Mood Disorders

The Nature of Melancholy: From Aristotle to Kristeva, *edited by Jennifer Radden. New York, Oxford University Press, 2000, 373 pp., $35.00.*

Jennifer Radden, a professor of philosophy at the University of Massachusetts, has produced an informative anthology capturing nuances of melancholy and melancholia. Part 1 of this book (Aristotle to Freud) has 25 authors, joining (in part 2, After Freud) seven post-Freud writers. In addition to expected contributors, Radden includes literary passages by Goethe, Keats, and Baudelaire, as well as more polemical pieces by Jean Baker Miller and Julia Kristeva.

Such a heterogeneous mix is not unreasonable when "melancholy" (as a temperament style with romantic and creative connotations) was often intertwined with clinical "melancholia." Radden's inclusion of many artistic depictions underscores that point and distinctly enriches the introduction.

As in any anthology, it is tempting to quibble with the inclusion and exclusion criteria—here the inclusion of some authors whose model of "depression" does not stretch to melancholia and the exclusion of the more contemporary writings of Stanley Jackson and German Berrios. Jackson's monograph (1) remains a classic, providing a rich historical overview of the same topic.

Both Jackson and Berrios (2) emphasized the long-standing historical description of melancholia (from the time of the Ancients to early in the 20th century) as being as much a movement disorder as a mood disorder—a view recently reargued (3). Radden is critical of any such view, stating that "a disorder increasingly understood in terms of its behavioral manifestations will also serve to 'silence' its sufferers" (p. 35). No argument is offered to advance such a perturbing judgment, although Radden declares a preference for "subjective" above behavioral analyses. Her definition of "melancholy" as "both a normal disposition and a sign of mental disturbance…a nebulous mood but also a set of self-accusing beliefs" (p. ix) does not inspire confidence about her preference for subjective analysis.

Other polemical thrusts in her introduction detract and distract. Her imputation that melancholia is overrepresented in women is factually incorrect but provides a springboard for rococo asides such as, "Melancholy, with it loquacious male subject, leaves little room for the mute suffering of women" (pp. 48–49).

Radden's historical interpretation that melancholy/melancholia was long defined by "states of fear and sadness" (p. 10) risks trivializing the gravid clinical picture of melancholia. Further, it cannot be reconciled with her own primary text pieces. For Burton, the "fear" descriptors focus on psychotic and overvalued ideas. "Sadness" or "sorrow" are limp words for capturing Burton's descriptions of tortured thinking and "perpetual agony" (p. 144).

Reviewers risk being viewed as prissy when they point out sloppy editorial work. Nevertheless, misspelling the name of the Editor-in-Chief of the *American Journal of Psychiatry* on the opening page of the introduction heralds a general sloppiness. Together with a minimalist "index," Oxford University Press deserves to swallow some "black bile" and have the shadow of the managing editor fall on the ego of some staffers.

The book is, nevertheless, useful in having the rich pickings of so many seminal writers captured in one volume. The opportunity to reread many classic pieces by, for instance, Burton, Kraepelin, Maudsley, and Freud is welcomed. The long-observed link between mania and melancholic depression provides a good example of how we are condemned to report derivative research if we fail to respect history. Finally, the book reminds us of the rich clinical descriptions provided for so long in the European literature before the global adoption of criteria-based diagnostic systems.

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Hypochondriasis: Modern Perspectives on an Ancient Malady, *edited by Vladan Starcevic, M.D., and Don R. Lipsitt, M.D. New York, Oxford University Press, 2001, 402 pp., $65.00.*

Hypochondriasis has been a term used by physicians as well as the general population for centuries. Kenyon's classic review of hypochondriasis (1) offered little except to emphasize that hypochondriasis is commonly comorbid with depression (secondary hypochondriasis) but is rare as a primary entity. He was correct in that the DSM-IV categorical diagnosis of hypochondriasis is rare within psychiatric settings; however, it is often found within general medical clinics.

Over the past 25 years our knowledge base of this phenomenon has greatly expanded because of careful empirical research. The major contributors to this renaissance of research are the chapter authors in this superb volume. The research has focused on hypochondriasis as both a noun (categorical classification) and as an adjective (a dimensional construct). Thus, terms such as the "medically unexplained complaint," "illness worry," "illness phobia," "somatization," "illness attitudes," and "illness behaviors" all have similarities with hypochondriasis. Understanding these concepts further elucidates the nature of hypochondriasis. This outstanding book joins other volumes that address the complicated problem of hypochondriasis and its related problem of somatization (2–4). The editors, Drs. Starcevic and Lipsitt, are well-known for their work in somatization. Contributors to the volume represent an outstanding array of international scholars in this area.

The book begins with a chapter on the history of hypochondriasis by German E. Berrios, the great medical historian from Cambridge University. Dr. Starcevic contributes a chapter on the clinical phenomenology of hypochondriasis as well as a chapter on the role of reassurance in the treatment of hy-

pochondriasis. The latter chapter, itself, is reason enough to purchase the book. Not all individuals respond to reassurance, and Dr. Starcevic reviews how reassurance should be provided. Dr. Lipsitt contributes two chapters, one on the psychodynamics of hypochondriasis and one on the importance of the physician-patient relationship. The chapter on psychometric assessment of hypochondriasis by Anne E.M. Speckens should be required reading for anyone who wishes to study this disorder. Chapters on hypochondriasis and anxiety disorders by Giovanni A. Fava and Lara Mangelli and the relation of hypochondriasis to personality disturbances by Michael Hollifield complement the clinical consideration section of the book. Russell Noyes, Jr., reviews the epidemiology of categorical hypochondriasis, illness worry, and illness phobia. Laurence J. Kirmayer and Karl J. Looper review the role of hypochondriasis in primary care settings by focusing on the different roles of disease conviction, illness worry, and vulnerability as factors within hypochondriasis.

A chapter on mechanisms such as somatosensory amplification by Arthur J. Barsky is included, as well as a chapter on the constructs of abnormal illness behavior by Issy Pilowsky. The treatment section of the book is outstanding. The cognitive behavior treatment of hypochondriasis is discussed by Hilary M.C. Warwick and Paul M. Salkovskis, who have been pioneers in this field. The book closes with a chapter on pharmacological strategies for hypochondriasis by Brian A. Fallon, who has made important contributions in this area.

Nice additions to the volume are copies of questionnaires for hypochondriasis, including the Structured Diagnostic Interview for Hypochondriasis, the Whiteley Index, the Illness Behavior Questionnaire, the Illness Attitude Scales, and the Somatosensory Amplification Scales. This allows the reader to review the actual instruments that were used in so many of the studies cited. The book is beautifully produced, with many helpful tables. The cover features a wonderful reproduction of a print titled "The Hypochondriac" by H. Daumier that encapsulates much of what the hypochondriacal patient experiences.

Difficult somatizing patients who cannot be managed in primary care are increasingly being referred to psychiatrists. This book will offer not only understanding of what fosters hypochondriacal complaints but also treatment options. It is for this reason that this book should be part of any clinician's library. The editors have brought together an extraordinary collection of authors. Their careful editing makes this volume a great gift to our field.

