For the readers of the *Journal,* the chapter titled "Psychiatric Aspects of Movement Disorders of Sleep" by Mann, Campbell, Caroff, and Ross may be a bit disappointing. It summarizes what is known about sleep in several psychiatric diagnoses, most of which is inconclusive. However, it also reviews the effects of the major antidepressant and antipsychotic agents in common use on different aspects of sleep as well as the long-term efficacy of clonazepam for the control of REM behavior disorder and the non-REM parasomnias. All in all, the editors have provided a good introduction to the movement disorders of sleep.

ROSALIND CARTWRIGHT, PH.D.
Chicago, Ill.

Agitation in Patients With Dementia: A Practical Guide to Diagnosis and Management, *edited by Donald P. Hay, M.D., David T. Klein,Psy.D., Linda K. Hay, R.N., Ph.D., George T. Grossberg, M.D., and John S. Kennedy, M.D., F.R.C.P.C. Arlington, Va., American Psychiatric Publishing, 2003, 250 pp., $47.00.*

"Agitation" is the term currently applied to a wide range of disruptive behaviors exhibited by the demented elderly and other patients with severe brain damage. One classification system groups behaviors according to the independent dimensions of aggressive-nonaggressive and physical-verbal-vocal. This scheme is probably useful in identifying risk to patients and caregivers, but it has not as yet proved useful in identifying neurochemical correlates or pharmacotherapies for agitation.

After consideration of the issues of terminology and measurement, additional chapters are devoted to epidemiology, ethical-legal issues, drug and hormone therapy, and nonpharmacological therapies ranging from psychotherapy to ECT. Although support for the usefulness of each form of therapy is claimed, typically the evidence is sparse and limited to reports of a few cases. The contrast in the poor quality of the research on agitation in dementia with the many large double-blind, placebo-controlled drug trials on cognition in dementia is quite striking. The reason is unclear in view of the fact that almost 50% of dementia patients exhibit some form of agitation at any one point in time. A second observation about the literature is that the majority of studies of treatment have been done in nursing homes. Although agitation, particularly wandering and physical aggression, appears to be more common in nursing home populations, agitation poses a much more serious management problem for caregivers who live with a demented person than does cognitive decline. After incontinence, agitation is the second most cited reason for placing a demented relative in a nursing home. If caregivers could be provided with better ways of dealing with agitation, the benefits for them and for the health care system could be substantial. Apparently, however, this sort of research has not been done.

It is certainly not the fault of the authors or editors, but there really isn't much new in this book. The state of the art is summarized by editor Donald P. Hay, reflecting on his feelings after receiving a call in the middle of the night from nursing home staff about an agitated, disruptive patient. He states, "We often wish that we had a magic pill or a surefire technique to recommend, but unfortunately we do not."

WILLIAM M. BEATTY, PH.D.
Oklahoma City, Okla.

THERAPIES FOR PSYCHOSIS

Personal Therapy for Schizophrenia and Related Disorders: A Guide to Individualized Treatment, *by Gerard E. Hogarty. New York, Guilford Publications, 2002, 338 pp., $39.00.*

Gerard Hogarty, a social worker and research scientist, is Professor of Psychiatry at Western Psychiatric Institute and Clinic, University of Pittsburgh. It was his research in the early 1970s that proved the efficacy of drug treatment in preventing rehospitalization for schizophrenia, and the same research clearly showed the scientific world that drugs alone were not enough. Hogarty's research agenda has been straightforward ever since: to clarify the elements of social therapy that add to the efficacy of drugs and to integrate the two approaches into a seamless whole. He has carefully scoured the literature on patients' personal experience with this illness, on subjective and objective signs of prodrome and recovery, on what helps at different stages of illness, and on theories of why it works. He has kept the elements of supportive therapy that empirical research supports and has added a blend of medication management, psychoeducation, alliance building, cognitive strategies, and social skills training. He has tested each element, weeded out the superfluous, and kept the whole flexible and attuned to the individuality of people who may share a diagnosis but differ in many other ways. He has used his clinical skills to pace his interventions pragmatically, keeping an eye out for what individuals can bear at acute, middle, and semi-recovered stages of the progression of their illness. He understands that therapy itself can unwittingly make a person ill. And he has packaged all this wisdom into a wonderfully readable book, a practitioner's guide to the gradually staged and proven-to-be-effective therapy of schizophrenia.

Among the how-to, he has slipped in, almost imperceptibly, theory, mechanisms, even statistics. Students knowing only what's in this short book would effectively know most of what they need to know about schizophrenia, its theoretical causation, its epidemiology, its evolution, its complex management, its unanswered questions, and its prognosis. The outlook is practical and always hopeful. Achieving stability is possible, asserts Hogarty, but it's hard work. It needs to draw on a powerful alliance and to persist. It's a life-long effort. But it works!

Thank you for a great book, Gerard Hogarty.

MARY V. SEEMAN, M.D.
Toronto, Ont., Canada