NEUROPSYCHIATRY

Neuropsychological Differential Diagnosis, *by Konstantine K. Zakzanis, Larry Leach, and Edith Kaplan. Lisse, the Netherlands, Swets & Zeitlinger, 1999, 272 pp., $79.00.*

Impairment in cognitive functioning is a feature of many different psychiatric and neurological conditions. These impairments are often evaluated with neuropsychological tests, and the number of different tests available is increasing by the month. Many articles published in psychiatric journals such as this one examine profiles of cognitive impairment in different conditions and the correlates of those impairments, such as deficits in adaptive life functioning. It is not hard to find statistically significant differences between different psychiatric populations and healthy individuals, but there are substantial methodological problems associated with many of these research studies. In fact, it is often difficult to find tests on which patients with schizophrenia or dementia do not differ significantly from healthy subjects because of these patients' overall pattern of impaired performance. Some research careers have been made simply by the exposition of methodological problems associated with the assessment of differential cognitive deficits in psychiatric populations.

The authors of *Neuropsychological Differential Diagnosis* take a different perspective, explicitly rejecting the concept that tests of statistical significance provide useful information on their own in terms of meaningful differences in classification between subjects with neuropsychiatric disorders and healthy individuals. Significant differences in cognitive test performance between two groups of subjects do not mean that there is much actual difference between the two groups in their overall distribution of performance scores.

An effect size of 0.6 standard deviations in the difference of two means, by convention a large effect and easy to detect in samples as small as 20 subjects per group, is associated with 62% overlap between two samples. In order to be able to tell with 90% certainty that an individual's test score is consistent with a psychiatric or neurological diagnosis and not part of the lower end of the distribution of healthy scores, an average difference of about 2.5 standard deviations between healthy and impaired samples is required.

To make their case, the authors performed an enormously ambitious meta-analysis of the differential performance deficits of patients with several common and well-characterized neuropsychiatric conditions, including schizophrenia, major depressive disorder, Alzheimer's disease, frontotemporal dementia, several forms of subcortical dementia, white matter diseases, obsessive-compulsive disorder, and mild traumatic brain injury. Their meta-analysis includes all of the research published on neuropsychological test differences between healthy comparison subjects and each of the target populations during the years 1980–1997. They review the performance of patients and healthy comparison subjects across a multitude of standard neuropsychological measures and present the effect sizes of the differences between the samples, as well as the variance across studies in the effect size of the differences and the resulting overlap between healthy comparison subjects and the patient populations. As a result, there is a wealth of detail on how much information each of these neuropsychological tests provides for test-based differential diagnosis of the target populations compared with healthy comparison subjects.

An intriguing result of this meta-analysis is that many of the tests often described as capturing fundamental characteristics of illnesses such as schizophrenia fare relatively poorly when evaluated with these standards. For instance, the Wisconsin Card Sorting Test, a multidimensional test of executive functioning, is associated with 40% overlap between the performance of patients and healthy comparison subjects. In schizophrenia, in fact, the top five discriminators, all associated with 20% or less overlap, are in the domains of verbal and visuospatial memory. In the domain of chronic multiple sclerosis, only one test is associated with less than 25% overlap between healthy individuals and multiple sclerosis patients, but many of the tests are associated with about 50% overlap between multiple sclerosis patients and healthy comparison subjects. These tests would provide essentially no data useful for differential diagnosis.

One factor not considered with this type of analysis is the importance of cognitive performance for within-illness variation. In an illness such as schizophrenia or multiple sclerosis, heterogeneity in course, symptoms, and outcome is much greater than in an illness such as Alzheimer's disease. Certain cognitive impairments that do not help in differential diagnosis may provide substantial information regarding the likelihood that a specific individual may be able to live independently or sustain employment. Therefore, in an illness such as schizophrenia, where there is considerable variation in outcome across patients, a test that identified every patient with the illness would not predict the substantial variation across patients in functional skills.

This book is not about gloom, doom, and the uselessness of cognitive assessment. In the domain of Alzheimer's disease there are 15 different tests, all of memory, that are associated with less than 5% overlap between healthy comparison subjects and patients with Alzheimer's disease, and the state of affairs for progressive supranuclear palsy is almost as good, considering that many fewer studies have been conducted for this disorder. For each of these conditions, a detailed hierarchy of the level of relative impairment across tests of affected patients compared with that of healthy subjects is presented in detail. These data are extremely valuable for researchers or clinicians who want to identify a battery of assessment measures that are likely to be highly discriminating.

For instance, in the domain of Alzheimer's disease, the variation in discriminative usefulness across different memory measures is substantial. The California Verbal Learning Test long delay free recall measure was 98% useful for discrimination of healthy individuals and Alzheimer's disease patients, but the California Verbal Learning Test free recall intrusions measure was associated with 50% overlap between the samples. Clinical neuropsychological conventional wisdom characterizes free recall intrusions as a specific sign of cortical dementia, a belief that is completely contradicted by these data.

This book is a very useful reference for researchers studying cognitive impairments in different neuropsychiatric condi-

tions. It will also be an excellent reference for trainees who are about to embark on a career that involves either administering or interpreting the results of neuropsychological tests. There is no other comparable reference, and it is an excellent supplement to previous books that provide detailed descriptions of neuropsychological tests and normative standards. The reference list is outstanding, and the authors provide suggestions for further reading at the end of the text.

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Neuropsychological Assessment in Clinical Practice: A Guide to Test Interpretation and Integration, *edited by Gary Groth-Marnat. New York, John Wiley & Sons, 2000, 672 pp., $89.95.*

As stated in the preface, this book tries to provide a comprehensive guide to neuropsychology—and so it does! It is divided into four parts. General insights into neuropsychology and neurological syndromes are provided and the terminology behind neurological assessments are explained in the first part. This is accomplished by presentations of short and prototypical clinical descriptions of paradigmatic disorders. These descriptions are taken from the points of view of different clinical settings, such as a neurological hospital, a rehabilitation unit, a psychiatric practice, and a judicial context. These sample cases start with a short history, present results of neuropsychological assessments, and explain test results in relation to the patients' medical condition and history. Therapeutic conclusions and a prognosis are derived from this information. In essence, the first section of the book emphasizes the importance of thorough history-taking and delivers concise insights into important neurological syndromes in which neuropsychological issues are particularly relevant.

The second part is centered around the description of the four major neuropsychological assessment batteries, namely, the Wechsler Intelligence Scale, the Wechsler Memory Scale, the Halstead-Reitan Neuropsychological Test Battery, and the Luria Nebraska Neuropsychological Battery. The history and the development of each battery, including its subtests, are discussed, and practical instructions on how to administer and evaluate test results, how to use norms, and how to calculate correction factors for age and education are provided.

The third part examines in depth the assessment and evaluation of functional domains. It provides a comprehensive overview of tests with respect to important higher cognitive functions, such as attention, visuoconstructive abilities, executive function, and emotional processes. Starting with the neuroanatomical background, this section of the book also presents patients' sample test results and provides normative data.

The fourth part is devoted to the integration of test results, treatment, and therapy planning. It culminates in a manual on how to report the neuropsychological results taken during clinical neuropsychological assessment. As in the previous chapters, this is done by presenting exemplary reports on patients.

The book is extremely readable and filled with illustrative stories. Readers who have not yet invested much time in the study of neuropsychology will not have problems following the author. Groth-Marnat does a very good job in catching the readers' attention and keeping it. This book is not only for the neuropsychological novice, however. It provides the clinical practitioner with what is needed to update and deepen his or her understanding of the field.

If you are looking for a thorough introduction into neuropsychological assessment, test interpretation, and integration of neuropsychological test results, this book is well worth adding to your library. It may not be the right book if you are looking for a fast, in-depth reference in daily clinical routine, or if you are looking for a quick reference on the variety of neuropsychological tests. However, if you want a practitioner's guide to practical test interpretation and integration, the book is definitely a very good choice.

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Explanation and Cognition, *edited by Frank C. Keil and Robert A. Wilson. Cambridge, Mass., MIT Press, 2000, 396 pp., $40.00.*

"Those books don't go out," our psychiatric librarian said when I told him I had been asked to review another book on cognitive science, this time focused on the burning issue of explanation: its development, its kinds, its domains, its whys, and its causes. So as I read this book, I sought an explanation for his observation that our psychiatrists and researchers, who seem to read everything, don't read much cognitive science. First the humble theory: it's too hard. There *are* formulas in this book, and few physicians love math or symbolic logic, but only two of a baker's dozen chapters have them, and they are not hard math, of the sort of

$$P(e)=1-[1-P(i)\,q_i]\,[1-P(a)\,q_a]\,[1-P(i)\,P(j)\,q_{ij}]$$

which addresses the question, Does i cause e, when a may cause e and j may interact with i to cause e? Perhaps we physicians do not ask ourselves questions in this way, unlike Patricia Cheng ("Causality in the Mind: Estimating Contextual and Conjunctive Power"). Our medical thinking has often been unicausal. We are spoiled by our experience that one thing is wrong with the patient at the moment and one intervention restores to good order an immensely complex but powerfully self-correcting homeostatic biosystem. I guess we doubt we need more logical orders.

