The Schizophrenia Spectrum

Negative Symptom and Cognitive Deficit Treatment Response in Schizophrenia, *edited by Richard S.E. Keefe, Ph.D., and Joseph P. McEvoy, M.D. Washington, D.C., American Psychiatric Press, 2001, 216 pp., $37.00.*

This is a timely collection of review papers by some of the leading researchers in the field of negative symptoms and cognitive impairments, who summarize this literature as it applies to treatment trials. Although the papers were written independently, they reflect a sometimes controversial ongoing dialogue, which makes this book lively reading. Rather than simply reviewing available evidence on the treatment of negative symptoms and cognitive impairment, the chapter authors focus on core methodological and conceptual issues that have been addressed incompletely so far, not only providing the reader with a good grasp of current knowledge but also pointing correctly toward limitations in current evidence.

This book clearly emphasizes negative symptoms. Several points of consensus emerge regarding the need for additional studies specifically designed to address their treatment response, given the traditional emphasis on positive symptoms in therapeutic trials. Indeed, convincing arguments are made for the need for longer duration of trials, longer washout duration, and sampling specific populations with predominantly negative symptoms. This book also reflects the disagreements on how direct effects on negative symptoms should be differentiated from indirect improvements of negative symptoms mediated by reduction in psychoses, improvement in extrapyramidal symptoms, or other indirect mechanisms. Indeed, although Buchanan and Carpenter call for studies including patients with deficit/primary negative symptoms, others point toward difficulties in distinguishing primary and secondary negative symptoms and in recruiting a sufficient number of such patients. The latter argue for the use of statistical techniques to disentangle direct versus indirect effects. The authors on both sides, who are probably the best suited to defend these opinions, present their positions very thoroughly, which provides an interesting debate that calls for the readers' critical sense.

Other very pertinent original contributions in this book include a chapter devoted to the perspective of the family, which is often overlooked. Another, coauthored by Limpert and Amador, provides a very insightful review of the literature on the subjective experience of negative symptoms. Hence, this book provides an in-depth overview of research on negative symptoms and its clinical implications. However, it would have been even more complete had it included a chapter providing clinical guidelines on the distinction between primary and secondary negative symptoms and had the literature on psychosocial treatment for negative symptoms been reviewed.

Concerning cognitive deficits, I would say that the title of the book is a little misleading, since this issue is provided much less emphasis than are negative symptoms. However, the chapter by Keefe on the assessment of neurocognitive treatment response is particularly interesting and provides, for example, a much-needed discussion on dosing issues, which tend to be somewhat overlooked when interpreting evidence on the impact of neuroleptics on cognition.

Overall, this book provides a thorough overview on the research regarding the treatment of negative symptoms (and, to a lesser extent, cognitive performance), making this complex literature much more understandable. The book should appeal to a broad readership, ranging from clinicians treating people suffering from schizophrenia to researchers in the field of negative symptoms and cognitive impairments.

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Schizotypy: Implications for Illness and Health, *edited by Gordon Claridge. New York, Oxford University Press, 1997, 360 pp., $115.00.*

Gordon Claridge and colleagues use this book as a platform from which to explore the boundaries of psychosis, which they argue are situated on a continuum with normal behavior and experience. This volume includes a compendium of chapters ranging from rather specialized discussions of such concepts as latent inhibition and cerebral lateralization to more freewheeling discussions of spiritual experiences and creativity in relation to schizotypy. *Schizotypy* is a book to be sampled and explored by those interested in this concept and the provocative questions the authors raise. Some clinicians may find some of it too abstruse or too peripheral to their clinical concerns, but those who are intrigued by the central theme will likely find it of value.

The central dilemma, addressed by Claridge at the outset, is that "schizotypy" is a rather specific term that is unambiguously associated with schizophrenia in its current usage. The terms used by Claridge and the chapter authors, however, appear to be more related to psychoticism. The choice of schizotypy fits well with some of the research literature that is presented, but the multidimensional approach espoused by the authors suggests that schizotypy consists of a number of dimensions, including psychoticism, negative schizotypy (marked by social withdrawal), and cognitive disorganization. Psychotic-like phenomena are the least specific aspect of schizotypy because they can extend from schizophrenia and bipolar disorder to other psychotic disorders, dyslexia, drug-induced states, and different forms of delirium. Yet, it is the rather quieter and sometimes more subtle social deficit symptoms that seem particularly specifically related to schizophrenia. At a time of intense interest in investigating the prodrome and endophenotypes related to schizophrenia, it is helpful to be reminded of this distinction. For example, Richardson reminds us in her chapter on dyslexia in schizotypy that psychotic-like symptoms can be common in dyslexia with no predictive power for a diagnosis of schizophrenia.

It may be that the dichotomies among organic, psychological, and psychobiological paradigms raised by Claridge are remnants of an era when our understanding of the implications of differences in brain function was much more primi-

tive. There is no doubt that there is a very real component to both the altered biology and the psychology of the schizophrenia spectrum. In distinguishing schizophrenia from Alzheimer's and other neurological diseases, however, Claridge states, "There is no evidence that schizophrenia leads to any cognitive impairment (in the dementing sense) or indeed to any impairment that cannot be explained as a secondary consequence of other factors," which belies data suggesting that at least a substantial proportion of subjects with schizophrenia may have cognitive impairment very similar to dementia, especially in their elderly years. Indeed, milder forms of cognitive impairment are now recognized as an essential construct in understanding schizophrenia.

I, for one, would have been more comfortable with the contents of this book if it were more oriented to psychosis-related traits, because these seem to be the backbone of the book. The academic discussions are somewhat uneven, and some material is dated, but, in general, the volume would be of interest to psychologists, psychiatrists, and other mental health professionals who are interested in the boundary between normalcy and psychotic disorders such as schizophrenia. Claridge's concluding remarks are thought provoking, and possibly the main disappointing aspect of this volume is the limited scope of the contributions of Claridge himself, whose *Origins of Mental Illness* (1) represented one of the most scholarly and penetrating analyses of the relationship between normalcy and mental illness in language that nonresearchers and even the educated lay public could understand. I hope, however, that the book will be read as a challenge to strictly deterministic models of illness as the authors call attention to the continuities between the altered states and traits we associate with normalcy and psychotic phenomena.