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Bipolar Disorders: Basic Mechanisms and Therapeutic Implications, *edited by Jair C. Soares and Samuel Gershon. New York, Marcel Dekker, 2000, 600 pp., $175.00.*

The last decades of the 20th century witnessed immense progress in the clinical characterization of bipolar disorders, in the evaluation of relevant genetic and environmental factors, in the differential diagnosis from other disorders, in the establishment of prognostic expectations, and in the clinical assessment of effective therapies. Much of this was achieved or influenced by the authors of the 26 chapters in this book.

Progress has not been linear. Many hypotheses are yet to be confirmed. The cyclic nature of bipolar disorder has yet to be incorporated into a useful animal model that would permit proper animal pharmacological research. Candidate genes are still being investigated. Neuroimaging and neurochemical techniques are very gradually yielding the clues about brain functioning that we have so long sought. The effects of adequate treatments on cellular function are still elusive, although the research is increasingly well targeted.

The distinctions between bipolar I and bipolar II and the use of rapid cycling as a course modifier in our diagnostic classifications are increasingly permitting a better selection of patients for therapeutic trials. The use of some anticonvulsants for treatment is leading to more studies of different compounds that may prove to be equally effective.

For the skeptical who believe that the research on basic mechanisms is not relevant to the lives of our patients, the answer may have come from U.S. District Judge Henry H. Kennedy, Jr., in Washington, D.C., who in February 2002 indicated that a patient suffering a bipolar disorder was entitled to the full disability benefits awarded to patients with physical conditions. Judge Kennedy cited statements by physicians indicating that the patient's disorder was visible on brain scans, was characterized by chemical imbalances in the brain, and might have genetic causes.

Perusal of this well-written book may lead some to believe that we are seeing a dawn in which the nature of bipolar disorders may be elucidated, its course may be predicted, and its treatment interventions may become regularly successful.

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The Suicidal Patient: Clinical and Legal Standards of Care, 2nd ed., *by Bruce Bongar, Ph.D. Washington, D.C., American Psychological Association, 2001, 376 pp., $49.95.*

I was pleased to review this book for two reasons. First, for the past 5 years, I have had the honor of holding an academic chair dedicated to the study of suicide, the Arthur Sommer Rotenberg Chair in Suicide Studies at the University of Toronto. My main, and perhaps only, justification for accepting this honor is that I work daily with "the suicidal patient." My second reason was my memory of reading Dr. Bongar's first edition of this book. It was a valued resource as I readied myself for my new role as Chair. The first edition was published in 1991. Now, some 10 years later, Dr. Bongar has updated this important text.

Dr. Bongar, a psychologist who is Calvin Professor of Psychology at the Pacific Graduate School of Psychology, states that the primary purpose behind this volume is "to present

suggestions for optimal psychological practice in the assessment, management, and treatment of the suicidal patient" with a particular focus on blending clinical and legal perspectives on the management of such patients. According to the author, the book is not intended to "impose standards of care" or to remove the need for consulting with colleagues or legal experts.

Before reviewing the merits of the book, I caution readers with a psychiatric background that this book is targeted at the practicing psychologist. Dr. Bongar not only directs his advice to the practicing psychologist but also often refers the reader to the American Psychological Association regarding standards of professional practice. For a reference book that focuses on suicide and psychiatric illnesses, I highly recommend *The Harvard Medical School Guide to Suicide Assessment and Intervention* (1).

Although *The Suicidal Patient* has been updated from 1991, I still found some sections to be lacking key references. For example, the psychological approach to repeat suicide attempters is discussed without reference to the work of Marsha Linehan. Risk factors for elderly suicide are mentioned without reference to the pivotal work of Yeates Conwell and colleagues. The discussion of gender and suicide does not include the classic paper by Canetto and Sakinofsky (2). In spite of these reservations, the book provides the practicing professional with much sound and practical advice that is not available elsewhere. For example, Dr. Bongar discusses the difficult issue of maintaining the confidentiality of a patient who is acutely suicidal. He unequivocally affirms "that if a breach of confidentiality is necessary to save the patient's life," the clinician is bound to take this step (p. 237). The book contains one of the few guides to "postvention," that is, helping the survivors after a loved one has committed suicide, and the sound risk management strategies of these activities. The book concludes with a discussion of the possible legal aftermath of a suicide and desensitizes the reader to the role of the attorneys and some common legal defenses that are realities of malpractice actions.

The book begins with a chapter on the empirical evidence regarding the etiology of suicide. Overall, the chapter is a very balanced overview of this topic. The second chapter examines the care of the suicidal patient from the legal perspective and includes many important topics, including a discussion of physician-assisted suicide. Chapter 3 is devoted to the assessment of suicide risk and is targeted toward the practicing psychologist, containing a section on the Rorschach Inkblot Technique, the Minnesota Multiphasic Personality Inventory, and the Millon Clinical Multiaxial Inventory.

The appendixes to the book are extremely useful and contain some actual assessment tools such as the Lethality of Suicide Attempt Rating Scale and the Los Angeles Suicide Prevention Center Scale. The book is rich with quotations, such as Motto's statement of the central clinical task of risk assessment: the clinician must "determine and monitor the patient's threshold for pain (either physical or psychological)" (3). Truly, suicidology is the art of pain management.

Chapter 4, on the outpatient management of the suicidal patient, is full of practical advice. Dr. Bongar insists that during disruptions in the therapy of a patient at risk of suicide, the backup therapist should meet face-to-face with the patient in preparation for the transfer of care. He likens it to the care provided by an obstetrician anticipating the need for immediate care during a vacation period. Chapter 5 discusses the inpatient management of the suicidal patient. It is during inpatient stays when the clinician is held most responsible for the care and safety of a suicidal patient. The last chapter reviews risk management strategies when caring for high-risk patients and includes the section on "postvention."

As I was reading this book for the *Journal*, I received a letter from a daughter of a former patient. She was writing to inform me of his suicide. I was immediately aware of this book's value. Most of the time, Dr. Bongar's practical, straightforward advice will seem self-evident. His advice was precisely what I needed after receiving this letter.

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CULTURAL PSYCHIATRY

Cultural Assessment in Clinical Psychiatry: GAP Report 145, *by the Group for the Advancement of Psychiatry Committee on Cultural Psychiatry. Washington, D.C., American Psychiatric Association, 2001, 240 pp., $38.00 (paper).*

Culture counts! That's what the Surgeon General's 2001 report (1) said in bold letters. In the mid-1800s, American psychiatrists became interested in culture when mental hospitals filled with Irish and German immigrants. At the end of that century, unusual syndromes such as latah, amok, and koro were discovered by Western psychiatrists, and Emil Kraepelin traveled from Europe to Southeast Asia, described differences in symptoms among patients, and developed the field of comparative psychiatry. Freud, an armchair archeologist, turned to cultural studies as he matured. A small cadre of psychoanalysts kept the torch burning, but only Harry Stack Sullivan and Erik Erikson really made much of an impact.

McGill University was the birthplace of modern cultural psychiatry; in 1955 a division of transcultural psychiatry was established there along with an ongoing journal. Out of the social ferment of the 1960s and 1970s came the community mental health movement, which, although primarily based on sociological constructs, had a cultural subtext. In 1971 the World Psychiatric Association started a Transcultural Psychiatry Section. Arthur Kleinman cofounded the journal *Culture, Medicine and Psychiatry* in 1976. The *American Journal of Psychiatry* published an overview article on cultural psychiatry in 1978 (2). A year later the still vibrant Society for the Study of Psychiatry and Culture was founded.

