History and Policy

Social Suffering, *edited by Arthur Kleinman, Veena Das, and Margaret Lock. Berkeley, University of California Press, 1997, 381 pp., $48.00; $17.95 (paper).*

Much more than a book on social suffering, this volume attempts to be a powerful scholarly statement about the value of a return to basics in cultural anthropology and, hence, the need to go beyond the point where any subject can be examined as "a single theme or a uniform experience." The reading is fascinating as, from the perspectives of anthropology, social history, literary criticism, religious studies, and social medicine, the authors proclaim that "the forms of human suffering can be at the same time collective and individual…the modes of experience in pain and trauma can be both local and global." Yet, what is fascinating is also complex, and what is complex cannot easily be integrated or reduced to a cosmetic simplicity—nor should it be. Thus, the main risk for the reader is that of wandering into a maze of dazzling rhetoric, convoluted hermeneutics, and brilliant insights. Reading this book can be a delight or an exhausting journey, and its content can be an inspiring tale or a painful realization of inevitabilities.

The first article, by Arthur and Joan Kleinman, sets the stage for the critical approach to the "cultural appropriations of suffering in our times," such as the distortions conveyed by the subtle crafting of the media, the gross manipulations of politicians in power, or the sophisticated coldness of World Bank statistics. In the next chapter, David Morris' study of the contributions of literature brings into sharp relief the conflicting dimensions and the absence of borders between words and images in the description and understanding of suffering. The notion that "whatever its wider resonance, suffering is ultimately an individual matter" sounds like a subtle rejoinder to the previous chapter. Illustrative of the complexities of the subject, however, it seems that even Morris contradicts himself: at one point, he emphasizes the detachment created by the literary images of suffering, and, at another, he comments empathetically on the open crying of readers of *Uncle Tom's Cabin*.

Lawrence Langer takes a more militant position in his chapter. He claims that "we need a new kind of discourse to disturb our collective consciousness and stir it into practical action that moves beyond mere pity." He insists on the difficulties in describing and believing in the suffering of others and indirectly blames national reconciliation efforts (without naming South Africa among his examples) because they defuse alarm by deflecting atrocities and create, in that sense, "a fragile peace." The myth of "civilized beings," all but destroyed by the testimony of victims, has mankind swinging indeed between hope and despair.

Veena Das examines the position of women in the scenery of suffering. She denounces the traditions that diminish women and permit the perpetration of subtle everyday violence against them. Describing the plight of Indian women, she mentions silence as an imposed response that thwarts the transactions aimed at an accurate construction of pain. In his chapter commenting on Das' essay, Stanley Cavell deepens the search for "words and tones of words" that will allow sufferers to break their silence, itself a reinforcer of the social silences perpetuating the suffering. A similar purpose colors Mamphela Ramphele's chapter, "Political Widowhood in South Africa: The Embodiment of Ambiguity," which deals with the personification of "social memories for the benefit of society."

The notion of ambiguity is taken up by Vera Schwarcz, who writes about the public uses of personal grief in modern China. Political language covers up grief, translating "individual suffering into a public commodity," making suffering a "didactic value in communal life." At the opposite end, the sufferer's voicing of his or her own sorrow opens a pane of truthful attentiveness. Intellectual figures, muted and humiliated by the Cultural Revolution but resilient enough to create their own suffering-transcending testimonies, give sorrow a unique meaning of dignity and power.

Maoism as a source of social suffering in China is also the subject of Tu Wei-Ming's essay. He narrates vividly the process that in a few decades "destroyed the intelligentsia" and created a massive, collective conspiracy of silence, a docile multitude of workers, and the covering up of indescribable violence. Political leadership, ideological legitimacy, and moral authority were manipulated by Mao to foster an aggressive anthropocentrism, the myth of the general will, and a romantic utopianism that numbed the country and caused a "moral inversion on the social level."

Another look at the distortions of human suffering comes through Ann Harrington's examination of Nazi medicine. Trading on historical contradictions and dialectic maneuvering, the Nazi regime created a medicine that was at once "objective" and "holistic," each tendency demanding to be recognized as the "official truth." The extreme example of scientism (science as ideology) should make us reflect on the current obsessiveness with reified "facts" on the one hand versus the ascendance of "prevention and education" full of vagaries and vagueness on the other.

Far away from the miseries and suffering of war and torture, Margaret Lock's chapter on the reconstruction of death in North America and Japan is a powerful, novel approach to "the havoc and misery that technology can create." Although technology is an integral part of the history of human aspirations, Lock insists that it is by no means autonomous and points out that "the characterization of suffering, being culturally constructed, has a profound influence on [technology's] development, associated discourse, and application." For instance, the implementation of transplantation technology requires a "redefinition of death," about which North American and Japanese views differ significantly. Modern Western thought is seen as having "capitulated to the view that death is essentially a biological event." This "fetishization" of the American population and the "flow of organs from the poor to the rich, from the Third World to the First World" eloquently reflect the motto of "progress as tragedy." Lock calls this the "slippery slope of personhood" or moral integrity.

Allan Young comments on the "new rhetoric of suffering, grounded in the authority of science, and predicated on the mechanism called psychogenic trauma." He writes about the

historical genealogy of traumatic memories, concluding that "fear, like pain, was transmuted into an evolutionary gift, enabling the organism to anticipate threats and to avoid its destruction." In the next chapter, Paul Farmer discusses "mechanisms through which large-scale social forces crystallize into the sharp, hard surfaces of individual suffering." Farmer ascertains that structural violence runs through the axes of gender and ethnicity and is aggravated by cultural differences. Furthermore, the World Health Organization (WHO) now acknowledges that poverty is the world's greatest killer, and the poor are not only more likely to suffer but also more likely to have their suffering silenced.

Paradoxically enough, Talal Asad finds that the rules enshrined in the WHO Universal Declaration of Human Rights "cover a wide range of qualitatively different kinds of behavior" that go from the definition of what is truly human to moral and legal judgments about pain and suffering, and to the always colliding nature of individual and social interests. In examining torture, Asad finds it inseparable from a "disciplinary society," a practice that unfortunately seems to be as current now as it was many centuries ago. Although some attribute torture to "primitive urges," others think that it is "a practical logic integral to the maintenance of the nation states' sovereignty."

E. Valentine Daniel examines the plight of refugees, using the example of the three immigration waves of Sri Lankan Tamils into Britain, each of them dealing differently with "the unavailableness of a nation." The worst thing about suffering of this kind is a true "disaggregation of identity." The pace of time and the passing of history caught three generations of people from the same land carrying three different images and one common alienation. In spite of these "bleeding realities," Daniel also sees an opportunity to reach "authenticity of being," caring for themselves and others, and for the pursuit of individual and collective potentials. Solidarity may very well be the common name for these endeavors.

The final chapter, "Religions, Society, and Suffering," is by J.W. Bowker. He comments on Weber's discernment of the different ways in which religions have constructed social meaning out of the experience of social suffering. In this view, religions are systems organized for the protection and transmission of the achieved discoveries of human competence, discoveries that have been truly prodigious; however, religions are also a complex group of interpretations of texts, beliefs, documents, books, and doctrines. The spectacular advances in medical knowledge and interventions have led to the increasing isolation of religion as a human activity, a situation that becomes even more abstruse when economic factors start playing a role. Religions look to the wider context of society in their attempts to account for illness. This came initially from ignorance, but the "other side of the coin of ignorance bears the imprint of concern" and consolation.