Reference

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Schizophrenia and Comorbid Conditions: Diagnosis and Treatment, *edited by Michael Y. Hwang, M.D., and Paul C. Bermanzohn, M.D. Washington, D.C., American Psychiatric Press, 2001, 256 pp., $46.00.*

This book addresses the issue of comorbid conditions in schizophrenia and has a two-fold aim. The first is relevant to the clinical practice of psychiatry and consists in pointing out the importance of recognizing and assessing symptoms and syndromes that, even though not directly related to the "core" clinical features of schizophrenia, may complicate the course and the long-term management of the disease. Comorbid obsessive-compulsive, panic, and depressive symptoms are examples of these conditions.

The second aim of the volume is more theoretical. It consists in challenging the view of schizophrenia as a homogenous and unitary category and proposing a more realistic, dimensional approach to the disease. According to the classical hierarchical/categorical approach, the occurrence of depressive or anxiety symptoms in an individual with schizophrenia and pervasive paranoid ideation is usually viewed as the obvious and direct consequence of the psychotic symptoms, and the condition is treated according to this perspective. However, this approach does not provide any explanation about the reasons why only some, and not all, paranoid patients develop anxiety or depressive symptoms.

The chapter authors suggest that patients with schizophrenia and comorbid conditions should be considered in the context of the disease's heterogeneity and managed on the basis of their individual and peculiar clinical characteristics.

Several well-recognized experts provide an exhaustive overview in the chapters on the comorbid psychiatric conditions frequently associated with schizophrenia. Siris discusses the co-occurrence of depression and schizophrenia. Depressive symptoms during the course of schizophrenia are probably the most frequently observed in clinical practice, and several lines of evidence underline the need for careful assessment and management for their possible implications (e.g., higher risk of suicide attempts).

In chapter 3, Hwang and associates address the problem of comorbid obsessive-compulsive disorder (OCD) in schizophrenia. The prevalence of the phenomenon (1% to 6% of patients with schizophrenia have comorbid OCD symptoms during the course of their illness) is quite high and deserves careful assessment, particularly when the obsessive symptoms overlap with delusional phenomena, leading to a complex and difficult-to-disentangle clinical picture. The authors focus on the relative onset of the two phenomena and identify three groups of patients with schizophrenia and OCD—i.e., those whose OCD symptoms preceded the onset of schizophrenia, those with simultaneous onsets of schizophrenia and OCD, and those whose OCD symptoms developed after the onset of schizophrenia. These three groups show clear differences in clinical course, but overall their outcome is worse than that of patients with schizophrenia who do not have comorbid OCD. The problems related to treatment management are also discussed. For example, the addition of a serotonergic antidepressant with antiobsessional activity may interfere with the antipsychotic treatment.

Other clinical features that may occur in a patient with schizophrenia and complicate the course of the illness are panic symptoms (chapter 4 by Pitch and associates), aggression and violence (chapter 8 by Citrome and Volavka), and substance abuse (chapter 9 by Ziedonis and Nickou). The presentation of case vignettes in this book is very useful and helps the reader understand the complexity of the conditions discussed. The vignettes provide examples of the practical clinical management of patients with schizophrenia and comorbid conditions.

Additional chapters complete the overview of comorbid conditions that can complicate the course of schizophrenia, such as medical and surgical conditions and pregnancy (chapters 5 and 6 by Gilmore and associates).

In conclusion, *Schizophrenia and Comorbid Conditions* is a very useful tool for both clinical psychiatrists and researchers in the field. Particularly valuable is the fact that the book points out and supports with a good review of the literature and clinical examples that schizophrenia is a heterogeneous condition and that treatment management should be individualized for each patient. The evidence for the concept that a subclassification of schizophrenia on the basis of comorbid conditions will lead to a significantly better outcome of the illness (and better treatment strategies) is still controversial.

Symptoms like anxiety and depression, even though clinically relevant, may be not specific but represent epiphenomena of a cognitive and affective disruption caused by the core psychotic symptoms. However, these symptoms need careful clinical assessment and specific clinical interventions. In this context and in the view of future efforts toward a better understanding of the complex phenomenology of schizophrenia, this volume provides a valuable contribution to the field.

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Schizophrenia in Children and Adolescents, *edited by Helmut Remschmidt. New York, Cambridge University Press, 2000, 308 pp., $64.95 (paper).*

This book is simply excellent. It is rare to find a book on schizophrenia in children and adolescents, and it is even more rare to find one of this quality. The author is a distinguished professor at Philipps University in Marburg, Germany. This text is one in a series from Cambridge University Press and includes a list of contributing authors that is very impressive, with experts from both sides of the Atlantic. The book is incredibly well organized and could be described as crisp in its approach to material. The book does not waste words and is a high-precision guide to schizophrenia in youngsters. It starts out with a historical review of childhood psychoses over the past century that is quite comprehensive and impressive. The descriptions of epidemiology, neurobehavioral elements, psychosocial factors, and treatment are all superior in terms of readability and factual content. Each chapter is well referenced.

The concept of childhood psychosis is alien for too many physicians. This short text is a very valuable way to educate people who do not understand that schizophrenia and other psychotic conditions can strike early in life and can often leave devastating effects if left untreated. This book is strongly recommended for all psychiatrists whether they deal with children or not. I believe that it would also be a valuable textbook for residency training programs because many trainees do not receive adequate instruction about childhood psychoses. This book is delightful and extremely informative. I hope that we will be hearing more from Dr. Remschmidt in the future as well as the numerous contributors to this fine edition.

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Posttraumatic Stress

Post-Traumatic Stress Disorder: Diagnosis, Management and Treatment, *edited by David Nutt, Jonathan R.T. Davidson, and Joseph Zohar. Malden, Mass., Blackwell Science (Martin Dunitz), 2000, 260 pp., $69.95.*

Posttraumatic stress disorder (PTSD) is one of the most prevalent, disabling, and costly as well as the least understood of the anxiety disorders. Despite a century-old interest in the psychological and behavioral effects of trauma, systematic empirical research in this area is little more than a decade old. Responding to the recent upsurge of interest in this disorder on the part of clinicians and researchers alike, the editors of this volume seek to provide "mental-health professionals" with a comprehensive overview of PTSD from multiple perspectives that is "readable, informative and clinically helpful." They have selected a format that is strongly evidence-based, scholarly, and yet not too detailed or exhaustive, allowing the interested reader and clinician to grasp key issues in epidemiology, diagnosis, pathophysiology, and treatment through highly readable, relatively brief (15–20 pages), modestly referenced (often fewer than 50 references), yet fairly comprehensive reviews of key areas. The text is somewhat slanted toward the relatively recent appreciation of the biological basis of the disorder, which has replaced older, predominantly psychological paradigms and made this disorder one of the most interesting opportunities to study the convergence of environmental events and genetic/neurodevelopmental/biological predisposition. Throughout the book, there is a refreshing acknowledgment of the limitations of our current understanding, even as the excitement of discovery in this new area continues.