Then came fluoxetine, followed by a cascade of efficacious medications that pushed culture to the bottom of the psychi-

atric chain. A new, primarily biological clinical paradigm emerged. But strange things were happening in the world. The decline of Communism and its class consciousness was followed by the eruption of ethnicity with its emphasis on geography and religion. Disaster upon disaster in Europe, Africa, the Middle East, and, most recently, Afghanistan has made the entire world aware that culture is a powerful force. In this environment it is little wonder that psychiatry has finally institutionalized cultural concerns in its diagnostic and statistical manual, and that residency training programs are now mandated to produce culturally competent psychiatrists.

I was delighted to receive *Cultural Assessment in Clinical Psychiatry,* a report by the Group for the Advancement of Psychiatry (GAP), to review, especially since I am working on a new cultural psychiatry chapter for the next edition of Kaplan and Sadock's *Comprehensive Textbook of Psychiatry.* I promised myself not to be too disappointed; a number of GAP reports over the years have been mediocre. I shouldn't have worried. Ezra Griffith, Chairperson of the GAP Committee on Cultural Psychiatry, Renato Alarcón, the Project Coordinator, and colleagues such as Edward Foulks, Pedro Ruiz, and Ronald Wintrob have published a solid and useful book.

The report defines cultural psychiatry prosaically as

> the discipline that deals with the description, definition, assessment, and management of all psychiatric conditions as they reflect and are subjected to the patterning influence of cultural factors in a biopsychosocial context. Cultural psychiatry uses concepts and instruments from social and biological sciences to advance a full understanding of psychopathology and its treatment. (p. 7)

That's quite a mouthful. On a grander scale, I believe that just as culture strives to organize a society into a logically integrated, functional, sense-making whole, so too does cultural psychiatry strive to make clinical psychiatry more logically integrated, functional, and sense-making. It has no unique predisposition to biological, psychological, or social approaches and reductionisms but, rather, is a synthetic discipline. Matter, mind, behavior, and society are meaningless until they are interpreted, explained, and accepted as reality through the cultural process.

The cultural variables discussed in the report include ethnic identity, race, gender and sexual orientation, age, religion, migration and country of origin, socioeconomic status, acculturation and the acculturative process, language, diet, and education. These are all neatly described (no mean feat). However, I was taken somewhat aback by the statement that drinking grapefruit juice can dramatically elevate the blood levels of several psychotropics, including benzodiazepines. If this were true in practice then all the alprazolam heads would be growing grapefruits in their garages.

The real value of the report rests in the application of a cultural formulation to six clinical cases. The cases include an Irish American who was alcoholic and a ritual masturbator, who, with the help of therapy and Alcoholics Anonymous, turned to a life of celibacy and sobriety by entering a Catholic seminary to become a priest. In another case, a cocaine-addled, depressed immigrant from Kenya was helped when he likened the recommendations of the American multidisciplinary inpatient team to those of a traditional council of elders. Other cases include a Pakistani immigrant family, a Filipino American medical student, an Irish American "good Catholic girl," and an Ecuadorian immigrant who was a Baptist minister.

The formulations for each case are lively, detailed without being boring, and quite informative, covering multiple cultural variables. Several even contain brief nostalgic references to castration anxiety and demonized objects. The formulations are models that demonstrate clearly the importance of culture in assessment, diagnosis, and treatment. It is doubtful that most clinicians will be as comprehensive in making their formulations, but the report shows what can (and should) be done. I rank this among the best of the 145 GAP reports.

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Of Spirit and Madness: An American Psychiatrist in Africa, *by Paul R. Linde. New York, McGraw-Hill, 2002, 288 pp., $24.95.*

Linde's memoir recounting his experience working as a psychiatrist in Harare, Zimbabwe, presents us with a fascinating and important lesson in cross-cultural psychiatry. Linde, an emergency psychiatrist at San Francisco General Hospital, spent a year in Africa. He tells the stories of 11 of his patients, representing a range of familiar psychiatric illnesses with very diverse presentations and conditions, not entirely foreign to those who work in community psychiatry. What is unique is Linde's description of the complexity of the experience of illness for those afflicted and for their families, especially their understanding of symptoms and causes and their decisions about what to do to obtain help. Interpretations of bewitchment are aspects of practice that take us beyond the familiar views of Western psychiatry. The roles of spirits, ancestors, and exorcism are an important part of the construct of illness and the appearance of symptoms. Linde articulates his recognition that he has to learn the meaning and attribution of symptoms in a culture whose experience he does not share. The shadow of stigma also exists in a different form. It drives the direction of seeking help so that the mental health system is the last resort after other options are exhausted. Fortunately, Linde is able to rely on the knowledgeable and sympathetic "sisters" at the hospital for guidance and support.

Linde's experience rings very true; it echoes my own briefer visit to South Africa, where I also felt the lack of context with many of the patients I saw and struggled to understand the meaning of illness in a different culture. In his attempt to describe his experiences Linde navigates toward the clinical focus and avoids political references to government policy or practice in Zimbabwe, which resulted in the need for foreign doctors even though they were untutored in the local culture. He also avoids comments on what he found when he arrived—that the doctors were on strike, which had a profound effect on patients. Acknowledging these concerns would have

changed his concept of what he wanted to communicate in this book, although it might have offered us greater depth of understanding of the problems he and his patients faced.

At times it is not clear who is Linde's intended reader. His discussion of sexually transmitted diseases, especially AIDS, and his references to psychotherapy and psychoanalysis are based on his experience in Zimbabwe in 1994 and do not reflect current understanding or practice. Despite these minor concerns, Linde has opened an important door. This presentation of the cases is moving and empathic. Linde asks for a more complex view of culture and an appreciation of the construction of experience, including symptoms and illness, within the context of a culture.

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PSYCHEDELIC RESEARCH

DMT: The Spirit Molecule: A Doctor's Revolutionary Research Into the Biology of Near-Death and Mystical Experiences, *by Rick Strassman, M.D. Rochester, Vt., Park Street Press, 2001, 358 pp., $16.95 (paper).*

This book is a highly readable, intriguing, provocative description of Rick Strassman's theories and research concerning the effects of *N, N*-dimethyltryptamine (DMT)—a short-acting and powerful plant-derived psychedelic chemical that is endogenously produced in the human brain—and what its evolutionary and psychological function might be. In this intellectually courageous book, which reads more like a novel than a scientific text, Strassman, Clinical Associate Professor of Psychiatry at the University of New Mexico School of Medicine, recounts the history of psychedelic research; the bureaucratic labyrinth he had to navigate to begin the first clinical research with psychedelic substances approved by the Drug Enforcement Administration in more than 20 years; his methods and results (including case descriptions of what his volunteers encountered while taking the drug); the dangers of experimentation with psychedelics as well as possible beneficial effects; and speculations regarding the body's built-in mechanisms for contacting spiritual realms. Throughout, Strassman shares his feelings about his research and the personal and ethical dilemmas he encountered along the way in an authentic and honest manner, which makes him a narrator who seems not only sympathetic but familiar.