Do we need philosopher Paul Thagard's chapter to tell us that disease explanation is "causal network instantiation" and not deductive, statistical, or unicausal? Perhaps, when we recall that psychiatrists have argued that schizophrenia, autism, depression, homosexuality, or intelligence are caused by nature alone or experience alone and that psychotherapeutic effects could be ignored in favor of pharmacotherapeutic effects. Or maybe we would be edified by Robert McCarley's delightful musings about the naturalness of religion and the unnaturalness of science, which will never threaten the persistence of religion and is always itself in danger of disappearing (as it once did) because religion and human thinking generally prefer causal agents (in the case of religion, what McCarley terms "culturally postulated superhuman agents") and science restricts agent causality. We *did* once prefer the agency of schizophrenogenic or autistogenic mothers. Although the conveying of conceptual logic to children is much

a part of this book, it does not tread into the misconveying thereof.

Explanation runs through all of human life, the editors contend in their chapter. Explanatory theory is weaker than the "abyss" of theory, as they put it. But Keil's work has shown that even preschoolers know how pieces of explanatory knowledge are clustered in the minds of others. Welcome to what's called "theory theory." Philosopher Robert Cummins critiques five paradigms in contemporary psychology, including connectionism and neuroscience. Clark Glymour discusses Bayes nets as psychological models and proposes that they are descriptive of the acquisition of causal knowledge. He clearly explains the causal Markov condition for linearly related causal features, isomorphic to Bayes nets, by examples involving a toy train, a clap-on, clap-off light, and television. These statistical combinations in causal chains have been used widely in computer science and in scientific and engineering data analysis. So why not as a psychological model, he argues, since humans are the source for probabilistic expert systems?

These very non-Aristotelian and fuzzy systems are akin to brain and neural network models. The most vivid chapter is by computer scientist Herbert Simon, who argues that "the weakest link in the chain today is the general absence of bridging theories between the EIP [elementary information processes] and neurological levels" (p. 33).

There is much lore in this collection for the persistent reader, and persistence is required at times when philosophical cogitation approaches what oft was thought, yet ne'er so long expressed. Maybe it's patience for long-drawn-out theory that psychiatrists lack in our age of atheoretical DSMs.

Experimental work is included at the end of the book. Christine Johnson and Frank Keil describe their experiments on conceptual combination involving imaginary noun links such as "hospital bicycle" and "kindergarten bird." They found that, rather than superficial concept structures like feature typicality, it is the explanatory relations reflecting causal or intentional design that are the contingencies organizing a concept. Gregory Murphy explores explanatory concepts for his "kez" and "dax" nonsense categories, about which subjects are asked to form concepts from exemplars given to them on cards. It turns out that people's ability to explain the features of a category has dramatic effects on their learning, which is faster when features fit together better than when they are arbitrarily related, but categories with clashing features are no harder to learn than those which are simply unrelated.

Alison Gopnik, in the most gonzo—and a touch overinclusive—chapter titled "Explanation as Orgasm and the Drive for Causal Knowledge: The Function, Evolution, and Phenomenology of the Theory Formation System," argues that explanation, or uncovering causes, is to theory formation as orgasm is to reproduction; or perhaps as uncovering the spatial character of moving objects is central to the visual system. She argues that explanation is a drive (is this a return of the repressed old libido theory of Freud?); that is, our genes provide orgasm, and explanation, because reproduction, and theory (a veridical causal map of the world) are good for us in an evolutionary sense. Just as there is a phenomenology of emotions, Gopnik postulates a distinctive phenomenology of explanation, which she reduces to the "hmm" and "aha" experiences corresponding to "why," the search for explanation, and "because," the recognition that explanation has been reached. These are close, but not identical, to curiosity and interest, and Gopnik postulates distinctive facial expressions for each. She places the drive for causal knowledge in a child developmental context. For example, the terrible twos are a child's experiments with differences in desires, even though they may elicit a mother's rage; this is a drive going beyond mere cognition. Gopnik extrapolates that "in *Swann's Way,* Swann compulsively tests Odette in search of her secret life, in spite of the emotional and practical pain this will cause him, a rather advanced case of 'the terrible twos' " (p. 312).

Surely this tome explains something to everyone, and it will fly off our librarian's shelf.

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Clinical Neurology for Psychiatrists, 5th ed., *by David Myland Kaufman, M.D. Philadelphia, W.B. Saunders, 2001, 727 pp., $89.00.*

This classic textbook by Dr. Kaufman is now available in its fifth edition. The intended audience is practicing psychiatrists, as the title suggests. The volume is also designed to be of special use to psychiatrists sitting for board examinations in which neurology questions might be included. The textbook has two sections. In the first, Classic Anatomic Neurology, there are six chapters. The first chapter is a discussion of how to approach and examine a patient with a neurological complaint, followed by a discussion of how to formulate a case with suspected neurological disease. Chapters 2–6 take a systems approach and deal with common neurological presentations at all levels of the nervous system. Accordingly, one chapter deals with CNS disorders, one with psychogenic neurological deficits, one with cranial nerve impairments, one with peripheral nerve disorders, and the last one with muscle disorders.

The second section of the book, Major Neurologic Symptoms, includes 14 chapters dealing with a particular type of complaint: dementia, aphasia, headache, seizures, cerebrovascular accidents, visual disturbances, congenital cerebral impairments, chronic pain, multiple sclerosis, sexual dysfunction, sleep disorders, movement disorders, brain tumors/metastatic cancer, and traumatic brain injury. In this section there are also two chapters that are somewhat out of place, one dealing with lumbar puncture and imaging studies and the other dealing with neurotransmitters and drug abuse. The coverage is quite broad but with just the right depth for the practicing psychiatrist.

Each chapter is clearly written, without excessively technical language and with more than adequate explanations for complex terms and concepts. There are multiple illustrations, some photographs but mostly sketches, that illustrate key points. These extensive illustrations are of particular value to the reader. Each chapter is followed by a series of case-based, multiple-choice questions as well as their detailed answers. Thus each chapter is quite comprehensive and constructed so that learning is easy and thorough.

This is an excellent, comprehensive textbook that should be in the library of every practicing psychiatrist. Thorough review of this book is more than adequate preparation for the

neurology segments of the general psychiatry and geriatric psychiatry examinations. Practicing psychiatrists will find this book extremely useful to have available when they need to look up a neurology complaint or differential diagnosis or simply want to remind themselves of some aspect of the neurological examination or the presentation and management of common neurological diseases. Given how well written this textbook is, reading sections every now and then is also highly instructive, even if the book is not being used as a reference. As a practicing neuropsychiatrist I found reviewing this book to be a highly rewarding experience and an extremely valuable continuing education activity.

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Psychiatric Management in Neurological Disease, *edited by Edward C. Lauterbach, M.D. Washington, D.C., American Psychiatric Press, 2000, 346 pp., $44.00.*

All psychiatrists are familiar with drug-induced parkinsonism, and most psychiatrists in a long professional life see patients with Parkinson's disease, strokes, multiple sclerosis, and AIDS. Many psychiatrists see dystonias such as Meige's syndrome, spasmodic dysphonia, and neck dystonia (torticollis). Psychiatrists study Wilson's disease for board examinations, and most psychiatrists probably have seen patients with Fahr's syndrome and not known it. When a psychiatrist is treating a patient with a neurological syndrome, a review of neuroanatomy and neurophysiology is in order. Often, the clinician is left with best guesses with regard to psychiatric disease as to which came first, the chicken or the egg? Now comes a book that puts together the interaction of psychiatric and neurological diseases.

There are psychiatric symptoms attributable to the characteristic neuroanatomical lesions or neurophysiological alterations of neurological disorders. There are psychiatric symptoms attributable to psychological responses or the drugs used to treat to neurological illnesses. Finally, there are co-occurring psychiatric disorders that seem coincident. Many neurological diseases are rarely fatal for several years and have high psychiatric comorbidity. It behooves all psychiatrists to be familiar with the information in this book, especially psychiatrists who work with a geriatric population or do consultation-liaison work.