In large part, the editors have succeeded admirably in their task. The broad range of topics covered by the book contrasts with the more selective and detailed focus of many other edited volumes in this area. Even some volumes that purport to present comprehensive reviews of the area are not quite as comprehensive. In particular, this volume includes discussion of ethnocultural issues (a relatively sophisticated discussion for its length), childhood PTSD, and "traumatic grief," along with more mainstream topics. The volume provides information that is quite useful to clinicians, offering chapters not just on diagnosis but also on diagnostic dilemmas. Despite the breezy, brief, and readable treatment of these areas, the chapters are able succinctly to summarize what we know and do not know about the association of PTSD with major depression, the boundaries with normality, and the validity of the subtype "complex PTSD." The chapter authors provide guidelines about when an event "qualifies" for the diagnosis as well as richly detailed descriptions of the individual symptoms listed in DSM-IV.

Similarly, individual chapters review the evidence for the efficacy of psychotherapy (including the controversial technique of eye movement desensitization and reprocessing), the efficacy of pharmacotherapy, and the efficacy of psychological "debriefing," a widely accepted approach to secondary prevention of PTSD that recent studies have shown to be ineffective when broadly applied to all traumatized individuals. A chapter on epidemiology deals with clinical issues that are subsequently discussed in a larger public health context and provides a schematic model of PTSD risk that helps place subsequent discussions about prevention in perspective.

The editors' particular interest in biological models is reflected in three separate chapters, all quite solid, covering neuroimaging, neuroendocrinology, and biological mechanisms. The chapter on biological mechanisms is particularly well done and covers the neuroanatomy of fear conditioning, cognitive neuroscience paradigms that affect our understanding of memory and dissociation, sensitization and its role in hyperarousal, and the role individual neurotransmitters might play in all this.

As with any edited volume, there are shortcomings, although these are rather minor. The chapter on pharmacotherapy is devoid of any detailed discussion of data on the efficacy of selective serotonin reuptake inhibitors because of the unfortunate timing of the volume, which lagged a bit behind actual publication of these data. Similarly, this chapter does not discuss the recent interest in α_1 blockers for treatment of nightmares. These are two important areas that clinicians would want to know about. The very interesting chapter on the overlap between traumatic grief and PTSD never draws a definitive conclusion about whether this entity would be better "lumped" with or "split" from PTSD, even after exhaustively reviewing the areas of overlap and distinction. Overall, however, this is a solid and welcome volume that would help clinicians master the evidence base for this challenging and fascinating disorder.

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Psychological Debriefing: Theory, Practice and Evidence, *edited by Beverly Raphael and John P. Wilson. Cambridge, U.K., Cambridge University Press, 2000, 376 pp., $59.95 (paper).*

Psychological debriefing has become a fairly popular intervention used for victims and witnesses of traumatic events. Some employers feel obliged to provide debriefing after trauma encountered at work. Numerous "debriefing counselors" have been descending on disaster sites offering their "debriefing skills." Debriefing has slowly become a new industry. Interestingly, it is not clear whether debriefing has any role in the treatment and prevention of psychological trauma. It is also not clear who should be performing debriefing, when, and with whom. Trauma psychology researchers have not reached an agreement about the conceptualization and definition of debriefing. Thus, one might ask what debriefing is. According to the editors of this book, it means telling about what has happened, or going over an experience or set of actions, to achieve some sort of order or meaning concerning them. In their chapter, Dr. Ursano and colleagues define debriefing as a "systematic process of education, emotional expression, cognitive reorganization through the provision of information, fostering meaningful integration and group support through identifying shared common experience."

Debriefing has been ripe for reevaluation, and this book provides quite a thorough and timely reevaluation of this field. The editors gathered a group of 41 authors who have "made a significant contribution to the evolution of the field of debriefing." The book consists of an introduction by the editors, 25 chapters organized into four sections, and a conclusion. The introduction summarizes the key issues in the conceptualization of debriefing and points out its historical foundation. The editors emphasize that the scientific underpinning of debriefing needs to evolve to validate its relevance to acute posttrauma response and to ultimate recovery.

Part 1, Key Conceptual Framework of Debriefing, consists of four chapters. The first three are well written and informative. The overall message of the first chapter is that debriefing should sit in the spectrum of response to those who have suffered severe psychological trauma, and that the reason for early intervention is a moral one. However, it also points out that the conceptual basis for debriefing is very elusive. The second chapter brings our attention to the fact that there appears to be little evidence that talk reduces the symptoms that may follow trauma, although it may affect other outcomes, such as distress and disability. It also discusses who attends debriefing and who talks during debriefing. The third chapter describes five categories of groups in group stress debriefing and provides historical glimpses on support provided after psychological trauma. I enjoyed the comment in the discussion of the role of the church in posttrauma support: "Compared with what the priest can do for the soul, the medical doctor is a rather helpless person." The chapter closes with a discussion of leadership responsibility and the role of mental health professionals in stress management.

The second section, Debriefing: Models, Research and Practice, contains 11 uneven chapters dealing with specific issues: "Critical Incident Stress Debriefing: Evolutions, Effects and Outcomes," "Debriefing With Emergency Services: Critical Incident Stress Management," "Debriefing and Body Recovery: War Grave Soldiers," "Debriefing and Body Recovery: Police in a Civilian Disaster," "Debriefing After Massive Road Trauma: Perceptions and Outcomes," "Debriefing and Motor Vehicle Accidents: Interventions and Outcomes," "Debriefing With Service Personnel in War and Peace Roles: Experience and Outcomes," "Debriefing Post Disaster: Follow-Up After a Major Earthquake," "Debriefing After Disaster," "Children and Debriefing: Theory, Interventions and Outcomes," "Debriefing Adolescents After Critical Life Events."

The chapters on children and adolescents involve a controversial area. The chapters on body handling and debriefing with service personnel clearly stand out as the most interesting. They emphasize that professionals lack training in debriefing and in handling traumatic situations. The author of the chapter on body handling was, as a trainee, accidentally involved in disaster victim body handling. His senior colleagues, some of them leading figures of British psychiatry, referred him to a chaplain to talk. The chapter on service personnel debriefing points out that debriefing could be harmful. Finally, one chapter emphasizes that debriefing must be regarded as an experimental intervention.