Beginning in the 1950s, DMT had been studied as a possible cause of schizophrenia, before the 1970 Congressional law made further research nearly impossible. Strassman begins with the question, What is DMT doing in our bodies? He wonders why the brain so actively seeks it out, transporting it across the blood-brain barrier and very quickly digesting it. He hypothesizes that DMT is produced by the pineal gland—what Descartes termed "the seat of the soul" and what he calls the "spirit gland"—and is released during naturally occurring psychedelic states, including childbirth, the dying process, dreams, and a variety of subjective mystical experiences. Thus, Strassman posits that human beings have been designed with a biological mechanism that enabling us to have spiritual experiences.

The research that Strassman describes, conducted at the hospital of the University of New Mexico between 1990 and 1995, includes a dose-response study, a tolerance study, and mechanism-of-action studies to determine which brain receptors mediate DMT's effects. Sixty volunteers participated. There was no development of tolerance. Findings were inconclusive as to which serotonin receptor regulates DMT's effects. Throughout the studies, Strassman monitored the effects of the drug on heart rate, pulse, hormone levels, and body temperature. For some subjects, he used an EEG or magnetic resonance imaging head scan to measure which brain sites were most active during a DMT experience. Throughout his report, he is sensitive to issues of set and setting; his orientation as a clinician is evident in the way he counsels volunteers through their psychedelic sessions and in his thoughtful follow-up with them.

Strassman emphasizes his frustration with trying to fit his spiritual questions into a biomedical research design. His ultimate goal was to establish the safe use of psychedelics under supervision and eventually shift to psychotherapeutically oriented studies. Unfortunately, Strassman never undertook his next wave of research—which was to involve work with the terminally ill—because of a multitude of obstructing factors, including family issues, lack of collegial support, criticism by his Buddhist community, the complexity of working with volunteers, ethical dilemmas regarding the use of psychedelics with the terminally ill, and questions as to the long-term benefits of psychedelics.

A major portion of the book is devoted to detailed descriptions of what the volunteers encountered during their sessions. These include the exploration and resolution of personal psychological issues; out-of-body states in which people experienced their own deaths; a variety of mystical states in which volunteers experienced a unifying presence of God within and without the self and a felt sense of love as the underlying fabric of the universe; and—surprising to Strassman—a large number of reports of contact with alien beings of various kinds doing intrusive experiments and/or healing work. Most volunteers had positive experiences, but there were some scares and some "bad trips." One volunteer nearly had a heart attack because DMT normally leads to a flight-or-fight physiological response. Another older volunteer almost went into shock. One young man had a traumatic vision of being raped by alligators. Despite some of the beautifully uplifting experiences of many of the subjects, Strassman was disappointed to find in his follow-up interviews that the experiences did not typically produce real change in the volunteers' lifestyles in terms of their behavior. None began psychotherapy or a spiritual discipline to further integrate his or her insights. However, several reported a stronger sense of self, less fear of death, and a greater appreciation of life (benefits Strassman may underemphasize).

After allowing himself to venture creatively into hypotheses that DMT allows contact with dark matter or parallel universes, Strassman argues that DMT must have provided an adaptive advantage to our ancestors in allowing access to alternate states of consciousness and thus perhaps greater problem-solving abilities and greater creativity. Clearly, there is a need for further research into many of Strassman's theo-

ries, and he ends by describing ways to investigate the role of the pineal gland in DMT production and how DMT might be involved in dreams, childbirth, meditation, and mystical visions as well as in mediating the exit of consciousness from the body. He also describes his ideal psychedelic research center and the best use of this research to promote the highest good, research one hopes Strassman himself may conduct one day.

This book will be of great use both to researchers and clinicians with an interest in spiritual/mystical issues and/or in psychedelics as well as to laypeople. It will undoubtedly also raise concern among those who worry that Strassman is promoting or condoning the widespread use of psychedelic drugs. However, he is quite clear about possible negative effects, urges close medical supervision, and questions the long-term beneficial effects of psychedelics without the support of concurrent therapeutic work or disciplined spiritual practice. Strassman clearly sees a beneficial use for these chemicals and expresses anger about the ways that psychedelic research has been mishandled in the past and is hampered as a consequence.

This book opens up doors of perception and encourages us to consider far-reaching questions. Strassman quotes Jean Toomer in his epigram, "We do not possess imagination enough to sense what we are missing." This book does a good job in painting for us the myriad possibilities.

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SCHIZOPHRENIA

The Early Stages of Schizophrenia, *edited by Robert B. Zipursky, M.D., and S. Charles Schulz, M.D. Washington, D.C., American Psychiatric Press, 2001, 288 pp., $43.00 (paper).*

The editors of this well-written book, chock-full of information about schizophrenia, make a startling assertion:

> The introduction of atypical antipsychotic medication, shifts in social policy, and new research findings have had a profound impact on current thinking about the expected clinical outcomes of schizophrenia. (p xiii)

The basis for this striking statement, which leaves me wondering what great improvement has occurred that has escaped my notice, is given:

> A very high percentage of patients receiving treatment for their first episode of schizophrenia will achieve a full remission of symptoms, with many returning to very good levels of functioning. These findings have renewed hope that early intervention may have the potential to dramatically improve the long-term outcome of schizophrenia. (p xiii)

Their second major claim is that "early recognition of psychosis and a fully coordinated approach to treatment have not been the norm" (p. xiii). In other words, we have ways of significantly improving the treatment of schizophrenia but we're not using them. Does the volume support such dramatic claims?

Patrick McGorry, Alison Yung, and Lisa Phillips describe their work on the holy grail of schizophrenia research: can we detect future schizophrenia and prevent it? They describe their work in selecting a cohort of people with some symptoms resembling schizophrenia and following them carefully. In a sample of 45, they found that 41% became psychotic within 12 months. The best predictors were duration of symptoms, more psychopathology according to several of the usual rating scales, normal left hippocampal volume, cannabis dependence, and maternal age over 30 years.

I find the significance of these findings tantalizing. Will this area of research bear fruit in enabling us to detect true prodromal cases and then allow us to do treatment studies to see if we can prevent the full illness? Or are they merely elaborate demonstrations of the obvious: many people who develop the full symptom picture of schizophrenia start with milder symptoms, so we are not detecting future cases but current ones? It still remains unknown if earlier treatment will be of benefit. I fail to see how this research justifies the editors' assertions about new optimism about course and treatment.

Evelyn J. Bromet, Ramin Majtobai, and Shmuel Fenning present the results of the Suffolk County Mental Health Project, which followed for 2 years a large sample of patients with first-episode psychosis. Many of their findings seem irrelevant to this book, such as the different outcomes for subjects with or without schizophrenia. Their chief relevant findings concern predicting poor outcome of schizophrenia. The predictors they found were insidious onset, longer hospital stay, negative symptoms, and lack of resolution of symptoms after 6 months. I don't find these results too exciting. They seem to be less predictors than ways of describing poor outcome. Here, too, we see nothing that seems relevant to the editors' claim that a new day has dawned in treating first-episode schizophrenia.

Jeffrey Lieberman describes the Hillside prospective study of first-episode schizophrenia, which used a large sample of patients admitted to Hillside Hospital in 1986 to 1996. The researchers carefully assessed outcome and used a standard algorithm for treatment. Of the 118 subjects, 87% remitted in the median time of 9 weeks, and most of these subjects had a full recovery without any symptoms and a return to premorbid functioning.