This book is a tribute to the commitment of social science and the intellectual community to examine collective suffering with a multidimensional richness that rescues lessons critical for the work of health professionals in general and psychiatrists in particular. It cleverly points out the boundaries of modern and postmodern dilemmas: science and society, technology and humanism, social and clinical phenomena, human misery and human greatness. It denounces while describing; it instills hope while condemning. It digs into history and covers vast geographies—although there is nothing about Latin America—and vindicates the individual's search for meaning in an ocean of social forces. After all, that is the substantive mission of the healer in the classic and eternal sense. The authors of the essays and the editors of this book have successfully conveyed, without concessions to simplicity, an elemental but profound and essential message.

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Outside the Walls of the Asylum: The History of Care in the Community, 1750–2000, *edited by Peter Bartlett and David Wright. Atlantic Highlands, N.J., Athlone Press, 1999, 260 pp., $90.00; $33.95 (paper).*

Samuel Taylor Coleridge wrote, "If men could learn from history, what lessons it might teach us! But passion and party blind our eyes, and the light which experience gives us is a lantern on the stern, which shines only on the waves behind us!"

In the British National Health Service, the number of asylum beds have more than halved since the mid 1950s. At its inception in 1948, the British National Health Service inherited 154,000 psychiatric beds. There are now fewer than 40,000. Most of the 130 large hospitals of that time have already closed. Most of the remainder will be closed by 2005. The closure of the asylum has occurred in parallel with the development of extramural or, as it is more usually known, community care. Bartlett and Wright open the preface to their book with the observation that this momentous change has "constituted one of the most contested programmes in contemporary social policy."

Outside the Walls of the Asylum is the report of two workshops held at Oxford University and the University of Nottingham under the auspices of the Wellcome Trust. The subtitle describes its ambition: *The History of Care in the Community, 1750–2000*. The geographical territory is Britain and Ireland. It is edited and written by social scientists and one psychiatrist.

The editors comment that the history of psychiatry thus far has largely been an asylum history. They suggest this is for two reasons. The first is that many of the histories were written by practicing physicians whose locus of work was the asylum. Second, there are archival factors that have shaped this tradition.

Broadly speaking, there are two strands in psychiatric historiography. One is a meliorist view of the history, exemplified by Kathleen Jones: a tradition of presenting medical practice as progressive, humane, and liberating mankind from error, celebrating the construction of the substantial and often ornate "museums of madness" as the acme of Victorian philanthropy. The alternative, "revisionist" history of the 1970s is exemplified by Andrew Scull. The revisionist discourse talks about the restrictive incarceration of the insane and the rounding up of delinquent and indigent individuals for "societal convenience." Societal and medical motivation is described as venal rather than humane.

In their introduction, the editors suggest that we will find the reality somewhere between these extremes. They want to demonstrate and exemplify that there was a great deal of community care (i.e., care between the asylum and the larger society) in Britain in the early modern period.

There follow 12 chapters that examine this theme in finer focus. The sources of information are voluminous. They include documentary records within the hospitals, national and local government records, and newspaper reports. A fifth of the book is references, the great majority of which are to primary sources. The contributors mix statistical information with illuminating individual stories and case histories.

Inevitably, there is interpretation by the authors of a large amount of information. This is the so-called frame problem in cognitive psychology, currently more widely known in public/political life as "spin." However, the "authorial frames" seem to me to be largely dispassionate.

To highlight only one particularly illustrative chapter, Dr. Harriet Sturdy and Prof. William Parry-Jones describe the policy pursued in late nineteenth-century Scotland of the "boarding out" of insane patients. This involved up to four patients being placed in private dwellings with relatives or unrelated individuals. These guardians were paid a weekly sum for the patients' maintenance. This was supervised, with some vigor, by the General Board of Lunacy based in Edinburgh. By 1890, the commissioners are quoted as stating the system was no longer a novelty, "its successful working is best shown by its unobtrusiveness and by routine performance of its functions." Its decline was not precipitated by any tangible dissatisfaction but by larger changes in society after World War I.

All the chapters are written in a clear and readable way. The last three contributions, reviewing the postwar era, are less compelling—perhaps because British society has become more complex and plural.

I think that the chapters support the assertion made by the editors in their introduction. The subject has many resonances for the present. This is a book, *pace* Coleridge, which I have learned from.

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The History of Elgin Mental Health Center: Evolution of a State Hospital, *by William Briska, M.S.W. Carpentersville, Ill., Crossroads Communications, 1997, 288 pp., $15.00.*

"Lunacy, madness, insanity, mental illness—all names for the same phenomenon. Yet as one term replaced another in common usage, the displaced term became looked upon with disfavor.…It is a serious mistake and misreading of history to assume the people working in mental hospitals or those who directed mental health policy more than one hundred years ago were any less concerned and compassionate than we are today." These words, by author William Briska, set the tone for this book, written in celebration of the 125th anniversary of Elgin Mental Health Center and chronicling the history of the second state hospital to open in Illinois. As the Northern Illinois Hospital and Asylum for the Insane, the Elgin facility admitted its first patient on April 3, 1872. On the same date in 1997, Elgin Mental Health Center celebrated its anniversary just months after having received its second consecutive commendation in the accreditation process of the Joint Commission for the Accreditation of Healthcare Organizations. As might be gleaned from his quoted statement, Briska writes not from the perspective of a detached observer or inquirer, but from the deeply empathic and affectionate perspective of one whose career has been devoted to service in the hospital community. His effort is a careful attempt to represent the historical development of a cherished resource for the alleviation of human suffering, and it instills in the reader an appreciation of the possibility that history might have unfolded otherwise.

Noting that during its 125-year history the cycles of change through which Elgin Mental Health Center evolved mirrored the cycles of state and national policy regarding the care of the mentally ill, the author effectively uses local history as a window to the history of mental health care at both state and national levels and, in turn, uses those larger contexts to shed light on and interpret local history. So, for example, rich descriptions of facility buildings and grounds are provided within the context of broader discussions of developments in hospital architecture, their philosophical bases, and their reciprocal links to mental health policy. Elgin, originally built on the Kirkbride plan, a congregate model for managing patient populations, later added cottages more consistent with a segregate plan. The book's 25 chapters are largely, but not exclusively, organized around transitions in hospital leadership, so that considerable interesting biographical information is provided on the individuals—mostly physicians—who served as hospital superintendent. The book is replete with a variety of illustrations (by my count more than 80), including photographs of people, places, and activities in progress, as well as architectural drawings, maps, and artistic representations.

By Briska's account, the hospital's development is roughly separable into five phases. The first period, characterized by stable leadership and gradual growth, ended in 1893. The second phase, during which the hospital more than doubled in size, involved politicization in the forms of patronage and unionization, frequent changes in leadership, and power struggles at all levels of the system. This lasted until nearly 1920 and saw the realization of civil service reform and centralized administration at the state level. The third phase witnessed even more rapid growth and an increase in the geriatric and veteran populations. Divisible into post-World War I and post-World War II periods, this phase drew to a close as the hospital population peaked in the mid-1950s. The fourth phase was associated with the advent of psychotropic medications, a decline in the hospital's census, the development of community mental health centers, deinstitutionalization, and, finally, the decentralization of authority and decision making. This phase lasted until the late 1970s or early 1980s. The fifth phase—Briska calls it a rebirth—began in 1983 with the hospital's census at an all-time low and the state's decision to close Manteno Mental Health Center rather than Elgin. This phase, which carries the reader to the present time, is characterized by physical plant rebuilding, the integration of community mental health center activities into hospital system operations, and the further development of forensic programs. Elgin's new affiliation as of 1996 with Finch University of Health Sciences/The Chicago Medical School and the associated upsurge in educational activities are also noted.