The first chapter, by the editor, covers general psychiatric principles in neurological disorders. He sets the stage for the book by stating, "Neurological disorders disrupt basal ganglia-cortical circuits at various levels." These are the "essential pathways that integrate and mediate mood, cognition, movement, behavior, and other functions critical to psychiatry." This chapter covers signs localizing to brain structures and behavioral findings helpful in localization. Lauterbach points out that depression is very common in patients with neurological disorders and describes the dilemma of distinguishing it from apathy. There are two useful tables listing potential interactions between diseases and psychotropic medications and potential drug-drug interactions. I found this chapter exceptionally well written and informative.

The remainder of the book reviews specific neurological disorders: Parkinson's disease, Huntington's disease, Wilson's disease, Fahr's syndrome, dystonia, stoke, multiple sclerosis, and AIDS. There is a final chapter on family management issues. Each of the disease/syndrome chapters is organized in the same format: a brief description of the disorder, prevalence, clinical recognition and neurological presentation, pathological features (including genetics), neuroimaging, laboratory investigation and predictive testing, psychiatric manifestations, neurological management and psychiatric management, and finally a brief summary. These sections of the chapters are well referenced.

I found myself highlighting "pearls" throughout the book. A few examples follow. "Psychosis is rare in untreated PD [Parkinson's disease] and usually indicates an adverse treatment response" (p. 51). "Dopaminergic agents typically produce silent, nonthreatening visual hallucinations of fully formed human or animal figures in a clear sensorium" (p. 51). "HD [Huntington's disease] demonstrates autosomal dominant transmission; homozygotes have no more severe disease than heterozygotes" (p. 75). "Clinical suspicion is critical to diagnosing WD [Wilson's disease]. The disease must be actively considered in the neuropsychiatric differential diagnosis in order to avoid missing the diagnosis" (p. 101). (Take-home message: remember it after taking boards.) With regard to Fahr's syndrome: "Every first-onset case with dementia, psychosis, or mood disorder deserves MRI scan" (p. 160) (to rule out calcification of the basal ganglia). With regard to dystonias: "All commercially available SSRIs [selective serotonin reuptake inhibitors] have been associated with acute dystonic reactions" (p. 207). With regard to strokes: "Pseudobulbar affect…pathological emotions occurred in 12 (18%) of 66 patients examined 2–3 months poststroke" (p. 222). With regard to multiple sclerosis: "Impairment of one or more cognitive abilities is present in 54%–65% of patients in clinic-based studies and in 43%–46% in community based studies" (p. 252). "Delirium is very common in HIV-infected patients. It is estimated that nearly 30% of hospitalized medical and surgical patients may have an undetected delirious process, and delirium has been found to be the most frequent neuropsychiatric disorder in patients with AIDS" (p. 276).

This is a very useful book for all psychiatrists, especially those who work in consultation-liaison psychiatry, medical psychiatry, and geriatric psychiatry. Neurologists may also find it useful. In the preface, the editor states that books exist on the psychiatry of Alzheimer's disease and epilepsy, but I hope that these diseases might also be added to future editions of this book. I also would hope that future editions might also include traumatic brain injury and psychiatry.

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PSYCHOTHERAPIES

Psychotherapy for Personality Disorders, *edited by John G. Gunderson, M.D., and Glen O. Gabbard, M.D. Washington, D.C., American Psychiatric Press, 2000, 224 pp., $32.50 (paper).*

This book is number 3 in volume 19 of the American Psychiatric Press Review of Psychiatry, edited by John M. Oldham, M.D., and Michelle B. Riba, M.D.

In this day of managed care, a "pill for every ill," and the pressures for shorter and shorter therapies, John Gunderson and Glen Gabbard are to be congratulated for assembling a volume that substantiates the centrality of psychotherapy in the care of patients with personality disorders, including the need for long-term treatment in many situations. The importance of this topic is highlighted by the editors' comment that "the recognition of the suffering inherent in personality disorders may ultimately help treaters to take a more empathic perspective to this large group of patients encountered in daily psychiatric practice" (p. 152).

Most psychiatrists have treated or attempted to treat some of these very difficult patients; they represent 13%–18% of the population! Given this magnitude, it is no wonder that patients with these disorders represent a substantial public health problem because they manifest a great deal of social impairment and use a disproportionately large amount of the general health care system. However, in their chapter, "Empirical Studies of Psychotherapy for Personality Disorders," J. Christopher Perry and Michael Bond assert that "the view that the personality disorders are intractable to treatment is due for a major revision" (p. 1). These authors stress that, given the current level of knowledge, patients and therapists need to be aware that patients with personality disorders can improve with psychotherapy and, furthermore, that empirical research has helped and can continue to help clinicians decide which directions to follow.

Because Perry and Bond's chapter is a gold mine rich with data from many sources, I will highlight some of the data in detail. Of 22 studies with at least one treatment arm for personality disorders and with outcome data, all reported positive changes in groups of patients with personality disorder following active psychotherapy. Examination of 20 studies demonstrated very significant changes in self-report and observer-rated measures after active psychotherapy with very large effect sizes (greater than 1.0, $p<0.0001$).

Three randomized, controlled psychotherapy studies compared active treatment with a wait-list or nonspecific control condition. For self-report measures, there was a moderate to large difference after psychotherapy (effect size=0.78, $p=0.002$). There was a less strong effect of psychotherapy when observer-rated measures were used. This seems a reasonable finding, given the concept of "illusory mental health"—that people may judge themselves healthier than would an objective observer (1, p. 57). The mean self-report effect sizes of five short-term therapies (16 weeks or less) were significantly larger than those of the seven longer-term studies (1.38 versus 0.92, $p=0.02$).

Perry and Bond discuss the several possible reasons for this difference. Short-term studies usually include patients who are less ill (those with cluster C personality disorders) in contrast to longer studies, which include mainly patients with borderline personality disorder, who do not experience immediate symptomatic relief. Most important, however, the possibility of a "honeymoon effect" (pp. 17–18) must be considered. Patients may be highly responsive to treatment initially, but their response might diminish with time. Observer-rated improvement seems to be more tied to duration of treatment.

Clearly, patients with personality disorders do not improve as much as patients with nonpersonality psychiatric disorders—as measured by either self-report measures or observer-rated measures. Patients with cluster C personality disorders improve more than patients with borderline personality disorders, who in turn improve more than patients with schizotypal personality disorders. Patients with antisocial personality disorder do not have good outcomes unless depression is also present. The authors hypothesize that "the association with depression may indicate the ability to form attachments and develop a positive therapeutic alliance" (p. 12). Fonagy and Target (2) found that children who experienced anxiety in association with their disruptive behavior or other psychological problems were more likely to respond positively to psychotherapeutic help.

Patients with cluster B and C personality disorders who remain in therapy can have a remission rate up to seven times faster than the natural remission rate for patients with borderline personality disorder. Patients with a cluster C personality disorders (dependent, avoidant, obsessive-compulsive) appear to recover in fewer sessions than patients with cluster B diagnoses (mainly borderline personality).

An important issue discussed by many of the authors in this volume is the issue of dropouts from treatment. Dropout rates vary from 10% to 30% depending on treatment length (shorter treatments have fewer dropouts). However, the empirical data demonstrate that a good therapeutic alliance (or one that is improving) characterizes successful cases. This is an absolutely central criterion in the treatment of patients with borderline personality disorder and antisocial personality disorder, which one study found may be treatable only in the presence of a positive therapeutic alliance.

Most important, the empirical data corroborate the clinical impression that social functioning and basic personality disorder traits improve much more slowly than symptoms do. From a public health standpoint, this is an area where the field of psychiatry has to take the lead—high-quality intensive long-term psychotherapy is a crucial ingredient for many patients and not simply a luxury or a procedure that should be relegated to those with the least training. For example, patients with borderline personality disorder often drop out of treatment if they are assigned to group therapy. Therefore, group therapy should not be imposed on patients with borderline personality disorder. A clinic offering only group therapy (because of cost factors, for example) would do a great disservice to many patients.

The centrality of good training for psychiatrists and therapists working long-term with patients who have borderline personality disorder is highlighted in the chapter by John Gunderson. Gunderson focuses on clinical, mainly psychodynamic, studies. He stresses the centrality of two issues: the impact of intense countertransference reactions in therapists who treat patients with borderline personality disorder and the real potential for boundary violations. Therefore, in the early phases of treatment, it may be important for therapists not to work in isolation so that monitoring by another professional can alert the therapist to oversights or excesses and to contain the inevitable splits or projections and flights. He stresses the importance of good training and the development of long experience treating these difficult patients. With experience one can observe different phases requiring different kinds of interventions or responses from therapists in the treatment of these patients.