Here we seem to have the exciting findings the editors extolled. Most patients with first-episode schizophrenia made a complete recovery. After 1 year the subjects had the option of discontinuing medication. The risk of relapse was five times greater in those who stopped taking medication. The cumulative relapse rate for all subjects was 82% at 5 years. For those who recovered from the second episode, the cumulative relapse rate was 78%, and it was 86% after 4 years in those who recovered from the third episode.

What does this mean? Is this the great revolution: many recover from the first episode, but most relapse several times? Improved treatment? Compared with what? The researchers found schizophrenia to be a chronic, recurrent disorder. Not exactly news. This project was not designed to study treatment. It certainly suggests that continuing to take antipsy-

chotic medication seems worthwhile, but this doesn't tell us that we have entered a new treatment era with better results.

Dr. Zipursky provides a chapter on the drug treatment for first-episode patients. Initially he deals with the question of the optimal dose of a typical antipsychotic, mainly haloperidol, giving the impression that low doses might be effective and safer. A close reading shows that we lack adequate data from pivotal studies to support that claim, and the issue seems moot once we decide that atypical antipsychotics should be our first-line drugs. The author leaves the question open, saying that the reduced side effects of the atypical antipsychotics might not offer an advantage over low doses of typical agents, especially considering the side effect of weight gain with the atypical antipsychotics. Ziprasidone is too recent a drug to appear in this discussion, showing the problem of trying to get up-to-date information from books in such a fast-moving field.

Dr. Zipursky doesn't assess the evidence as I do. We do not have clear evidence that low doses of typical antipsychotics are as beneficial as higher doses, so matching lower doses to atypical antipsychotics is speculative, not evidence-based. In the comparison of atypical antipsychotics with the usual doses of the typical antipsychotics, we face a difficult dilemma not emphasized in this book. Atypical antipsychotics have fewer extrapyramidal side effects and tardive dyskinesia compared with typical antipsychotics, but more weight gain, new onset of diabetes mellitus, and elevated blood lipids that may portend greater risk of heart disease. Ziprasidone avoids these risks, it seems, but has the possible risk of cardiac arrhythmias. Future research will have to provide the risk-benefit ratios of treating with the various antipsychotics, and we should avoid premature closure on the issue. One of the treatments to test should be low-dose typical antipsychotics.

We then hear about psychological approaches. One chapter discusses how to address "the emotional needs" of the patients. No studies have assessed psychotherapeutic approaches in first-episode schizophrenia, so the reader is left with not much to go on. Of course, we do not need scientific studies to determine that we should treat patients humanely and with sensitivity.

A chapter on family intervention summarizes data about expressed emotionality and psychosocial treatment, acknowledging that research has not addressed these modalities in first-episode schizophrenia. The author correctly points out that family intervention in chronic schizophrenia seems to reduce relapse and rehospitalization rates, but she does not mention the absence of evidence that such treatment improves pervasive positive and negative symptoms, overall social functioning, or occupational success (1).

The last part of the book has excellent chapters on childhood-onset schizophrenia, schizophrenia during adolescence, and cognitive impairment in early-stage schizophrenia. These chapters are full of interesting information, much of it new, but, once again, offering no justification for the optimism expressed by the editors that we have reached a new era of improved treatment, much less that this new knowledge has not been applied adequately.

All in all, this volume shows well the strengths and weaknesses of contemporary psychiatry. We feel justifiably proud of the advances in our understanding of the functioning of the normal brain, our ability to measure the anatomy and function of the brain, and the ever-increasing mass of knowledge about psychopharmacology. What we avoid facing, in our hubris over psychiatry entering the arena of a true neuroscience, is that this new knowledge has not done much to improve our ability to treat patients. We have not shown that the new antipsychotics improve symptoms to a significantly greater extent than chlorpromazine did in the 1950s, or that our psychosocial treatments and social policies have improved the lot of patients with chronic mental disorders, or, for that matter, that all the new drugs for mood and anxiety disorders work better than the few we had in the 1960s. There are some exceptions. Clozapine has added something new, but it hasn't had the large effect we thought it would.

Nor, as I read the literature, has our vaunted scientific approach to psychotherapy hit the pay dirt of showing equality or superiority to the drug treatments we have for most of the axis I disorders. I say this not to be nihilistic, but to focus attention on the important work to be done. I recommend this book strongly for the information it provides about schizophrenia, even if it doesn't bring us to the promised land.

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Schizophrenia Revealed: From Neurons to Social Interactions, *by Michael Foster Green. New York, W.W. Norton & Co., 2001, 207 pp., $32.00.*

This is a very interesting little book. The title seems to call for a huge, multiple-volume opus, ad tedium. I was pleasantly surprised by the compact and highly readable nature of this work. It contains a fairly large amount of information on schizophrenia in the 207 pages. It may seem difficult to imagine a text on schizophrenia as an exciting "page turner," but this book is actually enjoyable and hard to put down. Many clinicians may find it pleasant to spend a Saturday afternoon on this excellent summary.

The book covers descriptive pathology from Kraepelin and Bleuler to the current topics of DSM subcommittees. It moves along with the increasing knowledge of psychiatric illness through time and discusses treatments and new discoveries. There are several color plates that are quite good. More illustrations of this kind would have been helpful. The author takes an open approach that draws heavily from the medical literature. This is refreshing, as many general texts seem tethered to a psychosocial model. Dr. Green, a psychologist, is remarkably supportive of biological treatments and cites appropriate papers to support his remarks.

The sections of the book are well organized and demonstrate a well-thought-out approach to this multifaceted illness. The description of symptoms is excellent and quite clear. The discussion of neurodevelopmental risks is a good addition to this book. The association of the risk factors is, however, left unclear. A detailed review of exposure and outcome in an odds ratio format would have been a helpful contribution. The author covers genetics reasonably well, although more space could be given to Meehl's concept of

schizotaxia and the important implications of this concept. The genetics section is also very limited in scope, possibly an artifact of being a generally brief text, but there is a wealth of evidence supporting a genetic transmission for many cases of schizophrenia. A very interesting discussion of neurocognitive deficits follows the genetics section and includes an interesting clinical vignette. The chapter on neuroimaging is composed of odd combinations of material. The information is factually correct but seems uneven. For example, I found it odd that that the author mentions historical footnotes like pneumoencephalograms while virtually ignoring the single photon emission tomography literature. The discussion of treatment is well balanced and avoids the trap of condemning early practitioners' attempts and failures in the care of this enigmatic psychosis.

In all, the author avoids jargon and assembles the basic history of schizophrenia for us. *Schizophrenia Revealed* is a good book, but it falls short of being a major contribution to the literature. Many psychiatrists will enjoy it. People in academia might find it very relaxing reading, like a favorite novel. The book is not technical and should be very useful to the layperson who wants to learn more about schizophrenia than might be gleaned from the newspapers. Students will benefit from the concise nature of Green's work and the accuracy of his information. This book is pleasant to read, but not essential for one's library.