At about the time of transition from the second to the third of Briska's phases of the hospital's development, on its 50th anniversary, superintendent Ralph Thompson Hinton, M.D., wrote

> What an army of men and women, numbering 19,884, have passed through the front door of the main building to make the hospital their home for days or months or years! What stories could be written if one had the ability to portray a pen picture of the humor and the pathos, the hopes and fears, the joys and sorrows of those who have passed this way.…What wonderful changes have taken place in the past fifty years! But, are the problems of today much different than those of yesterday? Not to any appreciable extent if we but analyze carefully the reports of our ancestors. Perhaps we do some things a little differently: perhaps our nomenclature is not the same; but our problems are the same and we are compelled to meet them just as they did. The work of these pioneers, if they can be so designated, should not be passed by unnoticed and due credit must be given them for instigating some of the things which we are now carrying out. (p. 164)

These words are consistent with the theme, articulated by the author and very much in evidence within the book, that similar issues may be seen recurring throughout the hospital's history.

Elgin experienced the issues of the day—which were experienced by other facilities throughout the state and nation—and the issues of the day are abiding issues. Some might be characterized simply as problems: scarcity of resources leading to overcrowding, understaffed and underdeveloped programs, patient "warehousing," and insufficient wages to attract and retain qualified staff. Other issues are recurrent and ongoing dilemmas, in which opposing arguments often have merit and reasonable people may disagree: congregate versus segregate architecture, long-term and short-term care priorities, the management of addiction and substance abuse disorders, separation versus integration of forensic and civil programs, hospital versus community care, custodial care versus active treatment, the role of patient work or labor and its regulation within the hospital setting, and even the tension between individualized treatment plans and standardized programs. The roles of research and education within the clinical service system are perennial sources of controversy, but these components have been vital in Elgin's historical development.

Perhaps the recurrent impetus to abolish physical restraint is an issue that falls somewhere between the two: physical restraints are problematic in the sense that everyone would prefer not to have to use them (and in that sense their desirability is not debatable); on the other hand, debate and discussion regarding the appropriate guidelines for their necessary use have never stopped. It is of note that when the board of administration for state hospitals in Illinois abolished the use of restraint and seclusion in 1914, Illinois by Briska's account became the first state in the nation to take such an action. This action had been preceded at Elgin by such a policy introduced by the superintendent, possibly as early as 1911.

Numerous specific contributions by individuals and programs associated with Elgin Mental Health Center could be mentioned. Of those noted in the book, some that caught my interest in particular are the superintendency, from 1897 to 1898, of John B. Hamilton, M.D., who was editor of *JAMA* (1893–1898) and president of the American Medical Editors Association (1894–1895); the location at Elgin of the Illinois Psychopathic Institute during the early 1930s and of its laboratory for an extended period of time until the late 1940s; the Biochemical Research Laboratory of Max K. Horwitt, M.D., active from the late 1930s into the 1950s; publication of *The Elgin Papers* in 1936, 1938, 1941, and 1944, which reflected active research and training programs, primarily under the leadership of Charles F. Read, M.D.; the theological work of the Rev. Anton Boisen, originator of the clinical pastoral education movement and author of *The Exploration of the Inner World* (1934); and, finally, Elgin's association with Thomas Szasz, M.D., who interned there in the early 1950s. It is also noteworthy that veterans of both world wars were actively treated at Elgin, which had a special veterans hospital on site and transferred more than 200 patients to the North Chicago Veterans Administration Hospital when it opened, while continuing to operate more than 400 beds for veterans.

The History of Elgin Mental Health Center was for me a delightful tour through the hospital's history, weaving in and out of the larger state system, the national context, and the development of psychiatry and the mental health professions. Personally, I am grateful to the author for enriching my perspective on the system within which I work. For those less involved with the Illinois system, there is nonetheless much that is interesting about this particular hospital and much that is illustrative of the history of our work.

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PSYCHOTHERAPY

Group: Six People in Search of a Life, *by Paul Solotaroff. New York, Riverhead Books (Putnam), 1999, 352 pp., $24.95.*

This is a real-life account of the personal struggles of six diverse, savvy, and spirited adults who are patients in a psychotherapy group in New York City. It captures the unique drama of this form of therapy, doing so in a way that will appeal to a broad audience, although I think members of the professional community will be especially interested in it. I couldn't put the book down once I started it. My enthusiasm was shared by four of my colleagues in clinical practice, who were so engrossed that each finished reading it in less than a week!

The author, Paul Solotaroff, is a journalist by trade and former patient of a pseudonymous "Dr. Lathon," a psychiatrist in private practice. Solotaroff suffered from a panic disorder throughout his adult life and did not feel significantly helped by the psychotherapy he received from several therapists. He credits Dr. Lathon with giving him a correct diagnosis, treating him with effective pharmacotherapy, and transforming his life through group psychotherapy. After termination of therapy, Solotaroff was so moved by his experience that he proposed to write a nonfiction account of one of Dr. Lathon's upcoming therapy groups. The psychiatrist approved the idea, obtained cooperation from prospective patients, and allowed the author to join a new group as an observer. The ensuing group had eight members—six patients, Dr. Lathon, and the author—and met every other week for 1 year.

Solotaroff somehow succeeds in creating a comprehensible tale from a wealth of information collected from audiotapes

and his handwritten notes. He breathes life into his story through the use of crisp descriptions, humorous commentary, and a discerning use of dialogue taken directly from the group's interactions. The story he tells is by no means sanitized but honest, raw, and real, and the group process is described with all its messiness and unpredictability. It rings true to anyone who has had experience in a therapy group either as a patient or a practitioner.

This would make a terrific companion book to the main text of a residency or graduate seminar—not only on the topic of group psychotherapy but also on individual psychotherapy as well. Patient selection, therapeutic frame and boundaries, transference and countertransference, resistance and interpretation, competition and aggression, the uses of empathy and humor—each of these issues is easily identified. Theory and technique in the practice of group therapy continue to develop, and Lathon demonstrates how it is possible for the prepared clinician to develop a unique model of treatment and apply it thoughtfully and responsibly. Finally, the book makes us consider the crucial issue of the therapist's mental health and the challenge of identifying and treating our wounded healers before they harm themselves or others.

Solotaroff, Dr. Lathon, and the six group members have given us a special gift by allowing this book to be written. Lay readers will find their consciousness raised about the power of talking therapy in the current climate, where selective serotonin reuptake inhibitors have become an expected means of treating emotional ills. Psychotherapy's evolving narrative is deepened by this work, and we need others like it.