For example, in the first phase of treatment (up to 3 months) the therapist will have to be interactive, responsive, and educative. In the second phase, up to a year, he or she may be able to clarify for the patient maladaptive responses to feelings (such as frustration) and can validate the patient's experience as well as empathize with the patient's plight. In the third phase of treatment (up to 2 or 3 years), the therapist can identify conflicts and misattributions, while supporting functional capacities. In addition, the therapist can make connections between the patient's current issues and the patient's past experiences. In the fourth phase (2–3 years or longer), the therapist can interpret conflicts in the transference and may be able to confront the variegated avoidance techniques used by the patient.

Glen Gabbard discusses the concomitant use of medication with psychotherapy in the treatment of personality disorders. He stresses that empirical research for the efficacy of the combination is quite limited, in contrast to the growing outcome literature supporting the efficacy and effectiveness of psychotherapy for some personality disorders. He cautions that there is virtually no research evaluating the use of one modality alone versus a combination treatment for axis II conditions. However, in studies of pharmacotherapy some patients are also in psychotherapy, and in studies of psychotherapy some patients are receiving pharmacotherapy.

Gabbard stresses that combined treatment has become the clinical standard. For example, rates of comorbid depression in borderline personality disorder range from 24% to 87%. Even in nonpatient samples, 38.5% of patients with a personality disorder have a history of major depression. It is possible that the depression may be a distinct comorbid disorder. However, one has to distinguish between the depressive symptoms in a patients with borderline disorder with the depressive symptoms in someone with a unipolar depression. For example, depressed mood in a patient with borderline disorder is accompanied by loneliness, whereas in major depressive disorder the depressed mood is accompanied by guilt feelings and remorse. Gabbard concludes that it is unclear whether the effectiveness of selective serotonin reuptake inhibitors in patients who have borderline personality disorder is a result of the medication's antidepressive effects or as a result of its impact on the underlying temperament in these patients.

Gabbard underscores the need for the therapist to help the patient understand the meaning of medication for the patient and to be aware of the possibility of countertransference frustration resulting in a polypharmacy regimen. Gabbard is to be heeded when he describes the potential benefits and the potential complications that arise when psychopharmacology and psychotherapy are administered by one person and when the treatment is split (the psychiatrist prescribes medication and another professional conducts the psychotherapy). If the treatment is split, the clinicians need to collaborate with one another to ensure a more effective treatment and to minimize liabilities.

As a psychoanalyst, I found it refreshing and instructive to read the chapter on cognitive therapy by Peter Tyrer and Kate Davidson. They caution us not to assume that one can easily transpose the effectiveness of cognitive therapy for symptomatic axis I disorders to personality disorders. Very correctly, they recognize that personality disorders require an approach in which the patient's past needs to be explored, a therapeutic relationship is key to the work, and reworking of beliefs is required. All of these are necessary because a personality disorder is more intrinsic to the person and more ingrained than a symptomatic disorder. A very important contribution in this chapter is the empirical approach advised by the authors, which could very easily apply to the whole range of psychotherapy research. They discuss the use of a single-case method and a diagnostic checklist that can be used to measure the effectiveness of the treatment. As in so many of the studies described in this volume, the problem of dropouts from treatment by patients with personality disorders is an important problem that needs to be empirically evaluated.

Michael Stone's chapter, "Gradations of Antisociality and Responsivity to Psychosocial Therapies," is most depressing and hopeless. After reading this chapter, I thought of neurologists of old or alienists in ancient mental hospitals, who were superb diagnosticians but could not communicate any hope for treatment. Stone's approach is to weed out the very few treatable people from the large group of those with antisocial disorders. He does not give us a sense of how to approach this extremely malignant condition so that future patients with a potential antisocial personality disorder might be treated differently or early enough in life to prevent the full-blown, untreatable syndrome.

This approach of hopelessness is quite a contrast to the rest of this volume. Even Stone's limited reference to children communicates the same fatalistic attitude. He recommends that we pay close attention to "callous" and "unemotional" traits in children with conduct disorders in order to distinguish children who are "most likely from those who are least likely to benefit from the various treatment approaches currently available" (p. 122). Most striking to me was that in a chapter addressing the psychotherapy of people with antisocial disorders, there were no references to the pioneering work of Peter Fonagy and Mary Target.

In reality, the most forward-looking approach to the treatment of severe antisocial personality disorders available to us at the present time must involve the evaluation of treatments for the antecedents to the condition in childhood. It is clear that the lack of remorse and indifference to others in the older child, adolescent, and adult dates from difficulties during the earliest years of life. Fonagy and Target and others (3–7) have explored how early disruptions in the mother-child bond lead to the child's inability to conceive of the interpersonal experience in terms of mental states or minds—that another person's mind is independent of yours. The consequences of this inability can eventually lead to the conduct problems of childhood and the antisociality of adolescence and adulthood. Psychiatrists have to be in the forefront in trying to evaluate programs (long-term and intensive) that attempt to help children increase their awareness of their own feelings, learn to express their feelings in words, and begin to understand the consequences of their behavior, whether the treatment is long-term individual treatment or community-based treatment (8–10). We will then be able to test whether the enhancement of these capacities, whether as a result of in-school programs or intensive individual psychotherapy or psychoanalysis, could result in a greater awareness by the child of the impact of his or her behavior on others. Fostering such an approach would be much more productive than the

one outlined by Stone, in which child psychiatrists and adult psychiatrists simply act as gatekeepers and attempt to predict "treatability" or proneness to violence—an approach doomed to failure, since psychiatrists are notoriously bad predictors of future behavior.

The empirical data presented in this volume confirm that only within the context of a relationship can one expect to help patients with severe personality disorders. Children who later exhibit severe sociopathic pathology have difficulties in the internalization of cues for interpersonal interaction and the internalization of the norms of social behavior. These difficulties lead to greater and greater unsocialized behavior. We only have to think back to Freud's comments on aggression in "Civilization and Its Discontents" (11), where he states, "Homo homini lupus" (Man is wolf to man). Freud described long ago that because of man's inclination to aggression, civilized society is perpetually threatened with disintegration. He proposed that by promoting the identification with the values of others in the community we can begin to address the problem of aggression.

Children with disruptive disorders have the greatest difficulty controlling their aggressive impulses. In a chart review of the psychoanalyses of 135 children with disruptive disorders matched on demographic, clinical, and treatment variables with children who had other emotional disorders, Fonagy and Target (9), like the authors of the studies in the volume under review, found that, overall, improvement rates were lower for disruptive disorders than for emotional disorders. Furthermore, again like the finding of studies described in this volume, the treatment of nearly one-third of the children terminated within 1 year. However, and most important, of the disruptive children who remained in treatment, 69% were no longer diagnosable at the end of treatment. In other words, Fonagy and Target's studies, like those in the present volume, indicate that we need to understand what techniques are most effective in engaging and maintaining an ongoing psychotherapeutic relationship. The evidence is clear—if patients with severe problems can stay in treatment, they get better.

Many psychiatrists imagine that psychoanalytic ideas are not subject to rigorous empirical evaluation. Recently, however, Joseph Masling, editor or co-editor of 10 volumes of a series titled Empirical Studies of Psychoanalytic Theories published by the American Psychological Association Press, estimated that "there must be well over 5,000 empirical studies based on psychodynamic ideas; in fact, psychoanalytic theories have proven to be so robustly heuristic they have probably inspired more research in personality than any other set of ideas" (12).

The present volume is one further example of how psychoanalytic ideas can be helpful in the treatment of very difficult patients and how these treatment techniques can be subject to rigorous empirical study.

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Marital and Family Therapy, 4th ed., *by Ira D. Glick, M.D., Ellen M. Berman, M.D., John F. Clarkin, Ph.D., and Douglas S. Rait, Ph.D. Washington, D.C., American Psychiatric Press, 2000, 739 pp., $49.00.*

This broad-based and comprehensive text for students, clinicians, and teachers of family therapy covers a range of relevant topics presented in a well-organized format to guide the reader systematically through a vast amount of information. It is a companion text that readers will find useful in many different ways because it provides an up-to-date review of content areas and excellent suggestions for additional reading.

The book is divided into eight different sections with a total of 31 chapters. The sections cover topics related to the history of family therapy, family evaluation, treatment approaches, couples therapy, psychiatric disorders and family therapy, indicators for family therapy and outcome data, family therapy in medical settings, and professional and ethical issues. Each chapter starts with well-formulated reader objectives, which contributes to time-efficient reading and active processing of the material. There are specific chapters and references on issues related to ethnicity, gender, race, and culture as well as guidelines for being sensitive to the diversity of family life. The major theoretical models of family therapy are presented in a clear and systematic way. Well-formulated guidelines are provided for best practices when engaging families, planning treatment, and dealing with specialized areas such as violence, loss, and chronic mental illness.