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The Neuropathology of Schizophrenia, *edited by Paul J. Harrison and Gareth W. Roberts. New York, Oxford University Press, 2000, 374 pp., $69.95.*

This book comprises 15 chapters on different aspects of the neuropathology of schizophrenia. After a review of the macroscopic findings in chapter 1, some specific aspects are reviewed in chapters 2 to 6, including hippocampal, cortical, and synaptic pathology as well as the question of gliosis and cerebral asymmetry. At the end of each chapter the published data are critically summarized and a future perspective is outlined. In chapters 7 to 12, additional aspects from imaging and other, related diseases are presented. Additionally, the knowledge on cortical development and the organization of cortical circuitry is summarized. The concluding chapters deal with methodological issues, the consequence of neuropathological findings for the treatment of schizophrenia, and a skeptical view of the neuropathology of schizophrenia in general.

Trying to place a value on this very well-conceptualized and well-written book, one has to know that since the first neuropathological study on schizophrenia in 1898 by Alois Alzheimer, only summary chapters have been written to bring together the published data on what is regarded as a very controversial area of schizophrenia research. The value of this book, however, is that it not only critically reviews our current knowledge concerning different aspects of the neuropathology of schizophrenia but also discusses details that are vital to put the data within the conceptual framework of the neurobiology of schizophrenia. In addition to looking at gliosis and neurodevelopment, the chapter authors present relevant literature on cortical development and animal models. Finally, having some chapters specifically dedicated to methodological aspects in this area adds another important perspective to this work.

In conclusion, this is a very comprehensive book covering all relevant areas of the neuropathology of schizophrenia as currently understood. It is not only very valuable to readers interested in the neuropathology of schizophrenia, but it is also an interesting, readable introduction to the neurobiology of this severe mental disorder.

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Stress and Anxiety Disorders

Coping With Stress: Effective People and Processes, *edited by C.R. Snyder. New York, Oxford University Press, 2001, 318 pp., $45.00.*

When Dr. Andreasen asked me to review this book, I accepted with pleasure and anticipation. I knew that Professor Snyder is a respected professor of clinical psychology and an expert in his field. In addition, I have had an interest in studying successful coping with physical illness for more than 40 years. As a psychiatrist, I was somewhat intimidated when I received a copy of the book and discovered that it was prepared for an audience composed primarily of psychology graduate students, behavioral medicine researchers, and clinical psychologists. Furthermore, with rare exceptions the contributors are clinical and research psychologists. It had been many years since I read a psychology text, and I wondered if I was the appropriate person to review it.

Glancing at the titles of the chapters, I was alarmed by the title of the first chapter, "Dr. Seuss, the Coping Machine, and 'Oh the Places You'll Go.' " I feared that I was holding the latest "pop psychology" book and that the author would soon appear on daytime television. I skipped to the chapter titled "Coping With the Inevitability of Death: Terror Management and Mismanagement," somehow expecting a chapter related to terrorism, to find that the authors deal with anxiety disorders. The publication date is 4 months before the attack on the World Trade Center, and there is no mention of terrorism per se.

One of the many advantages of retirement is the gift of time. I had the book, the time, and the interest in the topic. I decided I had approached the task in the wrong manner. I opened the book and read it from cover to cover in one sitting. Somewhere into the first chapter I began to understand what Professor Snyder was attempting to convey, and halfway through the book I became a champion of the volume. It is uniformly well written and well edited, the information is conveyed clearly, with many clinical examples, and, most importantly, it is clinically relevant to my work with those few patients I continue to see in psychotherapy.

The references in each chapter are extensive and current, and they represent the work of psychiatrists, sociologists, social workers, and psychologists. I found the chapter by Drs. Redford and Virginia Williams on the management of hostile thoughts, feelings, and actions to be particularly effective.

Some of the material, although probably well-known in the field of psychology, was new to me. The theory of social comparison and the research on this interesting theory made a great deal of sense to me. The chapter on the cognitive approach to coping was very convincing. The chapter on procrastination was a delight.

To be sure, there are the usual problems with a multiauthored volume. The repetitive definitions of stress and coping (some better than others) seem redundant. However, each chapter must stand on its own, and most readers will not have had the pleasure of reading it from cover to cover. The chapter on religious coping is superb, despite the somewhat puzzling reference to Judaism as one of the "relatively unstudied religions of the world."

If I were to read the book again for the first time, however, I would start with the final chapter. In this, the editor demonstrates why he has won countless teaching awards at the University of Kansas and why he is a successful editor of a major journal of clinical psychology. He reviews his own volume, pulling together the ideas from each of the other chapters and highlighting the overlaps and similarities as well as the areas of disagreement and controversy. This is a brilliant demonstration of his knowledge of the field and his appreciation of the work of others. Envy the graduate student who has him as mentor.

In my review of the current literature, I learned that 20 books on "coping" have been published recently. I have no idea how this book compares with any of the others because I have not read them. But I recommend this book to all of my colleagues and students who are struggling to assist their patients coping with serious adversity.

ROBERT O. PASNAU, M.D.
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Posttraumatic Stress Disorder: A Comprehensive Text, *edited by Philip A. Saigh and J. Douglas Bremner. Needham Heights, Mass., Allyn & Bacon, 1999, 434 pp., $69.00.*

Treating Psychological Trauma and PTSD, *edited by John P. Wilson, Matthew J. Friedman, and Jacob D. Lindy. New York, Guilford Publications, 2001, 467 pp., $45.00.*

In a field as lively and fast-growing as traumatic stress studies, editing a comprehensive textbook is a daunting task, and one has to admire anyone with the temerity to attempt it. Saigh and Bremner's textbook, unfortunately, fails to achieve its laudable goal. In fact, the authors' view of the field seems strangely limited. Some topics, such as assessment, are covered quite exhaustively, but others, such as treatment, receive only cursory or highly selective attention. For example, group psychotherapy is reviewed only as it pertains to one particular population, Vietnam combat veterans. In the epidemiology section, publicly recognized traumatic events such as disasters, wars, and street crimes are heavily emphasized, but the private, secret, and often-repeated traumas most commonly experienced by women and girls, such as sexual abuse and domestic violence, tend to be noted only in passing. This seems curious, considering that posttraumatic stress disorder (PTSD) is twice as common in women as in men in the United States.

Some of the most intriguing issues in the trauma field are not addressed at all. Dissociation, for example, is barely mentioned. One would never guess, from reading this text, that for the past 100 years, major theorists have postulated that dissociative states are central to the pathogenesis of PTSD, or that we now have a large body of research identifying peritraumatic dissociation as one of the most powerful predictive factors for the disorder. The authors' avoidance of this important topic is simply inexplicable. For all of these reasons, one must conclude that the comprehensive textbook of PTSD has yet to be written.

Treating Psychological Trauma and PTSD also attempts an ambitious goal. At present, we have a wide diversity of approaches and no shortage of controversy regarding the most effective treatments for traumatized people. Achieving a balanced and sensible overview is no mean feat. Wilson, Friedman, and Lindy approach this task with refreshing humility and tolerance. Wisely, these editors do not attempt to codify an authoritative text, which no doubt would soon become obsolete, given the rapid pace of innovation. Instead, they advance a set of guiding principles that affirm the value of pluralistic treatment modalities. They view the traumatized person dynamically, as a resilient organism seeking to reestablish homeostasis within a larger ecosystem, and they argue forcefully for an integrative, biopsychosocial approach to treatment.

