is helped greatly by the avoidance of "psychopathologization" of problems. The reported narratives have been generated by the author retrospectively years after the sessions, mostly without files. Hence, they may be formed by the constructive element of memory and be endowed with a higher degree of coherence than would have been conveyed by an objective account of what had been negotiated and what has come out of it.

To sum up my impression of this book, there are useful intentions and procedures outlined in philosophy practice, foremost among them putting the client's problem into a wider frame of philosophical aporias. The rising attention philosophy practice is gaining at the moment is rooted in the unemotional, cold high-tech medicine with unsettled ethical limits to its ever-rising skills. Many aspects of philosophy practice put forward as original pleas in this book, however, correspond to a long history of research in psychotherapy. Hence, cooperation is desirable, not competition as the author describes. What remains unresolved is the responsibility of philosophers for unsuccessful counseling and with it the question of how to teach a method that wants to do without methods and be free of aims.

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Correction

In the letter by John P. O'Reardon, M.D., et al. titled "Desipramine Toxicity With Terbinafine" (Am J Psychiatry 2002; 159:492), the first sentence in the next-to-last paragraph should read, "After a single 250-mg dose of terbinafine, the elimination half-life is 16–100 hours; after 4 weeks of terbinafine, 250 mg/day, the mean plasma half-life is 22 days (3)."