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Psychotherapy for Borderline Personality, *by John F. Clarkin, Frank E. Yeomans, and Otto F. Kernberg. New York, John Wiley & Sons, 1998, 390 pp., $55.00.*

Beginning in 1967 with the publication of "Borderline Personality Organization" (1), Otto Kernberg has been developing and teaching a psychoanalytically based treatment for the heterogeneous group of disorders lying between psychosis and neurosis. Expressive psychoanalytic psychotherapy, now renamed transference-focused psychotherapy, has affected almost every therapist who seriously treats patients with borderline personality disorder. The extensive impact has come in spite of the incredible complexity of Kernberg's concepts and language. *Psychotherapy for Borderline Personality* makes Kernberg's work more accessible than ever before. Explanations are clearer, detailed clinical examples are woven throughout, and in those examples we gain access to the therapist's private considerations. The complexities, subtleties, and clinical pearls, which until now were available only to Kernberg's supervisees and students, are presented here.

The book is divided into three segments—the Ingredients, the Phases, and Special Issues of the treatment—the latter including crisis management and medication management. The authors delineate the theory of transference-focused psychotherapy, the overarching goals, the targets of each phase, the "broad stroke" strategies that prevail over weeks and months of work, the session-by-session tactics, and the techniques used to effect the tactics, strategies, and goals. The creation of a clear contract between patient and therapist is outlined, step by detailed step. The treatment is a melding of big-picture psychoanalytic guidelines with dozens of "mini-protocols" that direct the therapist's moment-to-moment thinking and intervention. The authors present this as a transference-focused psychotherapy manual but emphasize that it is not a rigid protocol.

The authors have taken the opportunity to address critiques and misunderstandings of their work. Let me summarize a few of these. On the one hand, transference-focused psychotherapy is used to treat a very broad and heterogeneous set of disorders. On the other hand, however, the patients for whom transference-focused psychotherapy is indicated represent a fairly narrow band within that spectrum: those who are not too isolated, not too much in need of external structuralization, those for whom secondary gain of symptoms is not too pronounced, and those with sufficient motivation and psychological-mindedness. The interpretations, of course, are based on inference and are always held tentatively at first, but they are often delivered with admittedly disproportionate force, in part to counter the patient's substantial resistance. The therapist hews to a position of technical neutrality, equidistant from id, superego, and external reality, refraining from supportive techniques, but technical neutrality, which presumes an attempted alliance with the healthy part of the patient, is entirely compatible with frequent, extensive, and powerful interventions. Technical neutrality is neither bland nor detached.

Confrontation, although intended to be firm and clear, is to be done tactfully, often including reference to the patient's healthier intentions. The authors are well aware that they have been criticized for having a negatively biased approach to patients with borderline disorder, especially as they "smoke out" the aggression that emerges early in the negative transference. They clarify that the aggression comes from the patient, that it is a destructive fact of borderline psychopathology, that it must be addressed early and relentlessly, that the libidinal transference is present (and usually more deeply defended), and that it too will have its day.

Beyond these clarifications, we are treated to some of Kernberg's clinical pearls that have rightly affected psychotherapies well beyond the boundaries of transference-focused psychotherapy. Kernberg has shown the power of vivid, engaging, often elegant metaphors in getting the patient's attention. He has provided a model of sitting with, staying with, and working with terribly chaotic and confusing situations that can prompt therapists to attack, run, or make mistakes. The comprehensive model of transference-focused psychotherapy, including rich use of countertransference, helps the therapist to preserve himself or herself and to persevere. The authors' presentation of the contracting process is masterful, including an excellent clinical example. Clarifying the therapeutic frame can immediately bring intense transferences to light, where they can be clarified, confronted, and interpreted. At the same time, the authors emphasize that the therapist does not commit to the treatment until the contracting is successfully completed. The point is made repeatedly that regardless of the level of chaos in the therapy, the therapist maintains a vision and a goal of a mutual, authentic, mature interaction.

In psychoanalysis, where treatments are validated on the basis of their clarity, their elegance, their applicability, and a preponderance of convincing clinical anecdotes, transfer-

ence-focused psychotherapy stands as a well-developed, if controversial, model. In the world of empirical treatments, where demonstrated effectiveness is the highest goal, transference-focused psychotherapy must be considered a pilot approach, not yet subject to even the first empirical trials. The authors are now in the process of empirically testing the treatment. As they describe it, the good news is that it has been relatively simple to train therapists up to adherence, which presumably means getting therapists to use clarifications, confrontations, and interpretations, while refraining from explicit supportive techniques. The difficulties come in teaching therapists to reliably identify the predominant object relation in the session; to determine which among various object relations is deeper; to identify and expose primitive defense mechanisms; to name the resistance and its source; to become aware of countertransference and convert it to an understanding of the patient; and to do this with tact and timing. All these and much more involve subtle judgments about invisible, inferred entities that often shift with the moment. Standardizing the measurement of this incredibly complex series of tasks, which the authors consider part and parcel of competent delivery of transference-focused psychotherapy, will be a challenge. Everyone knows that psychodynamic therapies have not typically been validated in the scientific sense. One hopes that the painful, often humiliating impact of leading patients to see the hypothesized hatefulness of their internal worlds will in the end be justified by positive outcomes.

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A Map of the Mind: Toward a Science of Psychotherapy, *by Richard Brockman. Madison, Conn., International Universities Press, 1998, 375 pp., $37.95.*

It is heartening to see just how much change has quietly been taking place within clinical psychoanalysis. Richard Brockman's *A Map of the Mind* is full of lively stories about patients whom he has either treated himself or supervised, without any excessive theorizing or genuflecting toward old doctrinal orthodoxies. Nor is it necessary for him to scapegoat rival ideologies. Each of the cases he describes was seen in face-to-face encounters, and he recounts his own efforts to arrive at some cautious generalizations from the clinical situations.

For Brockman, an important constituent to every case has to be the therapist's own countertransference feelings. Brockman does not trot out the concept of countertransference as a last resort or as the result of a clinical stalemate; rather, he assumes that psychotherapy is a genuinely human transaction between people capable of mixed, confusing, and only partly rational affects. Although he does not himself provide any examples of outstanding clinical failures, reading *A Map of the Mind* reminded me of just how brave Freud was in telling the world about his own frustrating therapeutic experience with the woman he named "Dora." Brockman does not proceed on the assumption that the therapist is in any way omniscient.

Brockman takes for granted the significance of the alleviation of distressing symptoms, and he also quietly endorses the utility of pharmacological medication. It is, I think, a tribute to the tradition in which Brockman works that he does not engage in an empty search for precise-sounding diagnostic classifications. His main achievement, and it is a considerable one, is to demonstrate the influence and role of emotions connected to transference feelings on the conduct of the therapy.

A Map of the Mind communicates, in its concrete illustrations, the rare kind of intimacy that takes place in the course of psychotherapy. Ideally, the time should come when psychotherapists like Brockman will discuss at length under what circumstances they recommend which sorts of drugs, just as, ideally, biological psychiatrists will be able to spend more time describing their human interactions with the patients they treat. In the meantime, and without awaiting the arrival of a utopia in which students of the mind and experts on the body will be able readily to converse with one another, *A Map of the Mind* represents to me an admirable bringing together of humanistic and strictly scientific perspectives.