The fourth edition of *Marital and Family Therapy* is an attractive and user-friendly text. The book is filled with useful summaries, tables, and graphs for quick referencing and easy access to information. It also provides a succinct and integrated view of the complex biopsychosocial continuum related to patient, context, and family. The strong interdisciplinary appeal of the book makes it an ideal text for training programs where the goal is to help students develop core competencies in marital and family therapy. The experienced family clinician may find some of the chapters too brief. However, the authors undoubtedly succeed in their goal of creating a "basic, but comprehensive textbook for individuals at different training levels and orientations" (p. xlvii).

We recommend the book highly for all mental health professionals and students in the mental health professions. It is especially useful for those individuals whose primary interests are in marital and family therapy.

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Treating Adult and Juvenile Offenders With Special Needs, *edited by José B. Ashford, Bruce D. Sales, and William H. Reid. Washington, D.C., American Psychological Association, 2001, 518 pp., $49.95.*

The multidisciplinary editorship of this book, representing social work (Ashford), psychology (Sales), and psychiatry (Reid), has coalesced to produce a rare commodity, a multidisciplinary tome devoted to treatment of those from the criminal justice world. Although only Dr. Reid may be a familiar name to psychiatrists, Drs. Ashford and Sales are prominent in their respective fields. The editorial triumvirate travels beyond the simplistic "mad and bad" paradigm. Instead, the book revolves around the theme of "special needs," defined as "any changeable factors associated with disorders of cognition, thought, mood, personality, development, or behavior that are linked to desired outcomes for offenders at any phase of the justice process." With this theme, the book specifically explores the special needs of offenders with conduct disorder, antisocial personality, psychopathy, substance abuse, mental retardation, educational disabilities, and suicidal potential. The book also devotes separate chapters to three classes of offenders that fall under the special needs rubric, i.e., sex offenders, violent offenders, and insanity acquittees (although insanity acquittees technically are not offenders and often fall in the shadow world between the correctional and mental health systems). Unlike many books on forensic and correctional mental health, this book covers both the adult and juvenile populations of offenders.

As with all multiauthored books, there is chapter-to-chapter variability in writing style. In addition, because each chapter is self-contained, some material is repeated throughout the book. Nonetheless, there are many excellent chapters; the editors have gathered an impressive array of authors. Each chapter provides an in-depth overview of the current knowledge base of the specific topic and numerous references.

The chapters on mental retardation, research on the treatment of adult sex offenders, and release decision making may be particularly enlightening for general psychiatrists because they contain new information and, more important, a different perspective from which to view these difficult clinical challenges. For the forensically inclined, the chapters on treatment rights and release decision making contain up-to-date compilations in these controversial areas. The multidisciplinary focus of the book serves as an important reminder that the biopsychosocial (or, more aptly, biopsychosociocultural) perspective is alive and well. Many of the clinical findings found throughout the book can be modified and have practical application in the everyday practice of psychiatry and other mental health endeavors. Also, there are repeated references among several chapters that not every offender should have or would benefit from treatment or intervention, a point that is often neglected by both those in the mental health fields and the general public.

This book should definitely find a place in the libraries of psychiatrists and other mental health professionals who treat the special needs offender, those who contemplate working with this challenging population, and those who have an interest in learning more about the subject.

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Odysseys in Psychotherapy, *edited by Joseph J. Shay and Joan Wheelis. New York, Irvington/Ardent Media, 2000, 428 pp., $44.95.*

The editors begin inauspiciously by asking, "Is psychotherapy a science or is it poetry? Is this even a meaningful question to ask?" Such musing led them to ask "luminaries of psychotherapy" to recount their careers and what they "believe" about psychotherapy (p. ix). The authors then wonder, "If an asteroid were arriving…soon to shatter our planet…[with] loss of most human life and recorded thought" (p. 1), which psychotherapy books would we wish to survive? Such overheated, jejune writing risks having the reader stop before reaching the psychotherapists' autobiographies that follow.

The editors' premise is that the lives of "a wide range" (p. 8) of prominent psychotherapists should illuminate the field. Even conceding the value of the wisdom of exemplars, one questions the editors' method. They claim to have recruited "stellar and internationally renowned therapists" of "the second half of the 20th century" (p. 7), but their selection is skewed. Most of the 16 alphabetically presented participants (nine men, six psychiatrists, six psychoanalysts, mainly Boston-connected, and one apparently the father of one of the editors) have decidedly psychodynamic backgrounds. Are they luminaries? I recognized about half the names. None is an empiricist, and most mention psychotherapy outcome research only naively and dismissively. Aaron Beck, presumably an important innovator, does not even make the index; nor do many others. Most cited, after authorial self-reference, is Freud. The reader never learns the rationale for selection, or how many therapists were approached but declined to participate.

Not all psychotherapists make superb memoirists. The writing is sometimes self-indulgent, self-important, and self-promoting. Some writers have led interesting lives, but most list events or define theory rather than describe their emotions in depth. Boston training programs evidently once taught elitist, paternalistic, misogynistic, rigidly intrapsychic psychodynamic theory, against which many of these writers

rebelled. Their accounts reflect this with a vengeance: many have utterly abandoned an internal perspective, from which we might have learned the determinants of their decisions, to focus instead on externalities.

There are exceptions, such as the rousingly opinionated septuagenarian Sophie Freud's ambivalently agnostic attitude toward her grandfather. Maltsberger, Pines, and A. Wheelis recount moving histories; Wachtel argues well. But the most surprising aspect of this book is the impersonality of most therapists' self-disclosure. Their opacity obscures how their lives explain their therapeutic direction. We learn that they changed, but not why—a singularly unsatisfactory result. Perhaps focused interviews—a more psychotherapeutic format—would have yielded greater introspection and information.

Some therapists, rejecting the old faith, converted to new ideologies: ethnocultural psychology, lesbian feminist psychiatry, social constructionism, relational psychology, and even psychoanalytic parapsychology! As nonempiricist clinicians, they can offer only opinions and exhortations to support their approaches, resulting in what A. Wheelis calls a "chorus of contending voices" (p. 402) of seemingly equal valence. As a helpful guide to the future, this serves only as a cautionary example.

The volume's late-20th-century time frame coincides with the collapse of long-term psychoanalytic hegemony. Most authors unsurprisingly seem to have moved from longer to briefer treatments and from an intrapsychic, theoretical focus to a more experiential, "responsive, connected relationship" (p. 77) with patients. They responded to the social unrest and liberation groups of the 1960s and 1970s. One acknowledges, "My coming of age…paralleled changes in the mental health field" (p. 84). Rather than highlighting individual differences, the book leaves an impression of secular change and reads best as an informal history of the already fading, pre-empirical, pre-managed-care era. Although the editors hope to provide "clues to the future" (p. 403), the psychotherapeutic prognostications are unhelpful, banal, or curious, auguring deterioration of therapeutic expertise under managed care or emergence of the "therapist-shaman-psychopharmacologist-psychotechnologist" (p. 62). The book is more oddity than odyssey.

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Crucial Choices, Crucial Changes: The Resurrection of Psychotherapy, *by Stefan de Schill. Amherst, N.Y., Prometheus Books, 2000, 458 pp., $56.00.*

In this bizarre 500-page diatribe, De Schill rants and raves about the "calamitous condition" of the field of psychotherapy. He attacks some of our most eminent psychotherapists, calling them "snake oil salesmen" and "immensely damaging" to patients and students. He says he and a few other valiant souls must fight to resurrect the field that is currently under the control of "incompetents."

De Schill is gratuitously argumentative, iconoclastic, pompous, and given to hyperbole. To take a typical example: "For well over half a century, I have been asking this: How is it that people without the slightest talent for our profession, with no sensitivity for human feelings and thus no sensibility whatsoever to comprehend dreams, can infiltrate our profession in such great numbers, become teachers, and have their writings published?"

Worse still, De Schill is repetitive, rambling, and circumlocutory. The manuscript was clearly written 8–10 years ago and has been awaiting publication by a vanity press. The author should have taken the time and effort to improve it. Not only is his tendentiousness off-putting, but the lack of editing demonstrates disdain for the readership. If De Schill claims to fight the "worst" in psychotherapy, then why does he present this hodgepodge of ideas without organization? Why, for example, include patient education materials (written to "you" the patient) in the midst of a chapter written for therapist readers?

Affiliated with the American Mental Health Foundation since 1948, De Schill says that his work and that of the Foundation has been unappreciated and unrecognized by the establishment—academic departments of psychiatry, professional organizations, psychiatric journals, and major public policy institutions. He says that the U.S. Congress has ignored and rejected his ideas.