The third section, Adaptations of Debriefing Models, consists of six chapters on issues such as delayed debriefing, debriefing in traumatic birth, debriefing after assaults by patients (interesting, yet not very informative), and debriefing in life-threatening illnesses. The last section, Debriefing Overview and Future Directions, includes four chapters. The two chapters dealing with concerns about debriefing are very interesting, raising such questions as, Can traumatized individuals effectively participate in debriefing? Is acute intervention even necessary? Does trauma have positive aspects? This chapter also questions the possibility of consensus about debriefing. I appreciated the statement that, unlike the stringent scrutiny of the Food and Drug Administration in regard to psychopharmacological treatment, "our profession has gone blithely ahead and subjected thousands of suffering, and nonsuffering, clients, presumed to have psychological wounds, with all manner of intrusive treatment protocols."

This is clearly an interesting and timely book dealing with a widely used but unproved, questionable, and controversial psychological intervention. The strength of the book is its comprehensiveness, inclusion of multiple and diverse views,

and editorial comments at the beginning of each chapter. The weaknesses are the uneven quality of some chapters and the length of the book. Nevertheless, this book will be an important resource for anybody interested in trauma psychology, debriefing, and treatment of psychological sequelae of severe trauma.

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The Mental Health Consequences of Torture, *edited by Ellen Gerrity, Terence M. Keane, and Farris Tuma. New York, Kluwer Academic/Plenum, 2001, 374 pp., $49.50.*

This information-packed book is broken down into six parts with 21 chapters in all. Part 1, The Impact of Torture, includes the first three chapters. Chapter 1 is an introduction, chapter 2 gives the survivors' perspective, and chapter 3 is a research overview. Part 2, Conceptual Models for Understanding Torture, includes chapters titled "Psychosocial Models," "Neurobiological Models of Posttraumatic Stress Disorder," and "Economic Models." Part 3, Torture and the Trauma of War, has chapters titled "Refugees and Asylum-Seekers," "Veterans of Armed Conflicts," "Former Prisoners of War: Highlights of Empirical Research," "Holocaust Trauma and Sequelae," and "Survivors of War Trauma, Mass Violence, and Civilian Terror."

Part 4, Torture and the Impact of Social Violence, includes chapters titled "Rape and Sexual Assault," "Homicide and Physical Assault," "Children, Adolescents, and Families Exposed to Torture and Related Trauma," and "Domestic Violence in Families Exposed to Torture and Related Violence and Trauma." Part 5, Clinical Issues for Survivors of Torture, includes the chapter "Assessment, Diagnosis, and Intervention," which is of particular interest to the clinician. Also in this section are chapters titled "Measurement Issues," "Mental Health Services Research: Implications for Survivors of Torture," "Provider and Caregiver Issues," and "Torture and Human Rights Violations: Public Policy and the Law." Finally, Part 6, Discussion, includes a chapter titled "Future Directions," which presents a summary of selected research findings and conclusions.

Because of the clarity of the writing, this book, based on a report prepared in March 1998 by a 24-member National Institute of Mental Health Working Group on the Mental Health Consequences of Torture, Related Violence, and Trauma, turned out to be easier to read than I had anticipated. The editors enlisted the help of 23 contributors whose impressive biographical data are listed at the back of the book. They obviously "know whereof they speak." The subject matter of the book is enriched by the fact that the perspective of the survivor of torture is integrated throughout. Most of the chapters in the book conclude with a list of research recommendations, and all are followed by copious references. There is a 26-page index section.

Space considerations naturally limit the amount of detail that can be included in a review of this sort, but I would be remiss if some of the psychological, behavioral, and medical problems that can result from torture were not mentioned. These are posttraumatic stress disorder, depression, anxiety disorder, psychosis, sleep disorders, sexual dysfunction, chronic irritability, physical illness, impaired interpersonal relationships, and impaired social, occupational, and family functioning.

In the second to last paragraph of the last chapter, the editors state, "Finally, we conclude with the hope that many who work in the field will find the information in this book of value in their work." In my opinion, there is little doubt that people working in the field will find this book of value. Indeed, it could be considered a sine qua non for those doing research in this area.

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The Trauma Model: A Solution to the Problem of Comorbidity in Psychiatry, *by Colin A. Ross, M.D. Richardson, Tex., Manitou Communications, 2000, 404 pp., $27.95 (paper).*

Dr. Ross, who was trained in psychiatry at the University of Manitoba and who directs trauma treatment programs in Texas, Michigan, and California, has written a book that, among other things, attempts to turn DSM-IV on its ear. According to Dr. Ross, most psychiatric conditions are comorbid with one another, thus losing their right to be categorized as separate and distinct disorders. For example, he believes the division between simple phobia, social phobia, panic disorder, and generalized anxiety disorder to be arbitrary and that the signs and symptoms of each overlap. Almost every diagnostic category has this fatal nosological flaw. Dr. Ross uses the term "polydiagnostic comorbidity" to refer to this phenomenon. At times he can sound like Thomas Szasz, the legendary psychiatric iconoclast, as in the following:

> Why out of all the behaviors carried out by human beings are fire starting, hair pulling, shoplifting and gambling given status as separate Impulse Control Disorders in DSM-IV-TR? Why doesn't DSM-IV-TR have categories for self-mutilation disorders, credit card overutilization disorders and migratory game bird excessive killing disorder?

As suggested in the title of the book, great emphasis is placed on trauma to explain the development of mental illness. In Dr. Ross's view, traumatic experience has a profound effect on the structure and function of the brain that can be undone with his version of trauma therapy—an eclectic mix of cognitive, behavioral, experiential, and dynamic approaches.

Dr. Ross has a long-standing interest in dissociative states—he has written four books on the subject—and he relies on that defense mechanism to explain not only multiple personality disorder but also anxiety, depression, and substance abuse, among others. He covers a wide territory with discussions on schizophrenia and personality, sleep, eating, sexual, and childhood disorders, continually emphasizing the role of physical, sexual, and emotional trauma acting on the individual's genetic vulnerability. There is an interesting chapter on false memory syndrome from which one can infer Dr. Ross's disapproval of so-called memory retrieval specialists and the harm they do by invoking false memories of childhood sexual abuse.