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Formulation as a Basis for Planning Psychotherapy Treatment, *by Mardi J. Horowitz, M.D. Washington, D.C., American Psychiatric Press, 1997, 168 pp., $28.50.*

With decreased funding for supervision of medical and psychology training programs, clinicians have focused on case formulation involving short-term interventions, brief therapy, and/or short-term psychotherapy. More recently, some clinicians have argued for psychotherapy case formulation focusing on longer-term psychotherapy models of care (1). In an era of managed care, psychotherapy is a lost art/science in some sectors of the mental health community. There is a need for senior supervisors and master clinicians to present their ideas to a general audience. Dr. Horowitz' book *Formulation as a Basis for Planning Psychotherapy Treatment* is just such an enterprise. Whatever the book's shortcomings, it provides trainees with access to the thinking of a senior clinician who provides an expert supervisory model for approaching treatment planning in a psychodynamically oriented psychotherapy involving the goal of changing the structure of one's self.

Over the years, Dr. Horowitz has provided his readers with an array of books on important topics in psychopathology and treatment. In this highly condensed, slim volume, he presents some very complicated ideas about how psychotherapy can effect real change in self structure. He does this with a unique supervisory style in a highly schematic context that provides us with many clinical gems. What is lacking in this tome is a rich array of clinical material and verbatim clinical process notes that would have offered more clarity to the process of how psychotherapy case formulation leads to change.

Dr. Horowitz says the goal of his book was "to teach a hypothetical trainee to go beyond diagnosis to the kind of formulation that helps facilitate adaptive change in psychotherapy." The main chapters of the book focus on the following: examining the phenomena under investigation; delineating the individual's states of mind; observing themes of conflict and defensive control processes; inferring core pathological beliefs

and relating them to contradictory identity, relationship, and value experiences in different states; and looking at treatment planning in terms of "what can this patient change now?"

Unless one is familiar with Dr. Horowitz' core concept of a self state, which he has focused on in earlier writings, the ideas presented in this book may be too confusing for the "hypothetical trainee" to comprehend—especially the material on self states and the concepts of modulation of self states (well-modulated, undermodulated, overmodulated, and "shimmering").

Dr. Horowitz has established himself as an expert in the areas of psychotherapy, defensive-control processes, neurotic functioning, and characterological issues in psychotherapy. His concept of cognitive psychodynamics is well regarded and woven throughout most of the themes in this book. However, the examples and texts given in this volume are so schematic and diagrammatically presented that, at times, the clinical gems can be lost in the tables and diagrams of the role relationship model. Chapter 6, however, is excellent and should be required reading in a course of psychotherapy planning.

The phenomena of self states and self coherence are critical concepts for clinicians. These concepts underscore the crisis in current psychotherapy. For many clinicians, psychotherapy has become mere symptom stabilization (influenced by a managed care approach to brief interventions) involving short-term or brief psychotherapy to stabilize the patient's acute symptom presentation. Horowitz is focused on the more enduring aspects of the self and its conflicts. He sees the need for understanding and working through the psychodynamic conflicts that may have led to impaired self states or self fragmentation. Working with pathological self states in psychotherapy can led to real change in self states and self functioning. This goal characterizes the core issues of Horowitz' cognitive psychodynamic psychotherapy.

During the past two decades, the field of long-term psychotherapy has been broadened and widely influenced by the dovetailing of rich traditions in psychodynamic psychotherapy, self psychology, object relations theory, cognitive behavior therapy, and relapse models from the addiction literature. All of these traditions seem inextricably related to Dr. Horowitz' main theses, and it would have been helpful for such an integration to have been made in the text and references. For example, Dr. Horowitz' identification of symptom triggers seems identical to the use of triggers in the relapse prevention models in addiction, and acknowledgment of those traditions would have been expected.

Writing shorter-length books has its shortcomings. Throughout the book I found that the ideas presented were too schematized and condensed. Dr. Horowitz is a marvelous clinician, and a longer book would have allowed more breadth and depth to include more rich case examples. Fans of Dr. Horowitz may forgive him for the array of complex diagrams he uses to depict how to formulate the goals of psychotherapy and focus instead on the clinical insights and gems, which occur regularly in this book.

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CHILD PSYCHIATRY

Cognitive Behaviour Therapy for Children and Families, *edited by Philip Graham. New York, Cambridge University Press, 1998, 292 pp., $110.00; $44.95 (paper).*

This volume, with several authors addressing a dozen differing topics, is well positioned. Cognitive behavior therapy is clearly advancing on multiple fronts, not only clinically. It emerged to underpin a large number of psychiatric research applications in Australia last year. Its theoretical appeal is obvious. Unlike many psychotherapies, cognitive behavior therapy has made itself available to empirical testing. For those who prefer to resist psychopharmacological approaches, cognitive behavior therapy is an alternative that retains scientific as against sect credibility. If it is found to be effective with children and adolescents, it would allow population-based interventions to be mounted, primary (as well as secondary) prevention to be advanced, and tomorrow the world.

As a longstanding clinical treatment for adult disorders, nevertheless, cognitive behavior therapy has come under some recent challenges. For instance, King (1) suggested that it has high "treatment principle credibility" for both clients and practitioners but that its benefits are not necessarily derived from treatment-specific factors. How then does it hold up for children when, for instance, we are informed here in a chapter by Harrington and colleagues that preschool children "only rarely show evidence of learned helplessness," that there "is little evidence" of cognitive schemata in children, and that children may not be mature enough to undergo cognitive behavior therapy in the same way as adults?

Editor Philip Graham notes that cognitive behavior therapy has been claimed to have a place in the treatment of most psychological disorders experienced by children and adolescents, that behavioral treatments appear more effective than nonbehavioral and family treatments, and (presumably a non sequitur) that all American authors invited to contribute declined the invitation.

The chapter format is standardized. Each disorder is defined; the rationale for a cognitive behavior therapy approach explicated; salient assessment, measurement, and treatment techniques noted; case examples provided; current research issues sketched; and existing evidence for cognitive behavior therapy for the particular condition considered. This is useful for those who seek to consider only one or two topic areas, but for those who tackle the whole book, predictable redundancy and overlap lead to attention deficits.

An introductory chapter by Ronen provides a useful background based on discipline and developmental stage, detailing age-relevant nuances and treatment principles. Other authors cover issues central to cognitive behavior therapy for children and adolescents (e.g., the common need to meld cognitive behavior therapy with a strong educational component and with family interventions). These are well argued and explicated, and numerous useful clinical strategies are detailed. The topics (e.g., attention deficit hyperactivity disorder, obsessive-compulsive disorder, anxiety and depression, conduct disorder, learning difficulties, posttraumatic stress disorder, pain, eating disorders, and interpersonal and socialization problems) are appropriate. Most authors meet the ed-

itorial request for an "intellectually satisfying theoretical framework" and for its evidence base. For one author, however, to state that the "potential" for those with even quite "severe" expressions of a disorder to benefit from cognitive approaches has "been confirmed"—and for the reader then to find that such a definitive statement is referenced to a single 10-year-old conference abstract—does strain credulity. "To your room" would appear a clear, specific, and direct alpha command response.

Thus, this book is well positioned in meeting a need for both the specialist clinician and those who might seek to understand broader issues such as the applications and limitations of cognitive behavior therapy for children and adolescents.