They propose a "tetrahedral model" of PTSD, presenting a three-dimensional image in an attempt to capture the complexity of adaptation to trauma and the interrelatedness of posttraumatic symptoms. They also identify five "portals of engagement" for establishing treatment goals. Three of these portals correspond to the standard descriptive triad of PTSD symptoms (hyperarousal, intrusion, and avoidance); the other two recognize the impact of trauma on personal identity and relationships.

Rather than presenting a formulaic, "one-size-fits-all" protocol applicable to all patients, the editors emphasize the importance of fit between the patient and the treatment modality. They also recognize that treatment may unfold in stages, with new aspects of the traumatic disorder becoming more salient and amenable to different types of treatment once the initial presenting complaint is addressed. These general principles are illustrated as they apply to particular patient populations (for example, dual-diagnosis patients, refugee survivors of political persecution, survivors of childhood abuse). The editors conclude with a warning against overly aggressive or zealous interventions and a reminder that the best treatment is not a prescription but a collaboration that respects the patient's autonomy, resourcefulness, and capacity for choice. "The site of recovery…is not in our office, our words…nor our prescriptions, behaviors or technologies. Rather, the site of recovery is within the…space of the survivor." With its broad and capacious view of the field, this book is a welcome companion volume to the recently published practice guidelines of the International Society for Traumatic Stress Studies (1).

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JUDITH L. HERMAN, M.D.
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Anxiety and Its Disorders: The Nature and Treatment of Anxiety and Panic, 2nd ed., *by David H. Barlow. New York, Guilford Publications, 2002, 704 pp., $75.00.*

Mastering the literature on anxiety disorders is a truly Herculean endeavor, thanks to the explosive growth of the field since the 1980s. Few scholars possess the intellectual range to tackle such a task. David Barlow is one of them. A clinical psychologist who has made important contributions to descriptive psychopathology, experimental psychopathology, and the development and evaluation of cognitive-behavioral treatments of anxiety disorders, Barlow is unusually qualified—perhaps uniquely qualified—to write the definitive book on this topic.

The second edition of *Anxiety and Its Disorders* is not merely an updating of the original edition, published in 1988; it is an entirely new book. It consists of two main parts. The first comprises eight chapters that present Barlow's theoretical views on fear, panic, and anxiety, cast within the context of emotion theory. The second part comprises seven chapters, each co-written with another author, usually one of Barlow's Boston University colleagues. In addition to a chapter on diagnostic classification, each covers one of the anxiety disorders. Theoretical themes developed in the first part are continued in the second part, and Barlow's "voice" is evident throughout. The influence of co-authors is most apparent in the issues emphasized. For example, the chapter on posttraumatic stress disorder concentrates on assessment, the specialty of coauthor Terence M. Keane.

Barlow was wise to invite others to join him in writing the second part of this book. Had he undertaken the entire project alone, it would have taken him so many years merely to finish a first draft that he would have had to start all over again on completing it. Such is the ever-changing nature of our vast and complex field.

The strength of the book is attributable to Barlow's breadth of vision and his latitudinarian intellectual style. He is refreshingly free of the parochial guild biases that so often cramp theorizing in psychology and psychiatry. He draws on an astonishing range of disciplines. His thinking is informed by research in not only clinical psychology but also cognitive psychology, neuroscience, psychiatric anthropology, psychophysiology, genetics, psychopharmacology, and ethology.

Occasionally, however, I experienced difficulty grasping some of his conceptual points. For example, I am not sure what he means when he characterizes anxiety "as a unique, coherent cognitive-affective structure" (p. 64), or when he says that stressful life events "trigger specific emotional action tendencies stored deep in memory" if they "present a sufficient number of response, stimulus, and meaning propositions" (p. 232). Otherwise, Barlow's prose is seldom obscure.

Anxiety and Its Disorders is a magisterial work of scrupulous scholarship. A lucidly written, learned treatise of panoramic scope, it is the most comprehensive book ever written on the topic of anxiety disorders. It will be essential reading for students, researchers, and clinicians in the field of mental health for many years to come.

RICHARD J. McNALLY, PH.D.
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Posttraumatic Stress Intervention: Challenges, Issues, and Perspectives, *edited by John M. Violanti, Douglas Paton, and Christine Dunning. Springfield, Ill., Charles C. Thomas, 2000, 225 pp., $49.95; $31.95 (paper).*

"Critical incident debriefing" following trauma was designed for primary prevention of posttraumatic stress disorder (PTSD) and widely employed before being evaluated. Numerous studies have since shown critical incident debriefing to have no effect or even detrimental consequences for some traumatized people. The authors in this edited volume denigrate critical incident debriefing and other unproven methods to prevent PTSD—a worthy quest that regrettably becomes repetitive in places. On the constructive side, the editors want to foster a new "salutogenic paradigm" for traumatic events, by which they mean a renewed emphasis on the potentially healthful or maturing properties of life-threatening or horrific experiences.

The salutogenic paradigm wanders a bit among chapters, so that a single salutogenic model does not evolve. That said, several chapter authors suggest that traumatized people may be oriented toward their own strategies to reduce the risk of subsequent PTSD. The latter may consist of 1) writing about the traumatic event, 2) discussing it with others who also experienced it, and 3) not abandoning thoughts and conversations regarding the event prematurely. Although some work does support these interventions, the data generally remain thin, with only a few studies or with the focus on a single type of trauma.

Literature reviews throughout the book are balanced. Some chapters review specific topics (such as Bartone's studies from the Gulf War). MacLeod's chapter addresses long-ago trauma, a common entity in clinical settings. Despite being extremely critical of critical incident debriefing, a few authors concede that it has taught some important lessons. Some authors' strongest venom goes to "trauma industry" clinicians, whether for-profit specialists or well-meaning altruists, who rush blindly to the latest scene of violence. They are not alone in their harsh judgment (see psychiatrist Sally Satel's recent editorial [1]).

Some authors' rancor against critical incident debriefing soars so stridently that the clinician might be intimidated into doing nothing for recently traumatized, victimized, or otherwise suffering people. No mention is made of crisis intervention for traumatized people seeking clinical guidance or the importance of clinicians providing an opportunity for their ongoing patients to discuss traumatic experiences. More evenhanded chapters by Perren-Klinger and Pennemaker do provide helpful recommendations for working with recently traumatized people who have become distraught or disabled.

Although most contributors recognize the potential for trauma to produce PTSD, a few perceive demons in the "medical model" of PTSD, in the DSM-III addition of PTSD as a diagnosis, and in attorneys seeking gain from the "golden wound." Some readers will find this hostility off-putting.

However, despite the doctrinaire approach of the opening chapter, eclecticism-creep is apparent throughout. For example, one can find descriptions of the psychological processes and phases of adjustment to trauma that would please any psychodynamicist. It is heartening to read behavioral scientists writing about resilience, courage, meaning, and the symbolic dimensions of suffering—mainstays in the therapy of traumatized people who seek psychiatric care.

Colleagues with a special interest in PTSD will find a wealth of information on specialized topics, from laboratory studies of investigator-induced stress to reviews of special traumatic circumstances (e.g., the Gulf War) or special occupations (e.g., police, firefighter). Readers looking for guidance in the treatment and rehabilitation of patients with PTSD can find more compleat texts elsewhere. The comorbid disorders associated with PTSD are almost entirely missing, and vulnerabilities associated with PTSD receive scant attention.