Dr. Ross writes with enthusiasm and zeal. At times he is too strident, but that may be a reaction to the critics be appears to

have picked up along the way. Indeed, the book has an appendix in which he defends himself against charges of "scholarly errors," many of which seem to have been committed by a person identified only as Piper. The more I read, the more I began to like Dr. Ross, who comes across as an ethical and skilled psychotherapist; unfortunately, however, I liked him more than I liked the book. In spite of that, I recommend *The Trauma Model* for its interesting observations about psychiatry and for its ability to provoke the reader into new ways of thinking.

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ANGER/HOSTILITY/VIOLENCE

Prisoners of Hate: The Cognitive Basis of Anger, Hostility, and Violence, *by Aaron T. Beck, M.D. New York, HarperCollins, 1999, 354 pp., $26.00; $14.00 (paper).*

Aaron Beck is widely known for his contributions to psychotherapy. His cognitive therapy is perhaps the most widely used mode in psychotherapy practice. In this book Dr. Beck focuses exclusively on the application of the principles of the cognitive approach to anger and hostility.

The well-known cognitive principle applied to angry outbursts between partners starts with the premise that there is a very rapid but analyzable train of thoughts that occurs between a perceived initial insult and hostile behavior—with an escalation of hot thoughts demanding justice in counterattack. The usual sequence is a perceived attack on self-esteem followed by a feeling of weakness, a feeling of being let down and wronged, and a fixing of blame on the partner, resulting in attack. That may be followed by a deep sense of guilt or continuing resentment, which can build to another attack.

The author is not presenting a new scientific study but an application of his principles for cognitive therapy to a particular interpersonal problem. Dr. Beck suggests that those principles are also helpful for communities or nations. Countries are moved toward war for the same reasons that couples argue. War, of course, is far more complex and destructive than family arguments no matter how complex or internecine the familial relationships. Dr. Beck also accepts war as a complex process but is inclined to include individual psychology as a major part of a war's genesis.

During the Cuban missile crisis, President Kennedy, angry at Khrushchev for introducing missiles into Cuba, said, "He can't do that to me," and the world unknowingly stood on the cusp of massive war. Calm heads prevailed, however (1). A cognitive therapist, Beck could say, might have provided a more comfortable margin against catastrophe.

The prelude to many hostile acts is shame and loss of self-esteem. James Gilligan (2) wrote about that brilliantly with regard to a contemporary epidemic of violence among adolescent boys. Self-esteem is essential to people (they will kill for it), and the therapist's appreciation of this fact can be sharpened by reading this book.

Many therapists might say that they already use the cognitive approach to patients and couples, including those who are angry. Indeed, cognitive "analysis" has a place in all therapies. The contribution of this book is in the underlining of the value of cognitive examination for a specific behavioral problem—whether a cognitive approach is the totality of the treatment or a part of it.

Dr. Beck also writes about hostile responses as part of evolutionary adaptation and fitness but not in great depth. His discussion of the anger-prone patient makes no reference to borderline disorders. The concept of distal origins, whether evolutionary or residing in certain personality types, is peripheral to Dr. Beck's prime thesis. He suggests that therapists deal with angry behaviors only in the present. There are, of course, therapists who want to do both—tracing angry interactions to roots in individual experience as well as identifying the contemporary cascade of thoughts from hurt to an irresistible need for justice. This book may not be a revelation to all readers/therapists, but it serves well to underscore the practical helpfulness of a cognitive mode with a particular form of dysfunctional behavior.

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THEODORE NADELSON, M.D.
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Women's Anger: Clinical and Developmental Perspectives, *by Deborah L. Cox, Sally D. Stabb, and Karin H. Bruckner. Philadelphia, Brunner-Routledge, 1999, 254 pp., $62.95; $25.95 (paper).*

In my work experience as a psychiatrist and life experience as a woman, I have found that, in general, women use approaches other than those involving anger to achieve goals and change the world. I have also found that anger does exist in women and that it can emerge in cryptically self-destructive ways. This book promised to be at least an interesting read, even if it did not seem to offer much new in terms of explanation beyond standard feminist theory, the innovative research on adolescents carried out by Gilligan, and the ground-breaking explorations of male-female interactions done by Tanner.

I was surprised to find that this volume does offer more, much more, than rehashed—and/or half-baked (to keep with the food metaphor)—personal-is-political rhetoric. There is truly little more powerfully and convincingly inspiring than examples of psychological liberation yielding confidence, competence, and conscious, spontaneous authenticity.

The authors summarize the existing literature on women's anger and conclude that, without appreciation of the context of the affective expression, any discussion of the meaning, intent, and consequences of anger is meaningless. They argue that 1) anger in women may be a healthy manifestation of self-definition and self-identity, 2) anger in women is very much shaped by culture, and 3) anger in women is very much interpreted by culture. The ultimate conclusion is that, through the lifespan of a woman, there emerges an increasing tension between her own putatively angering experience and the societal expectations of her to repress and/or suppress

those angry emotions. Obviously, in psychoanalytic terms, the latter could result in harmful diversion of anger into subjective psychological disorganization, dysfunctional family interactions, criminal aggressiveness, and/or general chaotic dynamics. At best, overt anger in women continues to be viewed as unfeminine, inappropriate, and off-putting.

Having succinctly presented all of the above in the introduction, the authors go on to substantiate their assertions in the following three chapters, which address theories of emotion, the socialization of anger, and clinical issues deriving from anger in women, respectively. The prefacing quotes from herstorically important women (Anais Nin, Elizabeth Cady Stanton) are lovely, as well as apropos, as are the case snippets, which are best represented in chapter 4, "Women Speak About Anger." In the final chapter, "Synthesis and Conclusions," the integration of traditional mental health paradigms with minority/feminist philosophies rang very true for me.

This is a thoughtful introduction to new ways of considering the role of anger and gender across various societies. Perhaps Gloria Steinem put it best, "The first problem for all of us, men and women, is not to learn but to unlearn" (p. 197).

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Medical Management of the Violent Patient: Clinical Assessment and Therapy, *edited by Kenneth Tardiff. New York, Marcel Dekker, 1999, 489 pp., $195.00.*

This book is part of a series, Medical Psychiatry, edited by William A. Frosch, M.D., of Cornell University Medical College, New York. Dr. Frosch writes the series introduction, and Dr. Tardiff writes the volume preface.