Reference

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Handbook of Child and Adolescent Outpatient, Day Treatment, and Community Psychiatry, *by Harinder S. Ghuman, M.D., and Richard M. Sarles, M.D. New York, Brunner/Mazel, 1998, 251 pp., $69.95.*

Dr. Ghuman and Dr. Sarles, the authors of this useful, up-to-date text, note that planning mental health programs for children and adolescents has become increasingly complex and difficult. They report that there has been a massive shift in health care in the 1990s, a shift that was observed first in adult patients and later in child and adolescent patients. Mental health service delivery has moved from long-term inpatient and residential care to care in the community and home. This change in service delivery has been touted as progress and in the best interests of children and families, but in reality it has been driven primarily by economic pressures to reduce costs. The stay in an inpatient setting has gotten shorter and shorter even if an appropriate treatment plan mandates a longer stay.

As the length of inpatient treatment has decreased, new programs have developed and are developing for outpatient and community care. A new lexicon of terminology has developed for child services in the home and community, including "family preservation initiatives," "wraparound services," "umbrella services," and "in-home services." The emphasis of all these programs is on treating children and adolescents in their home and community. The stated basis for this is to decrease a family's dependence on others and to strengthen family bonds. However, there remains a cohort of chronically and severely disturbed children, adolescents, and their highly stressed parents, who do not respond to using less restrictive community approaches. Unfortunately, mental health planners and insurance agencies have neglected the care of these children.

This book was designed to describe emerging clinical services both in design (theory) and in practice (administration and staffing). The text, divided into six sections, deals primarily with day treatment and community psychiatry and only peripherally with inpatient services. The first section deals with general issues related to administration, staffing, training, and collaborative aspects of outpatient work. Section 2 addresses assessment aspects of outpatient work, including the assessment of infants, preschool children, school-age children, adolescents, and their families. In this section, chapter 8 addresses psychological evaluation and assessment. This chapter is one of the most comprehensive I have read on psychological evaluation and assessment. It lists all the currently available reliable and valid tests, describes them, and addresses their assets and liabilities. It is a useful reference chapter for residents, child fellows, and practicing child and adolescent psychiatrists.

Section 3 addresses the common disorders of childhood and adolescence, including affective disorder, obsessive-compulsive disorder, tics and Tourette's disorder, separation anxiety disorder, attention deficit hyperactivity disorder, conduct and oppositional disorders, alcohol and substance abuse disorders, pervasive developmental disorder, and learning disorders. All of these clinical chapters are well written by experts in the field and adhere to criteria in DSM-IV. Section 4 describes therapeutic interventions; chapter 17 in this section is devoted to pharmacotherapy in children and adolescents. It is a comprehensive review of the medications that are approved or used off-label for children and adolescents. The author addresses psychopharmacology in young patients in a comprehensive fashion, including such issues as method of action of the medication, risks and benefits of the medication, dose schedule, and side effects. Obviously, much more could be said about each medication, but for a quick guide and reference, this chapter is useful.

Section 5 describes mental health services that are intermediate in level of intensity between inpatient and outpatient treatment. These include day hospital and day school. Each of these chapters addresses administrative structure, staffing ratios and physical facilities, and relationships to outside agencies. The last section, section 6, addresses different aspects of community-based programs, including mental health services in the schools, home- and community-based care, the therapeutic nursery, and foster care. Each of these chapters is written in an easy-to-understand, readable style.

This book would serve general psychiatrists well. The level of detail is inadequate for child psychiatry trainees, child psychiatrists, and child mental health personnel. Each chapter provides a detailed and comprehensive list of references and offers a pathway toward finding more information on a specific subject.

Our field is rapidly changing. Unfortunately, the pace of change is almost frenetic. By the time a book such as this, with a publication date of 1998, is in the hands of readers, much of the field will have changed. However, as much changes, much will remain the same. That is, chapters dealing with the diagnostic assessment of youth; principles of psychotherapy, cognitive therapy, and behavior therapy; and the different outpatient and community treatment programs are still current. The authors are to be congratulated in that they have managed to achieve a uniform style from a diverse and talented group of contributors. This makes this handbook a highly readable and useful reference text for general psychiatrists, psychologists, and other mental health clinicians.

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The Psychoanalytic Study of the Child, vol. 54, *edited by Albert J. Solnit, M.D., Peter B. Neubauer, M.D., Samuel Abrams, M.D., and A. Scott Dowling, M.D. New Haven, Conn., Yale University Press, 1999, 366 pp., $60.00.*

The Psychoanalytic Study of the Child is one of the most prestigious and outstanding annuals produced by the psychoanalytic community. The current volume carries on splendidly in that tradition and contains a whole series of sophisticated studies by an international array of psychoanalysts. Each study is preceded by a helpful summary in italics, a style that I wish would be adopted by all journals. The book opens with an article by Ethel Person dedicated to Gladys Topkis, who has retired from her full-time position as a senior editor at Yale University Press. Person discusses creativity, claiming that creative expression "often involves another person in either a fantasized or a real relationship that encourages or catalyzes creativity" (p. 2). Examples are given and a parallel is drawn with the findings of child researchers that development combines internal psychodynamics and interactions with significant others as well as cultural and social influences. Person contends that even when there is no significant partner available for the creative individual there may be an internalized "Other." This is consistent with Freud's drawing of a parallel between the child at play, the adult daydreamer, and the creative artist, and my recent formulations (1). Person's contribution is to focus on the importance of the social forces surrounding the emergence of creative insights.

All of the chapters in this volume are of outstanding technical quality, and there is something in it for every kind of psychiatric and psychoanalytic interest. The first major section of the volume is labeled Development and Technique. This 70-page section consists of three case reports from the Psychoanalytic Research and Development Fund's 5-year study group on coordinating the psychoanalytic and developmental processes in children and adolescents. The authors point out that in the treatment of children one must deal directly with the vicissitudes of ongoing development along with the different aspects of the usual psychoanalytic process. The 5-year study group attempts "to sort out some of the encountered difficulties and begin to address ways to manage them" (p. 20) and "to consider additional techniques that might assist the needs of development without necessarily compromising fundamental analytic approaches" (p. 20). The case reports offer the details of three treatments. Wendy Olesker reports on the psychoanalytic therapy of an unusual 4-year-old boy in which she had to develop a variety of ways to facilitate his growth and ameliorate deviational aspects. Anita Schmukler presents the report of a 6-year psychoanalysis of a girl that began when she was 16, focusing on the technical demands of working in psychoanalysis during a period of the patient's intense developmental change. Alan Zients presents the analysis of a 5-year-old boy with seriously compromised ego functions that might even be thought to have contraindicated psychoanalysis. Despite these problems, Zients contends that his traditional psychoanalytic position, which emphasized "dynamic interpretations" (p. 68), facilitated therapeutic changes.

The section on theory contains some important and stimulating essays. Leon Balter discusses three kinds of "unknowability" in psychoanalysis. These are "the patient's inherently unobservable unconscious mental processes, practicably unobservable, extra-analytic influences on the analytic material, and the practically unanalyzable effects of the analyst's activities" (p. 125). I found Balter's chapter exceptionally thought provoking and reread it three times. Arthur Couch focuses on the therapeutic functions of the real relationship in psychoanalysis and includes an extensive review of the literature as well as his own formulations. This essay should not be missed. Linda Mayes presents clinical material from analyses with a child and an adult and other interview material with 4–5-year-old children "to explore individual fantasies of how development and change happens. The central role of internalization and object relations in regulating psychological development is emphasized" (p. 170). Ronnie Solan, an Israeli psychoanalyst, explores what he calls "healthy" narcissistic function, which includes "the narcissistic preservation of self-identities during interaction between self and others" (p. 193).