De Schill claims that he has only the public interest in mind—his goal is to reduce human suffering—and that, unlike reputed leaders in the field, he is not swayed by parochial concerns. He condemns those "profiteers" who peddle simplistic, ready-made, abbreviated, and overly theoretical psychotherapeutic approaches. Although he criticizes the tendency of writers on psychotherapy to refer to authority, he himself engages in the most primitive ad hominem insults. Why is it necessary to resort to such underhanded tactics and cast aspersions on people's honor? The entire book is replete with ludicrous and irrelevant pronouncements.

Although De Schill savages the entire field of psychotherapy (according to him, less than 15% of psychoanalytic psychotherapists meet minimal qualifications), he singles out Yalom and Karasu for particular punishment. Yalom published a best-selling book on psychotherapy, and Karasu led an APA commission on psychiatric treatments and is editor of a psychotherapy journal. Whether one agrees or disagrees with the views of Yalom and Karasu, they have been able to articulate their ideas in a cogent and eloquent fashion.

De Schill is critical of existing training programs in psychiatry, psychology, and psychoanalysis that, in his view, serve to promote preconceived notions and place too little emphasis on clinical work with individual patients. As he sees it, theory gets in the way of understanding patients, and intellectualized language gets in the way of communicating with the patient's unconscious. As a psychoanalytic psychotherapist myself, I'm sympathetic with De Schill's values and focus on depth psychology and dreams. But he's preaching to the choir. I don't know of anyone who supports the use of cookbook, a priori interpretations. There is also nothing new in his critique of brief therapies. Everyone struggles with time and financial constraints. No one believes in or promotes shortcuts, although some of us more readily accommodate to those pressures.

As an educator and director of a psychology training program, I am confronted by the problem of selecting talented candidates and constructing an appropriate curriculum. De Schill offers no useful solutions. He cites one unnamed therapist who was in psychoanalysis for 13 years and in supervi-

sion for 20 years as an example of the kind of dedication required to meet his standards. There is no chance my psychology interns would be willing to wait that long for certification, and if they were, I'd have doubts about their sanity.

As someone who is concerned with my patients' suffering, I too am interested in identifying the most effective treatments. But how can De Schill reject the accumulated wisdom and legions of outcome studies and place his opinions above all others? Is he the only one who knows what "good" therapy is and who should be a practitioner? His critique of outcome studies and his analysis of psychoanalytic jargon is familiar and unoriginal. Finally, his proposals regarding intensive psychodynamic group therapy administered in 3-hour sessions twice a week seem just as quirky and potentially damaging as those treatments he criticizes.

Without exaggeration, this is probably the worst book I've ever read in this field! My summary makes the book appear to be much more coherent and sensible than it is upon reading.

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PSYCHOANALYSIS

The Historiography of Psychoanalysis, *by Paul Roazen. New Brunswick, N.J., Transition Publishers, 2000, 480 pp., $49.95.*

Since the 1960s, a time when Freud and Freudianism were still at their refulgent height, Paul Roazen has dedicated himself to the historical study of Freud and psychoanalysis. In the ensuing years, with the tide of judgment about Freud shifting in a more conflicted direction, he has steadfastly continued this endeavor. Roazen's lodestar has been his conviction about the seminal importance of Freud in the intellectual, literary, and moral (although more problematically so in the psychotherapeutic) life of the past 100 years. Equally, Roazen has been determined to maintain a fair and objective judgment of psychoanalysis and to distinguish himself from what he regards as the flawed hagiographic accounts of Freud that formerly were dominant and the present tendency toward debunking the Master. I believe it can be said that Roazen has creditably held fast and contributed to the position that Freud's importance warrants the best that scholarship can offer.

The Historiography of Psychoanalysis is a collection of previously published essays with current revisions and comments. It is a big book (more than 450 pages). Its 65 chapters are divided into sections on Freud studies, letters, interviews with contemporaries, relevant biographies, the ways Freud has been dealt with in different countries, intellectual histories, and new documents.

A review of this length cannot offer detailed accounts or criticism of the contents of the book, but some general observations are in order. Roazen urgently believes that Freud studies need to be rescued from the ideological and religious shoals on which many of them have foundered. He is properly scornful of the sequestration, until as late as 2020, of documents and letters in the Freud Archive. At a relatively early stage, Roazen recognized, before many others, that there was a distinct contrast between Freud as a theoretician advocating neutrality and as a therapist heavily involved in the private life and decisions of patients, as exemplified in his dealings with the analyst Ruth Mack Brunswick and her family and in his analysis of his own daughter. The book is replete with interesting comments, anecdotes, and observations, although the level of details sometimes becomes excessive. It also appears that Roazen is somewhat thin-skinned when he feels he is being given insufficient notice or unfairly criticized, as in the reaction to the unfavorable view of Freud in *Brother Animal: The Story of Freud and Tausk* (1), Roazen's account of Victor Tausk's relationship with Freud and Tausk's suicide.

The Historiography of Psychoanalysis will be of particular value to psychoanalysts and to people in the worldwide intellectual community who wish to further their understanding of the massive changes in the "climate of opinion" generated by the work of Freud and his followers. For psychiatrists generally, it should be of interest not only for the engrossing information it contains, but also to remind some of them, for whom dynamic psychotherapy is no longer of major importance, about the tremendous impact psychoanalysis has had on their profession.

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Clinical Studies in Neuro-Psychoanalysis: Introduction to a Depth Neuropsychology, *by Karen Kaplan-Solms and Mark Solms. Madison, Conn., International Universities Press, 2000, 308 pp., $47.50; $32.00 (paperback, published by Karnac Books).*

This book is a landmark in the rehabilitation, within psychiatry, of the psychoanalytic method. An earlier, rich, clinical psychoanalytic neuropsychiatric literature, exemplified by the work of Schilder (1), demonstrated many neurological symptoms to be within the realm of psychological functioning by addressing their multiple determinants and functions (including defensive). Working with brain-injured patients on a neurosurgical rehabilitation unit, the authors of *Clinical Studies in Neuro-Psychoanalysis,* both psychoanalytically trained neuropsychologists, modestly present their courageous efforts to reach deeply into the internal experience of the patient. They propose a bridge, namely, the clinicoanatomical method, between psychoanalysis and the neurosciences.

In a scholarly but quite readable style, they begin with a review of the historical underpinnings of their work, the highly productive, dynamic approach beginning with Freud and the Soviet neuropsychologist/psychoanalyst A.R. Luria. Brainstem activation of diencephalic structures proceeds to the cortical areas, the anlage of the ego apparatus, an ever-changing, distributed structure consisting of linked components operating in concert to subserve different psychological functions. A concise review of the authors' own neuropsychological studies of dreaming supports Freud's earlier theories of motivation and meaning. The authors suggest that "it is pos-

sible that anything that arouses a sleeping brain has the potential to trigger the dream process."

Next, the authors point out that different brain areas support symbolic and concrete visual spatial representations (left and right parietal), visual imagery (occipital and temporal), and motivational impetus (ventromedial frontal). Dreaming and reality may be blurred with frontal limbic lesions. There appears to be a "backward projection" from higher-order constructs to concrete perceptual representations; they quote Freud, "The fabric of the dream-thoughts is resolved into its raw material."

Process notes and discussions of the treatment of 12 patients with a variety of lesions illustrate the power of the method. Neurological reductionism withers in the face of the authors' struggles to compensate for devastating loss of function. For example, in exploring how patients with right perisylvian lesions can have both melancholic and paranoid syndromes, they point out that "the same lesion can produce two diametrically opposite emotional states."

In their striving for a bridge between basic and clinical neuroscientists and psychoanalysts, perhaps the authors are overly apologetic about the psychoanalytic end. Their striking therapeutic reversal of hemineglect challenges the still common assumption that "neurological" disorders are "hardwired" and therefore not amenable to psychotherapeutic understanding or change; indeed, it challenges the very concept of a mind-brain dichotomy. It is not an overstatement that this book should be required reading for any psychiatrist or mental health professional, not only those working with neurological patients.

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Listening to Patients: Relearning the Art of Healing in Psychotherapy, *by Richard G. Druss, M.D. New York, Oxford University Press, 2000, 133 pp., $19.95.*

In this very small volume, Druss does an excellent job of showing how he works with patients. His insights are useful for other therapists, or for those who want to understand how insights from psychoanalysis can be applied. Even one not psychoanalytically oriented would have to admit that Druss has good insights that seem useful and on target. He does not go into great detail in any chapter but gives a brief understanding of the important issues. The chapters deal with such topics as the initial session, transference, supervision, and termination of psychotherapy.