This is a well-edited, well-written, and well-referenced book on violence in almost all its aspects, beginning with causes of violence, treatment of violent patients, multiple factors involved in violent behavior, victims of violence, legal aspects of violent behaviors, and preventing violence. The book is well divided into various sections, initially introducing the reader to the causes of violent behavior, including medical, psychiatric, organic, social, political, and other factors. The editor defines violent behavior as the intentional harm to another person or persons. It is good to restrict the discussion of violent behavior to that definition even though much violence may occur accidentally, by nature, or unintentionally. There is not much physicians can do about preventing or treating the accidental or unintentional behaviors that lead to violence. However, it is important for the physician and clinician to understand the causes leading to intentional violent or destructive behavior that can be predicted, managed or treated, and, one hopes, ultimately prevented.

The editor has selected excellent authors for the chapters, which are consistently well written and well edited. Many of the chapter authors are considered experts in the field in which they are writing. It is important to present violence in the multifactored manner in which the editor organizes this fine book. Inasmuch as the causes of violent behavior are seen as multiple and diverse, the assessment of the violent or potentially violent individual must include all known factors, including medical, psychiatric, social, and political.

Treatment or management of the violent patient must include consideration of all these factors to be successful. In his chapter on treatment of the psychiatric patient who becomes violent, the editor considers three different types of psychiatric patients: the psychotic, the organic, and the nonpsychotic and nonorganic. In my experience, the assessment of the psychotic patient or the organic patient may be more readily achieved than identification of the factors leading to violence in the nonpsychotic, nonorganic patient. We tend to consider such issues as antisocial personality disorder, drug abuse, and other social factors. Treatment of the nonpsychotic, nonorganic patient becomes less specific, inasmuch as there are fewer medications or treatments available to these patients.

The editor presents a nearly complete consideration of violence in our society. The one area that seems to be missing is the perpetration of violence in the geriatric population. Dr. Leah J. Dickstein, in her chapter on domestic violence, covers primarily spousal violence, although she does include a number of areas in her section on special issues. The chapter by the late Dr. Arthur H. Green, "Patterns of Violence Transmission in Physically and Sexually Abused Children," is very important in view of the fact that a number of individuals later charged with violent behavior have had histories of physical and sexual abuse. In my practice, I have seen serial killers and mass murderers, all of whom have described serious sexual and physical abuse as youngsters.

The chapters on prediction of violence and prevention of violence are also quite important inasmuch as these are controversial areas that often become legal issues in malpractice cases in which psychiatrists line up on one side or the other regarding the prediction or prevention of violent behavior. Finally, the chapter by Dr. Peter M. Marzuk, "Violence and Suicidal Behavior: What Is the Link?" paves the way toward further understanding of the relationship between violent and self-destructive behavior, a link that needs to be explored more thoroughly.

In summary, this is an excellent book on a very important topic that covers the relevant issues as well as I have seen in one volume. It is essential reading for all psychiatrists working in the forensic field because it offers a wide range of understanding in a forensic psychiatric context. For all other psychiatrists, it is an important book to read to understand the risks involved in assessing and treating violent patients.

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Base Instincts: What Makes Killers Kill, *by Jonathan H. Pincus, M.D. New York, W.W. Norton & Co., 2001, 239 pp., $25.95.*

The true cause, or causes, of violent behavior and other behavioral and cognitive disorders is an area rife with contentiousness, nebulousness, and intellectual disharmony. In this powerfully absorbing book, neurologist Jonathan Pincus strives assiduously to penetrate the thick haze enshrouding violence by forthrightly postulating a theory purporting to explicate its etiology. According to his theory, childhood abuse, including physical and/or sexual abuse, causes the violent urge, and neurological deficits and psychiatric diseases affecting the brain, particularly paranoia, untether restraints on the urge.

Of these elements, childhood abuse is the most important one in Pincus's view, as well as the one most amenable to correction. Thought of metaphorically, childhood abuse is a cask that needs only a spark (in the form of neurological disturbance and/or paranoid thinking) to ignite it into a great conflagration unleashing forces of violent criminality.

Pincus is no stranger to the subject of violent crime. A neurology professor and inveterate writer, during the past 25 years he has neurologically examined about 150 murderers; slightly lurid details of some of the crimes perpetrated by these persons are recounted in the book. Pincus is an unusually good writer, possessed, as well, of great erudition. Indeed, his intellectual rigor, passion, and energy are practically palpable to the engrossed reader.

Pincus's riveting treatise on violent crime is configured into 12 chapters; a detail-laden, clinically directed appendix (pertaining to neurological diagnostic tools); and copious, annotated research notes, which may delight the research-minded reader. Pincus takes on the formidable task of developing a theory to explain violent crime in doughty, thoughtful, meticulous fashion. In search of the correct answer to the enigmatic question of why some people act in a criminally violent manner, Pincus capably and carefully guides the reader along a fascinating, hard-to-follow path, strewn with tantalizing bits and pieces of information proffered by an expansive array of subjects. These include abuse-drenched living environments, brain damage, paranoia, aberrant behavior and social pathology, genes, frontal lobotomy, attention deficit hyperactivity disorder, mania, toxic encephalopathy, and dissociative identity disorder.

Although definitive answers may be lacking, it cannot be gainsaid that this thought-provoking book illumines a profundity of invaluable information and insights germane to the causation of violent criminal behavior. A plethora of interesting questions are generated, which one hopes may stimulate robust discussion and examination. For example, Why do people kill? Does behavior in the particular form of violence originate in the brain? What is the proper definitional meaning of intensely value-laden terms, such as "violence" and "evil"? If violent criminals are, in fact, brain-damaged, why are they even considered criminals? How should the criminal justice system demarcate legal responsibility, if any, for legally proscribed behavior by brain-damaged persons? How should medical clinicians most appropriately treat brain-damaged persons exhibiting violent behavior? If "evilness" is the result of brain damage, is anyone really responsible?

The foregoing questions bring together, although probably uneasily, two quite disparate worlds: one with criminal-justice-based roots of case law and statutes; the other immersed in medical science and focused on the pathogenesis, diagnosis, and treatment of illnesses involving behavior and the brain. Some may question whether any one theory of violent criminal behavior can be cobbled together that fully respects and reconciles the traditions and mainstream thinking of these respective realms.