The clinical section begins with Judith Chused's presentation of material from the analyses of three children who developed obsessional behavior during the course of their analyses. Her purpose is to try to understand the unconscious determinants that led to this as a way to deal with anxiety and psychic pain. Donald Coleman studies the nature of narrative and tries to explore why it has been so natural, important, and universal to people throughout the world over the centuries. He addresses the question of how this information will help the psychoanalyst in day-to-day work. Oscar Hills describes his psychoanalytic treatment of a patient "who experienced distortions in the perception of his body on the couch" (p. 259) and discusses how this relates to the well-known Isakower phenomenon involving certain hypnagogic phenomena (2). M.A. Tallandini studies the dread of integration in a chronically ill patient with borderline disorder who seemed to be terrified that integration might involve a loss of the self.

The final section is on adolescence. Debra Rosenblum et al. present a psychodynamic overview of the relationship between adolescents and certain elements of the popular culture: "Theoretical perspectives are integrated with case material to illustrate some of the roles of popular music and fashion in the lives of teenagers as a means of expression and in potential therapeutic alliance formation, dynamic understanding, and working through developmental conflicts in displacement" (pp. 319–320). Anita Schmukler reports and discusses the treatment of a preadolescent girl over a 7-year analysis, with a focus on the patient's use of insight within the context of the transference.

As the reader can see even from this brief summary and book review, *The Psychoanalytic Study of the Child* contains high-quality chapters that will appeal to a great variety of interests among psychoanalytically oriented psychiatrists and other mental health professionals. It is a volume not to be missed by anyone engaged in psychodynamic psychotherapy or psychoanalysis.

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COGNITIVE NEUROSCIENCE

The Cognitive Neuroscience of Action, *by Marc Jeannerod. Oxford, U.K., Blackwell Science, 1997, 223 pp., $45.00; $29.95 (paper).*

As I sit now at my computer to write this book review, I can easily find words to describe the general topic of this book ("the neuroscience of intentional motor behavior"), words to describe the things I liked about the book ("clearly written, comprehensive, provocative"), and words to tell you about some of the ideas the book has inspired in me ("the role of the failure of representations for action in disorders such as schizophrenia"). And you probably are able to get a pretty clear picture of what I am trying to communicate to you, even though these are complex and highly abstract concepts.

So why is it so much more difficult for me to find the words to describe the concrete and simple actions that my eyes and fingers and hands are carrying out at this very same moment? Imagine that you aren't familiar with computer keyboards and typing—would you really be able to comprehend this laborious description of "my brain directs my eyes to scan the computer screen and the target letters on the keyboard underneath my fingers while simultaneously giving commands to my hands and fingers to move above the target letters as it is forming a word in consciousness so that as the word is formed the fingers can flex and move downward to strike the keys for each letter of the word in the correct succession"?

This paradox—that it is inherently difficult to describe even the simplest motor behavior in any accurate and detailed way, that it is in fact much easier to show someone a motor sequence and have them imitate it rather than try to use words to explain what you are doing—is related to one of the core themes explored in *The Cognitive Neuroscience of Action* by Marc Jeannerod. The paradox results from the way our brains carry out the task of instructing our motor system to perform actions.

As the author states at the outset, his book aims "to investigate the main aspects of representations for actions. It explores in detail the contribution of cerebral structures, particularly that of the cerebral cortex, to the various aspects of movement preparation and execution" (p. 7). After a brief introduction, Dr. Jeannerod discusses the neural substrates for object-oriented actions (chapter 2) and then moves to the question of task-dependent representations for action (chapter 3). For those of you who are new to the field of cognitive neuroscience, an example of an object-oriented action might be the act of my finger moving to strike the keyboard; the task-dependent representation would then be all of the things my brain is doing as it has me execute the movement.

Early in the book, Dr. Jeannerod provides an overview of the two diverging corticocortical vision pathways: the ventral "perception" system for salient objects in our visual field (what is it?) and the dorsal "action" system for such objects (where is it?). He presents a thorough examination of the data relating to these systems and to their role in motor behavior, explores experimental findings on the brain mechanisms involved in reaching and grasping movements, and notes that the ensemble of the research data suggests that "actions are driven by implicit 'knowledge' of object attributes, such that stable and decomposable motor patterns arise to cope with external reality" (p. 51).

From here, Jeannerod introduces his own more general distinction between a pragmatic and a semantic representation for action. Pragmatic representation refers to the rapid transformation by the brain of sensory input about an object into motor commands (visuomotor transformation—where I see and then hit a letter key—being but one example). As in my opening example about typing on a keyboard, it is not easy to describe these operations, even though we often perform them easily and automatically. In contrast, semantic representation in the brain refers to the use of cognitive cues for generating actions. In this series of operations, the brain binds together all of the elementary visual features of an object (color, contrast, depth) into higher-order properties (volume, form) and then finally performs supraordinate processing, where the semantic and contextual properties of the object are understood and the many separate attributes become a coherent and meaningful entity (so that, for instance, I am able to search for and then strike the specific letter key "I" as I begin to recount a personal anecdote).

In other words, "the same object has to be simultaneously represented in multiple ways, simply because the environment asks different questions to the nervous system and because the answer to each of these questions requires accessing different types of representations" (p. 79). To paraphrase work by Dr. Jeannerod and others, my pragmatic system, which directs my finger to type the letter "I" quickly and efficiently, has chosen a letter that is simultaneously experienced and chosen in my semantic system, with all its attendant meaning structures.

From this point, Dr. Jeannerod goes on to discuss the contribution of mental imagery to understanding motor representations (chapter 4), then covers action planning (chapter 5), and concludes with a chapter proposing a design for motor representation. Along the way, his far-reaching coverage of the literature touches on the research of C.D. Frith and colleagues on schizophrenia and the work of Patricia Goldman-Rakic on executive function and the frontal cortex. Neurodevelopmental issues pertinent to motor representations and action are not presented in this book, however.

The Cognitive Neuroscience of Action is clearly Dr. Jeannerod's synthesis and integration of his own research and the research of others in his field, but experimental data are presented and reviewed in detail throughout the book, there are ample citations of the literature, and the discussions appear well balanced. For the reader who might feel overwhelmed by the sheer complexity of the material to be assimilated, each chapter contains a succinct summary of its major points and conclusions.

Although this book aims to cover only the fundamentals and is written as a general overview of the brain's role in motor action, the level of the exposition is detailed, and Dr. Jean-

nerod assumes that his readers are familiar with basic aspects of experimental neuroscience, brain neuroanatomy, and current concepts in cognitive science. It is fascinating and useful reading for any research psychiatrist whose work is grounded in the principles of systems neuroscience and in the underlying brain mechanisms of mental activity and behavior. It is not for the general psychiatrist or the clinician, unless she or he has developed a strong interest in the field and is willing to engage her or his own semantic and memory systems in some heavy autodidactic activity.