Druss is not rigidly psychoanalytic. In seeing himself as a collaborator with his patients, he is much like behavior therapists and somewhat unlike the stereotyped, seemingly detached psychoanalyst, who says little but knows all. In one instance, Druss pays much attention to the patient's lifestyle, and the patient consults with a nutritionist and joins a group to help him stop smoking. It is hard to imagine Freud, or his traditional followers, doing something like that. Like psychoanalysts, however, Druss conceptualizes the cases in such terms as transference and repression. Thus, the reader gets a sense of how a case can be handled psychoanalytically but with more flexibility than in traditional psychoanalysis. Druss has great insights into the cases he presents, so the book is useful to all, not just psychoanalysts, who try to understand what is occurring.

One of his most interesting cases is that of Ms. E, a high school sophomore who came to New York City from Puerto Rico. A devout Catholic, Ms. E suffers from conversion hysteria; she has become deaf and totally paralyzed from the waist down. The cause is found to be her conflicts between emerging sexuality and her strict Catholic upbringing. Specifically, in the girls' locker room at school, she overhears two popular girls talking about going to the school dance and seeing which one will be the first to cause an erection in their boyfriend by dancing close. Of interest, during the therapy session Dr. Druss gives Ms. E three 15-mg phenobarbital tablets, one each at different times, to ease her anxiety and foster her speaking about her problems. Part of his technique is to discuss boring school topics initially in the session, such as Latin and other courses she was taking. This, along with the phenobarbital, puts her enough at ease that she eventually discusses the sexually charged locker room incident.

Ms. E was cured via abreaction, the bringing to consciousness of repressed material. Druss defines abreaction as occurring when the repressed material is quickly brought to consciousness. Thus, all of the treatment occurred in one 5-hour session, when he saw Ms. E in the emergency room of a hospital on a Sunday morning. This goes against the notion of psychoanalysts or other therapists only seeing patients in their office, at scheduled times. Finally, it was not only getting her to unmask the repressed material that seemed to cure Ms. E but also the discussion that she could go to the dance but adhere to her own values and not have to be like those popular girls whom she overheard.

There are several other interesting cases in this small book. It should be useful to many, both those who believe in psychoanalysis and those who do not. Druss has good insights into people, and he writes well about them.

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Freud: Darkness in the Midst of Vision, *by Louis Breger. New York, John Wiley & Sons, 2000, 472 pp., $30.00.*

Breger's central thesis in this "demythologizing" exploration of Freud's character is that the main tenets of psychoanalysis were determined by Freud's ambition to be a hero and by his correlative identifications with and idolization of military leaders, especially, the vengeful Semite Hannibal. The main reasons Breger gives for Freud's emphasis on the warrior rather than the healer mode are 1) Freud's experience of maternal deprivation and 2) the existence of Austrian anti-Semitism. Reacting to these influences, Freud allegedly became angry and vengeful and developed theoretical ideas that arose "primarily from his needs and personal blind spots" (p. 4).

This 472-page book is divided into three parts: Freud's Life: The First Thirty Years, The Birth of Psychoanalysis, and The Psychoanalytic Movement: 1902–1939. There is an introduction titled "The Development of the Hero," an appendix,

background and sources, notes, bibliography, credits, and an index. For the most part, the book is well written and interesting, demonstrating familiarity with both classical psychoanalysis and the "dissenters" such as Jung, Adler, and Rank. By now, the claim that Freud was an often nasty, mean-spirited, and even destructively judgmental person is old hat. What is unique about Breger's exposition is the linkage of Freud's character pathology with maternal deprivation and anti-Semitism. His contention that Freud's theories were seriously distorted by these factors bears careful examination.

Breger sets up a bit of a straw man in order to claim that there was "never any evidence" for Freud's "sweeping generalizations and imperial theories." He cites the "*universal* Oedipus complex, sexuality as the driving force for *all* human action,…the theory of penis envy…[and] the theory of unconscious homosexuality" (p. 4). Given these emphases, Breger is correct. However, it is not clear as to what he would regard as "convincing evidence"; he never states his criteria. Yet, during the course of a rigorous personal analysis, one might be expected to find fairly convincing evidence for the existence of less controversial phenomena such as the dream-work, transference, the infantile neurosis, the primal fantasy, the ego mechanisms of defense, and even some of the theses Breger targets, provided that they are stated more cautiously.

Psychoanalysis is ultimately a journey of personal discovery; whatever Freud's initial empirical goals, psychoanalysis is not white rats running mazes or chemical reactions in a test tube. It seems anachronistic to have to say that what Freud discovered was a different kind of truth, a subjective one that ultimately, for the analysand, is as real, perhaps more real, than the "substitute world" (1) offered by traditional empirical science (2).

The case for substantial maternal deprivation during Freud's childhood is not convincingly or consistently made. Repeatedly, Breger emphasizes Freud's "loss" of his mother caused by the arrival of siblings and family hardships. Because of this hypothesized unsolacing maternal relationship, Freud would "for the rest of his life find a variety of targets for his fears, unhappiness, disappointments and hatreds" (p. 17). From what Breger concludes, one would think that Freud was an orphan or had been totally abandoned the way that Oedipus was by Jocasta. The facts, however, as Breger states them, say differently. Freud's mother was virtually always physically there, and she was very invested in his "precocious" intellectuality (p. 23). Breger says, "She herself [Freud's mother] valued males over females and gave preference to her sons, especially her firstborn. She would achieve power through her connection with his success" (p. 29). If anything, she emerges as a kind of psychoanalytic stage mother pushing and demanding public acclaim for her son.

Breger emphasizes, specifically, the lack of solace, comfort, and soothing Freud received from his mother (see, for example, pp. 2–3, 17, 29, 31). Such deprivation, if true, would likely have caused the baby Freud to grow into a psychopath rather than a cold, intellectualizing narcissist (3). Yet, Freud, unlike the psychopath, derived solace from a great many objects and activities both tangible and intangible. Indeed, I found Breger's description of the multitude of ways, mostly very normal, by which Freud solaced himself (see pp. 23, 25, 31, 42, 48, 51, 54, 76, 77, 161, 237, 240, 244, 268, 361) one of the most interesting features of the book. Freud's addiction to cocaine was perhaps his most self-destructive self-comforting strategy and, although Breger does not discuss it, may have played a pivotal role in many of Freud's angry, paranoid attacks on Catholics, dissenters, and others.

The argument for deprivation of maternal comfort is further undermined by what Breger tells us of the pivotal role Freud's nursemaid, a Czech Catholic woman and a "vital maternal figure" (p. 14), played in the young Freud's life. She "told him pious stories, took him to church, and shaped his early education and sense of himself" (p. 14). Later in life, Freud spoke openly of his fondness and appreciation of what she had done for him (p. 15).

Freud's "extreme and atypical aversion" to music (p. 127), which for adolescents is the most frequently used solacing transitional phenomenon and second only to another person for adults, may provide some support for Breger's contention that there were distortions in the mother-child bond. However, while observing that music was "at the very heart of Viennese cultural life" (p. 33), Breger does nothing with Freud's curious emotional disability.

Although Breger fails to convince us that maternal deprivation was central to Freud's antipathetic nature, he gives the basis for consideration of other contributing maternal factors. Freud's mother, Amalia, is variously described as aggressive, insensitive, violent, belligerent, volatile, shrill, domineering, tyrannical, and selfish (pp. 17–31). Freud may simply have identified with her. Also, there is the hereditary angle that Breger touches on without apparently seeing its potential significance for Freud. Freud's son Martin described "the Jews of East Galica as a peculiar race [with] little grace and no manners…whenever you hear of Jews showing violence or belligerence, instead of that meekness and what seems poor-spirited acceptance of a hard fate sometimes associated with Jewish peoples, you may safely suspect the presence of men and women of Amalia's race" (p. 28).

Breger finds complementary causation to maternal deprivation in the alleged existence of Austrian anti-Semitism. From beginning to end, the reader is reminded that Austrians were "anti-Semitic" (see pp. 3, 7, 16–17, 25, 27, 39, 40–42, 58, 62, 66, 101, 126, 161–162, 174–175, 177, 191, 356, 357, 359, 361, 392–393). However, Breger presents little evidence for this and, if anything, makes a strong case for the contrary.

Breger acknowledges that Freud himself, as well as those close to him, had actually experienced very little that could be construed as anti-Semitism but "let the impression stand that he had suffered this, that he was a Jew, an outsider, fighting against the 'compact majority' " (p. 42). In the all-important matter of career advancement, Breger notes that not only was a Jewish background not a handicap in advancing Freud's career, it "may well have been an advantage" (p. 41).

Perhaps sensing that his case for pre-World War I Austrian anti-Semitism is weak, Breger saves his strongest statements about it for the section titled Notes: "Children would be taunted, called names, and occasionally beaten up in certain neighborhoods" (p. 393). But children are taunted, called names, and occasionally beaten up in neighborhoods where few if any Jews live; competitive conflict and bullying are ubiquitous. Moreover, Breger tells us that "there is no evidence that Freud encountered this himself as a child" (p. 41).