In my opinion, although Pincus's theory of violent criminal behavior may not necessarily resonate fully with other possible views and paradigms regarding violent behavior and other behavioral and cognitive disorders, he surely deserves hearty felicitations for painstakingly sculpting a theory about violence that should force the reasonably informed, discerning reader to think hard. Indeed, for the student of violent crime, including mental health and criminal justice professionals, this very fine book provides a wealth of insight, knowledge, and wisdom concerning violent behavior.

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SEXUALITY

Psychological Perspectives on Human Sexuality, *edited by Lenore T. Szuchman and Frank Muscarella. New York, John Wiley & Sons, 2000, 682 pp., $69.95.*

Clinical work with people with sexual problems, like therapy with those who arrive complaining of other mental difficulties, often proves to be more complex than research has indicated. The complexity is not so much accounted for by practitioners' inadequate grasp of the presenting problems as it is by reality. Afflicted men and women in every age group are dynamic, maturing beings. They create private meanings from their diverse life experiences. When they seek help, they have an array of circumstances competing for their attention. Often their presenting problem is the lesser of their limiting patterns. Clinicians look to colleagues who conduct research to provide us with new concepts about a problem, its sources, and effective interventions. We hope that their efforts will take us a little farther in our efforts to help the sexually distressed. Sometimes research does. The rate, however, is low.

The editors of this fine book trust in the utility and power of scientifically derived information about human sexual problems. They have a point when they assert that such information is the best way to train students to be clinicians or researchers. They have given their 39 authors free rein to exhaust their topics in 17 chapters. The average chapter consists of 38 pages with an extensive bibliography. The editors are interested in ideas that do not pathologize unconventional sexual identity development. Most authors are academic psychologists who write from social, psychological, or cultural perspectives. Biology is not heavily emphasized in the book. None of the authors seems to have a striking allegiance to a particular mental health ideology. Many have committed viewpoints.

The book has five sections. The first, titled Background, has superb chapters on research and male and female sexuality and should be required reading for everyone with a professional interest in sexuality. The Core Issues section, besides covering the topics of gender transpositions, varieties of orientation, and erotic fantasies, refreshingly includes a chapter on love. Although victimization has its own section, the topic is frequently addressed elsewhere in the book. The victimizations caused by HIV/AIDS, incest, childhood sexual abuse, varieties of rape, therapist-patient sex, and Internet addiction are discussed, as is treatment of sexual minorities, disabled people, and older adults.

One compelling chapter, "Genital Surgery in Children Below the Age of Consent" in the Issues of Cultural Concern section, is far more polemical than the rest. The authors used the term "mutilation" for the Sudanese practice of female circum-

cision, the treatment of intersexed babies, and the circumcision of American neonatal boys. Their purpose is to change values. Their grassroots political approach added to my appreciation of those academics whose viewpoints are more prudently uncertain and who take more trouble to be respectful and balanced in their presentations.

It was a pleasure to be in the company of the talented cadre of thinkers assembled by Szuchman and Muscarella, despite the occasional rant, holier-than-thou attitude, or unbalanced emphasis on the lack of data. Many chapters are terrific; none is less than good. *Psychological Perspectives on Human Sexuality* provides the intellectual background for understanding many important matters. Clinicians like myself will want it on our bookshelves and will recommend it often to students and colleagues.

The book provides much more background for clinicians than guidance for being a therapist. It is relatively silent about two highly relevant current issues: the explosion of progress in our ability to help erectile dysfunction pharmacologically and the frustrating inability to avoid sexual side effects in many psychotropic medications. While clinicians are immersed in intangible forces such as relationship evolution, the consequences of past personal choices, and defenses against knowing and feeling when we attempt to help a person or couple, researchers must deal with measurable matters. This provides their data with their strengths and their limitations. Happily for the reader, most of the authors recognize that in our quest to help others most of us do our best with the tools that we have. A few strident voices shout about our incomplete knowledge; these are the ones, ironically, who demand that things be their way. This is the varied landscape of the profession dealing with human sexuality that Szuchman and Muscarella have ably illuminated for us.

Librarians, invest in this one. *Psychological Perspectives on Human Sexuality* has too much to offer faculty and trainees to allow the work of these 41 people to drift away into a line item on their curriculum vitae.

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Castration: An Abbreviated History of Western Manhood, *by Gary Taylor. New York, Routledge, 2000, 304 pp., $25.00.*

In Woody Allen's triumphantly silly early movie *Bananas,* he is trying to pick up Louise Lasser, who has a women's lib chip on her shoulder but explains, "Oh, the liberation of women does not mean castration for the male." This causes Allen to wince and crumble up; just mentioning the word, he explains, causes such a reaction. According to Gary Taylor, however, a castrated man is just what some women would want and have wanted for centuries. This will sound peculiar to those raised in the 20th century on Freud or those who have followed the follies of John and Lorena Bobbitt. What Lorena did, and what Freud theorized on, was not castration as it had been understood for centuries. Before Freud, castration meant removal of the testicles, not removal of the penis. The 17th-century Byzantine physician Paul of Aegina gives the earliest medical description of the operation, which involved removing the testicles by compression or excision. (I wish that Taylor had told more about how the operations, especially self-castrations, were done, and what sort of survival rate or complications there were.)

As animals became domesticated, farmers learned that there were advantages to castrating bulls, for instance, to make pliable, working oxen. (Farmers never made the Freudian confusion and cut off the penises of their animals; that would have served no useful purpose.) It would not have been long before people began to wonder about the advantages of keeping men who had been castrated (the corresponding operation on women was much too difficult to consider).

Clearly, testicles were more important to Renaissance artists than were penises. Taylor explains that when a copy of Michelangelo's *David* was unveiled at Caesar's Palace in Las Vegas, its equipment was covered by a fig leaf, which got complaints from the punters (and perhaps from art lovers as well). When the fig leaf was removed, "some customers then began to giggle because the leafless *David*'s *cazzo* was obviously, by modern standards, a little…well, little. Underendowed. The customer is always right. So the statue was taken away again, and *David* was given a couple of extra inches where it counts." But no one complained about the size of the testicles, which Michelangelo had made as prominent as his society would have wanted. It was reproduction that was important then, and the "stones" were what mattered. Now that we have reproduced entirely enough, the "scepter" is more important. Sex for pleasure is now more vital than sex for reproduction. Freud's theories about men's fretting about an upcoming castration and women's envying penises misrepresent the history of castration and the history of patriarchy.