Reference

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TREATMENT PERSPECTIVES

A Guide to Treatments That Work, 2nd ed., *edited by Peter E. Nathan and Jack M. Gorman. New York, Oxford University Press, 2002, 681 pp., $85.00.*

The first edition of this book was published in 1998 with the objective of offering, in a single volume, a compendium of psychiatric treatments considered to work effectively from a clinical point of view. The second edition is intended to update the treatments and interventions that clinically work, those which don't, and those which still remain beyond the scope of our current knowledge. The contributors selected for this edition represent a well-recognized group of scientists, educators, and clinicians from the fields of psychology and psychiatry. This second edition has also incorporated the most recent psychopharmacological and psychotherapeutic advances as well as new and well-established clinical interventions and procedures.

In total, 25 chapters address a series of diagnostic categories. Each of these chapters rigorously focuses on what is currently available in the medical literature. Specific attention is given to the type of studies analyzed. That is, randomized, prospective clinical trails with blinded assessments; clinical trails with interventions but without double-blind methodological techniques; open treatment studies aiming at securing pilot data; reviews with secondary data analysis; reviews without secondary data analysis; and, finally, reports based on case studies, essays, and opinions. In other words, the editors and contributors make a strong effort to differentiate the scientific nature and validity of what the medical literature has offered so far.

A final chapter focusing on "Efficacy, Effectiveness, and the Clinical Utility of Psychotherapy Research" was prepared by the editors. I found this chapter of much value, given the flux that for years existed with respect to evidence-based psychotherapeutic interventions and approaches. Actually, I think that this type of rigorous review and analysis is what will permit psychotherapeutic interventions to prevail through these years of challenges.

Another useful feature of this book is the excellent summary of treatments that work, which is presented in the beginning of the book. This summary notes not only the treatments that work but also the evidence on which the opinions are based and where in the book these treatments are addressed and discussed. This summary is both practical and quite beneficial for the busy practitioner and young clinician. Besides, it is an outstanding teaching and educational resource.

Finally, what is also practical and pragmatic about this book is that the information and data are presented in one single volume. In contrast to the numerous practice guidelines and books that have been published in recent years with similar objectives, this book, like DSM-IV, should be kept handy for daily use. I commend Dr. Nathan and Dr. Gorman for an outstanding contribution to the field, and I strongly recommend that clinicians and practitioners read this book and have it nearby, as I intend to do myself.

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Cognitive Rehabilitation: An Integrative Neuropsychological Approach, *by McKay Moore Sohlberg and Catherine A. Mateer. New York, Guilford Publications, 2001, 492 pp., $55.00.*

This is an excellent book, providing insights into neuropsychology and into the cognitive rehabilitation of clients. The authors cover a great deal of information in their 15 chapters, which are organized into four parts. Part 1, Fundamentals for Practicing Cognitive Rehabilitation, includes much important information about neurological disorders. Part 2, Management Approaches for Cognitive Impairment, gives practical strategies for addressing such issues as memory theory applied to intervention, management of dysexecutive symptoms, and communication issues. Part 3, Interventions for Behavioral, Emotional, and Psychosocial Concerns, deals with managing depression, anxiety, challenging behaviors, and working with families. Part 4, Working With Special Populations, has two chapters: chapter 14, "Rehabilitation of Children With Acquired Cognitive Impairments," and chapter 15, "Management Strategies for Mild Traumatic Brain Injury." Anyone who wants to know about neuropsychology, cognitive impairment, brain damage, and the treatment of such will find this a very useful book.

A couple of valuable insights will be briefly mentioned. On page 235 the authors begin a discussion of a clinical model of executive functions involving neuroanatomy and cognitive-based theories. The authors show that executive functioning involves the person's being able to deal successfully with such things as initiation and drive (starting behavior), response inhibition (stopping behavior), task persistence (maintaining behavior), organization (organizing actions and thoughts), generative thinking (creativity, fluency, cognitive flexibility), and awareness (monitoring and modifying one's own behavior). It becomes apparent that impairment in executive func-

tioning can seriously impair one's ability to function in everyday life as well as more serious tasks, such as work.

Another excellent discussion starts on page 346, where the authors discuss caregiver communication strategies. These include selectively ignoring behavior, redirecting the person's attention, providing choices, reducing expectations, backing off and trying again, speaking quietly and maintaining a neutral stance, identifying signs of the patient's escalating distress, and active confrontation and power struggles. Although these applied techniques might seem obvious, they are not. Surely, one is inclined to forget or miss some of them, and by providing them in just over 2 pages, the authors do us a real service.

The book combines technical knowledge with insights into treatment strategies. It is an excellent book, dealing with topics that many mental health professionals have had limited training in or have not pursued, even though we might readily have to deal with a client whose problems stem from problems of neuropsychology. This book gives us an excellent understanding of a wide variety of issues related to cognitive rehabilitation of neuropsychology problems.

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Coping Strategies Therapy for Bulimia Nervosa, *by David L. Tobin. Washington, D.C., American Psychological Association, 2000, 247 pp., $39.95.*

In this innovative and interesting book the author integrates many of the recent research findings for treatment of bulimia nervosa with well-known clinical observations of these patients. The main concept of this book is that patients with different coping styles and different comorbid diagnoses need different doses and types of treatment. The author provides a guide for choosing the appropriate treatment based on a hierarchy of defense mechanisms and assessment of readiness for treatment. Four possible doses of treatment are described, ranging from one or two sessions to more than 100 sessions. The importance of transference and countertransference issues is emphasized, including analysis of the transference in doses 3 and 4. For each dose of treatment, outstanding clinical examples are provided.

In section 1, the author describes the concept of coping strategies therapy. For example, in dose 1 of therapy, the patient is in the action stage of readiness for treatment, is using the coping strategy of problem engagement, and may need only one or two sessions of cognitive behavior therapy; the patient may be able to self-administer cognitive behavior therapy. Patients who require dose 2 are likely to be in the preparation stage of readiness for treatment, are engaged with the problem, and will probably benefit from 10 to 15 sessions of individual or group cognitive behavior therapy. Patients who require experiential processes before they can use active behavioral interventions require dose 3 of treatment, usually requiring about 20 sessions. Patients needing dose 3 are usually in the precontemplation phase of readiness for treatment and benefit from therapies that focus on self-esteem and interpersonal concerns; these patients often have some pervasive personality problems or trauma-related difficulties. Patients who are unable to form satisfactory attachments need to learn how to form a satisfactory relationship with the therapist in dose 4; this usually requires 50–100 or more sessions. Many of the principles of psychoanalysis are important in this dose of treatment, including analysis of the transference and recognition of countertransference issues. Patients requiring dose 4 are usually in the precontemplation phase of readiness for treatment.

Section 2 of the book provides detailed descriptions of each dose of treatment with illustrative case examples. The coping strategy of projective identification, typically seen in patients requiring dose 4 of treatment, is described particularly well. In projective identification the patient projects internal feeling states onto the therapist; this often evokes countertransferential responses that must be identified and managed for the patient's benefit.

This outstanding book is a major step forward in explaining many of the confusing contradictions between well-publicized research findings on cognitive behavior therapy and the experience of the clinician working with bulimia nervosa patients who present with widely different problems. It is indeed heartening that the author retains many of the useful concepts and techniques of psychoanalysis and integrates them into current clinical strategies.

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