This book is part of a series titled Fundamentals of Cognitive Neuroscience, edited by Martha J. Farah and Mark H. Johnson. This series proposes to produce "concise, readable and up-to-date reviews of a particular problem area by a leading scientist" and is designed to help foster the "growing rapprochement among cognitive scientists, specialists in artifical intelligence, neuropsychologists and brain scientists in their various efforts to understand human mental activity." This rapprochement represents the future of psychiatry. On the basis of the high quality of Dr. Jeannerod's book, I am eager to see others in the series.

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Fundamentals of Neural Network Modeling: Neuropsychology and Cognitive Neuroscience, *edited by Randolph W. Parks, Daniel S. Levine, and Debra L. Long. Cambridge, Mass., MIT Press, 1998, 428 pp., $65.00.*

When the first report on neural network modeling of psychiatric symptoms, authored by Ralph Hoffmann and published in *Archives of General Psychiatry,* appeared on the scientific map in 1987 (1), people must have wondered what this type of reasoning was all about. After all, there are roughly 20 billion neurons in the human cortex, and any attempt to really understand their function and link it to psychopathology must have appeared deeply misguided. The ensuing decade, however, has witnessed nothing short of a revolution in brain science and an ever-increasing stream of research on brain function. While we learn more than ever before about neurons at the cellular level, thinking in psychiatry has undergone a major change toward so-called descriptive psychopathology. The concepts have been refined and sharpened and at the same time cleansed of useless theoretical baggage. The net result is that within this framework of clearly defined diagnostic criteria and biological brain science, research in psychiatry has flourished. The problem, however, of how to relate brain and mind—a psychiatric symptom, for example, on the one hand and a dopamine receptor subtype on the other—remained and became increasingly bothersome. This is where neural networks enter the picture.

According to Parks, Levine, and Long, as well as many of the contributors to this edited volume, neural networks are needed to bridge the gap between neurobiology and psychology, including psychopathology. The book starts with a general introduction to network modeling, but subsequent chapters take the term "neural network" to denote just any connected brain areas. So we learn—in well-written chapters by well-known authors—about neuroanatomy (chapter 2), attention networks (chapter 3), lexical retrieval (chapter 12), and semantic abnormalities in patients with Alzheimer's disease (chapter 16) without learning anything about neural network models. But there are also role-model chapters on simulations and real-world data, which show what this type of research can do for the understanding of such diverse phenomena as mathematics and acalculia (chapter 10), cognition and schizophrenia (chapter 8), and hippocampal function and memory (chapter 13). Within these and other chapters, the reader can find valuable ideas and discussions regarding neural network modeling. Such models, for example, rarely prove any hypotheses, but they are great in generating them. They are the "theoretical concepts that are intermediate between the details of neuroscientific observations and the box-and-arrow diagrams of traditional information processing or neuropsychological theories," as Servan-Schreiber and Cohen (p. 191) point out, and they may in some cases "be viewed as an existence proof that such a learning mechanism is feasible" (Dehaene et al., p. 246). The limitations of some models are explicitly discussed in some chapters (for example, p. 267), while other chapters explore their applications to psychology.

A minor criticism applies to the way the essays are arranged in sections. Why are alcoholism and depression discussed in the section titled Behavioral States, whereas mathematics, attention, and lexical retrieval are to be found under Neuropsychological Tests and Clinical Syndromes? Parkinson's disease is not dementia, and, in general, why discuss dementia separately in several chapters and leave out autism, obsessive-compulsive disorder, and attention deficit disorder as well as hallucinations, delusions, and thought disorder? Why are we advised to learn back-propagation and/or adaptive resonance models (p. 25), but self-organizing feature maps (Kohonen networks) are hardly mentioned, although they provide the basic means to understand the formation and change of cortical maps?

Network models are a theoretical tool for the investigation of the behavior of idealized neurons. If we need these models (and the editors argue we do), then we need textbooks to educate the psychiatrist about modeling (and the editors claim they have provided us with one) and to help us see the link between models and the real world of psychopathology. There must be consequences of modeling psychopathology for clinical practice. In addressing these issues, what does the book tell us about the field of neural network research in psychiatry, and what are the advances made in the field within the past decade?

Sadly enough, the first thing to notice is that there really is no field. Neural network research in psychiatry has never taken off the ground to become a mainstream enterprise. Although there remains hardly a symptom, syndrome, or psychiatric disorder for which there is no computational model, network modeling has remained a sacred trade performed by a handful (or two) of devoted psychiatrists. Just seven out of the 37 contributing authors (i.e., less than 20%) in this book work within a psychiatric department; add a few more and the world's psychiatric modeling community is assembled.

Does the book provide a means to change just that? The authors have made a brave attempt, but more needs to be done. The book comprises 17 chapters of different scope, quality, and level of sophistication, ranging from neuropsychology and cognitive neuroscience to some aspects of modeling. The very term "neural network" is used technically as well as col-

loquially (denoting any connected brain areas), and there is little, if any, common theme that links the chapters. Although the editors provide an introductory chapter to network modeling, they fail to provide the common thread that would make this book a whole that is more than the sum of its parts. So the book is likely to leave the clinician with questions about the consequences for the real world and has nothing to say about how network models relate to the diagnosis and treatment of mental disorders. More work in this regard is needed, and the book may help to encourage the reader to get involved.

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The Prefrontal Cortex: Anatomy, Physiology, and Neuropsychology of the Frontal Lobe, 3rd ed., *by Joaquin M. Fuster. Philadelphia, Lippincott-William & Wilkins, 1997, 320 pp., $83.00.*

The third edition of Dr. Fuster's book lives up to the standards set by the first and second editions, providing a comprehensive, informative overview of the frontal lobe. The third edition extends the previous editions to include more human neuropsychology and functional neuroimaging.

The introduction provides a framework for the rest of the book. The intervening chapters discuss cortical anatomy, chemical neurotransmitters, animal lesion studies, neuropsychology, and neuroimaging. The final overview chapter provides a theoretical framework of frontal lobe functioning. Throughout the chapters, the author complements the basic research review with an overview of a particular structural or chemical function in a clinical disorder. Among the disorders briefly discussed in the book are schizophrenia, dementia, obsessive-compulsive disorder, and depression.

Each chapter is organized in a similar fashion, starting with early processes of sensory perception and attention and moving toward more downstream functions such as movement, memory, and intelligence. Each chapter also contains sections on development and involution that prove invaluable in creating a well-rounded perspective of each of the major areas of frontal lobe research. The order of the chapters systematically constructs a more and more complex picture of the prefrontal cortex, building from cellular to more modular units. The standardized structure of each chapter makes the entire book easier to integrate. The concise, informative summary at the end of each chapter further reinforces the information provided and serves as a quick reference to those who have already read the book.

Once again Dr. Fuster has provided a comprehensive, integrated, up-to-date overview of an extremely complex structure. This book is a must for students as well as a highly recommended reference for both the neuropsychologist and the cognitive neuroscientist.

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Reprints of Book Forum reviews are not available.

Correction

The article "Divalproex Treatment for Youth With Explosive Temper and Mood Lability: A Double-Blind, Placebo-Controlled Crossover Design" by Stephen J. Donovan, M.D., et al. (May 2000, pp. 818–820) contains an error on page 819. In the Results section, the sentence beginning on line 10 should read: "The DSM-IV diagnoses found in these children were ADHD (four subjects), marijuana abuse (six subjects), and disruptive behavior disorder (oppositional defiant disorder or conduct disorder; all subjects a priori).