Breger seems to be essentially taking "the-everybody-knows-it" position about alleged Austrian anti-Semitism. Not

only is it *not* safe to assume that everybody knows it, but it is crucial for the scholarly credibility of a claim such as Breger's to document instances in which anti-Semitism was developmentally pivotal for *Freud*. For example, the case for prejudice against blacks in America is made with reference to such things as lynchings, church burnings, relegation to the back of the bus, deprivation of job and residential opportunities, and other discriminatory practices. Nowhere does Breger give comparable, specific evidence of such experiences having affected Freud's perceptions, attitudes, and beliefs.

Breger also presents many facts that serve, paradoxically, to pull the rug out from claims of substantial prewar Austrian anti-Semitism affecting Jews in general (see, for example, pp. 22, 29, 33, 39, 40–41, 292–293), thus undermining the claim that Freud suffered from identification with the victim. Indeed, his descriptions of Jewish success in Austria actually support a contention of undue and disproportionate Jewish influence in pre-World War I Austria. It is hard to imagine anti-Semitism as having had legs in a country in which Jews had become so powerful. For Freud to have believed that anti-Semitism similar in magnitude and effect to the African American experience existed, in the face of what Breger tells us, would have required that Freud's reality testing have been significantly impaired. Rather, he shows Freud as rageful, cruel, and vindictive—not psychotic. Perhaps the explanation for Freud's preoccupation with anti-Semitism lies in Breger's descriptive phrase, "Freud the propagandist: subtle but insidious" (p. 350).

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Mental Illness and Its Boundaries

I Am Not Sick, I Don't Need Help! Helping the Seriously Mentally Ill Accept Treatment: A Practical Guide for Families and Therapists, *by Xavier Amador, Ph.D., with Anna-Lisa Johanson. Peconic, N.Y., Vida Press, 2000 (originally published in 1959), 239 pp., $17.95 (paper).*

This is a guidebook primarily meant for families of severely and persistently mentally ill patients who don't realize that they are ill, don't want to seek treatment, and, once discharged from involuntary hospitalization, are not likely to continue in treatment. The author has had personal experience of this at home with his brother. He has also had professional experience with it, being at the forefront of a scientific approach to the study of insight or recognition/acknowledgment of illness. Unfortunately, such patients form a substantial proportion of those with illnesses like schizophrenia, which means that, no matter how our treatments for these conditions improve, only a minority will ever take full advantage of them. This, perhaps above all else, is the tragedy of schizophrenia and related disorders. It is one thing to develop treatments aimed at eradicating delusions and hallucinations. It is another to develop treatments aimed at improving the recognition that beliefs so fervently held and constantly confirmed by the most minute of everyday events are, in fact, "figments of one's imagination," nightmares conjured in waking life by a disorder of the brain.

Families will welcome this book; indeed, it receives well-deserved endorsements from many highly respected mental health professionals. It even provides a web site through which families and others can write in and have their questions answered—an innovative and useful extra to the information provided.

For therapists, the conversational style and heavy use of dialogue seem less immediately helpful, although there are some very useful tips for enlisting a reluctant patient's cooperation. These include the following: 1) Set aside the time to listen. 2) Agree on an agenda (even if it ends up being agreeing not to have an agenda). 3) Understand the patient's own beliefs about himself or herself and the illness. 4) Don't react (with shock, surprise, dismay, fear, disappointment, disbelief, etc.). 5) Let chaos be (if the patient can stand it, so can you). 6) Echo what you've heard. 7) Write it down. Another helpful recommendation, for therapist and for family member, is to convey empathy for the many frustrations, fears, discomforts, and desires (perhaps unreasonable) that the patient expresses. This includes normalizing the psychotic experience as much as possible when the oddness of it seems to be a source of humiliation. There are times, of course, when the patient does not want the experience normalized because the one saving grace is the feeling of being specially selected for the harrowing things he or she is being subjected to. Grace notes on the general theme are learned through experience, but the basics are well covered in this primer. I will be recommending it to the families of my patients.

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Being Mentally Ill: A Sociological Theory, 3rd ed., *by Thomas J. Scheff. New York, Aldine de Gruyter, 1999, 220 pp., $45.95; $22.95 (paper).*

My first thought when I received this book to review was to look to see if Thomas Scheff had a web site. He does, but I was not prepared for what I found. Prominently displayed is a full-length picture of him in formal attire. His beard is neatly trimmed, he appears lean and fit, and altogether he gives an elegant impression. This is far different than I remembered him when I went to Santa Barbara in 1969 to meet him after having read and been impressed by the first edition of this book. My recollection is that he looked every bit the part of a 1960s professor challenging the conventional wisdom of the day.

In any case, I thought he had much to say that was important—I still do—and I quoted him extensively in subsequent publications. Briefly, he believes that the presence of mental illness is determined by societal labeling. How does a person

become labeled as mentally ill? First of all, symptoms of mental illness are viewed as violations of social norms. Such behavior as rambling or disorganized speech, unprovoked violent outbursts, delusions, attempts at suicide, bizarre facial grimacing, and extreme anxiety are clearly abnormal by most social standards. However, many such gross violations are not noticed, are ignored, or are rationalized as eccentricity. A close look at any neighborhood in any community will reveal large numbers of seriously disturbed persons who have never come to the attention of a psychiatrist. The violation of the social norm in itself, therefore, does not necessarily cause a person to be labeled as mentally ill. The person is labeled, rather, when circumstances bring about public and official recognition of aberrant behavior—for example, when a request is made that the person be committed to a mental hospital. The result? The person is stigmatized and labeled as mentally ill.

Scheff points out that labeling of a person as mentally ill is facilitated by stereotyped imagery learned in early childhood and continually reaffirmed, inadvertently, in ordinary social interaction and through the mass media. Thus, when a person's violation of social norms or deviance becomes a public issue, the traditional stereotype of "crazy person" is readily adopted both by those reacting to the deviant person and, often, by the deviant person as well. A person completes the process of acquiring the label "mentally ill" when the stereotyped imagery becomes part of the person's self-concept and begins to guide the person's behavior. In a crisis, when the gross violator of social norms is publicly recognized, the person is profoundly confused, anxious, and ashamed. The deviant person may be highly suggestible and may accept the proffered label of mentally ill as the only way to get out of an intolerable situation. The person may prefer being taken to a hospital as crazy to being taken to jail as a shoplifter. Later on, the person finds that playing the stereotyped deviant role of being mentally ill provides such rewards as hospitalization, where the person is taken care of, and relief from having to fulfill normal social and vocational roles. Once having been labeled "mentally ill," the person may find it difficult to become delabeled.

Scheff himself observes that these theories were taken seriously in the 1960s and 1970s, began to wane in the 1980s, and had been all but dismissed by the mainstream disciplines by the 1990s. A major reason was biological psychiatry, with its emphasis on biological etiology, more scientific classification, and effective treatment with psychoactive drugs. Other major reasons were critiques within Scheff's own field of sociology, which proposed that since labeling theory was not substantiated by empirical studies, it should be abandoned.

The book, therefore, begins with a counterattack on both biological psychiatry, which has largely ignored not only labeling theory but sociological theories generally, and on those who specifically have attacked labeling theory. Scheff then goes on to reiterate the labeling theory of mental illness with substantial elaboration and clarification and places more emphasis on the contributions of psychological approaches.

Although some of Scheff's critiques of biological psychiatry have merit, in some ways they also seem to me to be a distraction. The most important new contribution of the third edition of this book, in my opinion, is that Scheff more strongly emphasizes than he did before that the labeling theory of mental illness is only one of many points of view and that it will be necessary to integrate the differing standpoints of the psychological, sociological, and biological approaches.

Scheff's labeling theories were an important contribution when they were originally proposed, although, unfortunately, they have been misused by some in the antipsychiatry movement. In my opinion, Scheff's theories remain important and add to our understanding of mental illness. The tremendous advances in biological psychiatry should not be minimized. On the other hand, if we are to have a truly biopsychosocial approach to mental illness, contributions such as those of Scheff remain essential.

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Corrections

In "The Lexington Narcotic Farm" by Thomas R. Kosten, M.D., and David A. Gorelick, M.D., Ph.D., the location given for Dr. Gorelick was incorrect. He is in Baltimore, Md. (Am J Psychiatry 2002; 159:22).

In the article "Antipsychotic Medication Adherence: Is There a Difference Between Typical and Atypical Agents?," by Christian R. Dolder, Pharm.D., et al. (January 2002; 159:103–108), the fourth sentence in the third paragraph of the Data Collection section (p. 104) should read, "Fills obtained within a period equivalent to 80%–120% of the period covered by the previous prescription were considered adherent (19, 32)."