Eunuchs, like oxen, were useful. The word itself comes from a Greek compound of "bed" and "guard." Eunuchs had the responsibility of guarding the marriage bed. "They were qualified for that social function by being disqualified from a biological one." Eunuchs promoted the harem system because a dominant man could thereby ensure that his harem would bear only his children. Importantly, it must have been realized that eunuchs were capable of desire, of erections, of orgasm, and even of ejaculation, but any semen produced contained no sperm. Diddling within the harem would have meant little, since there could be no issue. The Romans and Ottomans used eunuchs for centuries but eventually introduced the sensible precaution of importing rather than manufacturing them, so that the eunuchs might have been angry at their castrators but could not take revenge on them.

Being a eunuch, whatever its disadvantages, had its perks. Playing games in the harem was one. Another was that only socially dominant men could maintain eunuchs, and so the eunuch was often rewarded with money or power. In some dynasties, eunuchs were the real power, and some had full control of the state. Power in the bedchamber became power in law and power over the military. Abelard, following his castration, was an important figure in the medieval Christian church. These eunuchs were not defective men but improved ones, in the view of their societies.

Taylor's thorough scholarship is especially well focused in his discussion of the Bible, early Christians, and Augustine. In Matthew 19:12, Jesus says, "For there are some eunuchs, which were so born from their mother's womb: and there are some eunuchs, which were made eunuchs of men: and there be eunuchs, which have made themselves eunuchs for the kingdom of heaven's sake. He that is able to receive it, let him

receive it." Jesus here speaks highly of eunuchs, but Augustine couldn't stand eunuchs. So to Augustine, this could be nothing but allegory; Jesus was obviously speaking of priestly celibacy. Paul stressed a circumcision of the heart rather than actual surgery; Augustine stressed a eunuchism for priests that had nothing to do with surgery either. Taylor makes the case that Jesus was not speaking allegorically at all. An enslaved eunuch was the lowest member of his society, and "the last shall be first." Jesus blessed the barren and encouraged his listeners to gain heaven by forsaking family and children. The clear condemnation of reproduction taken figuratively by Augustine has been taken literally by sects like the Shakers, but castration has been taken literally by plenty of others, such as the Skoptsky in Russia, who may have been actively self-castrating for Jesus until around 1970.

Taylor perspicaciously asks why the decrees against reproduction were not literally carried out and finds that it was simple Darwinian survival. The sects that kept Matthew 19:12 allegorical were able to reproduce and keep going, and those which took it (and other antireproduction verses) literally simply didn't have a next generation to take up their traditions.

Taylor is a Shakespearean scholar (an editor of the Oxford Shakespeare) and cites plenty of the Bard, but he bases much of his work on a close reading of *A Game at Chess,* a 1624 tragedy by Thomas Middleton, of whom I hadn't heard. Taylor thinks Middleton the second greatest English dramatist, but, knowing that we don't know a thing about the play, an allegory that revolves around a castration (of testicles, to be sure, not of the penis) of a black pawn by a white one, he describes it fully and shows how eunuchism tells in sex, religion, politics, and racial affairs.

The modern eunuch is the vasectomized man; sex for men with vasectomies and their partners does not have the goal of reproduction. With citations from artists from Shakespeare and Jonson to Tori Amos and Christina Aguilera, Taylor suggests that "abnormal" sexuality and gender identities can become normal and desired, and a eunuch is just the thing to answer Freud's famous but somewhat mutton-headed question of what do women want. Funny, provocative, scholarly, and decidedly offbeat, *Castration* is a witty tour de force.

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Self-Injurious Behaviors: Assessment and Treatment, *edited by Daphne Simeon, M.D., and Eric Hollander, M.D. Washington, D.C., American Psychiatric Press, 2001, 240 pp., $34.00 (paper).*

Editing a volume on self-injurious behaviors might be characterized as an act of bravery. Few authors, excepting Dr. Armando Favazza, a contributor to this volume, have dedicated a book to this topic. The scope of the book is capacious, covering self-injurious behaviors encountered in autism, Tourette's syndrome, mental retardation, psychosis, trichotillomania, and borderline personality disorder. Bravery is certainly involved in working with patients who injure themselves. As Guralnik and Simeon point out, "Clinicians are often scared away from work with such patients…[and, partially as a result,] a suspicious paucity of literature deals directly with treatment of self-injury" (p. 191). The editors' objective was to target a book for clinicians yet make it "sophisticated in its data base and research findings." Their predicament is that their heroic goal involves a clinical area about which little has been written. I might boldly suggest that the editors could have strengthened the book by examining the boggy ground between self-injurious and suicidal behavior. Unfortunately, these areas of inquiry have tended to have separate literatures and theoretical models, although patients' intentions in injuring themselves are seldom purely separated.

Drs. Simeon and Hollander have enticed many prominent researchers to contribute on their areas of expertise. Dr. Favazza coauthors the first chapter on phenomenology and assessment of self-injurious behaviors. This chapter is by far the most original and meaningful contribution. Drs. Simeon and Favazza classify self-injurious behaviors into four categories that have vital clinical relevance: stereotypic behaviors, as found in mental retardation and autism; major self-injurious behaviors, as found in major psychosis; compulsive behaviors, as found in trichotillomania; and impulsive self-injurious behaviors, as found in borderline personality disorder. The rest of the book follows this categorization and discusses in more depth each of the types of self-injurious behaviors.

Dr. Dan Stein contributes chapters on the neurobiology and psychopharmacology of stereotypic and compulsive self-injurious behaviors. One chapter reviews the phenomenology, neurobiology, and treatment of psychotic self-injurious behaviors; however, little research exists that is specifically related to interventions for self-injurious behaviors in these patients. A detailed case example of a psychotic patient with major self-injurious behaviors might have been more enlightening. Dr. Larry Siever co-writes a chapter on the neurobiology and psychopharmacology of impulsive self-injurious behaviors. However, other reviews of the psychopharmacology of impulsive behavior exist that are more up-to-date in that they include recent double-blind placebo-controlled trials of divalproex and more thorough in that they include the evidence regarding novel antipsychotics. Dr. Marsha Linehan and colleagues review dialectical behavior therapy for impulsive self-injurious behaviors; however, most of this information has been published several times before. The book concludes with an interesting chapter on the different psychodynamic therapies for impulsive self-injurious behaviors.

This volume is part of the Clinical Practice Series; therefore, the length is quite manageable for the busy clinician. The book is nicely organized and free of production errors. Since little else exists on this topic, I am not timid in recommending the book to clinicians interested in patients who injure themselves.

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