cept to encompass. There are sections dealing with health promotion, resilience, the effects of stigma, and the involvement of consumers of psychiatric services in the design and conduct of mental health research. There are a number of definitions of the recovery concept, but the following example, in which the authors summarize Davidson and colleagues (1), is particularly illuminating: "Recovery does not necessarily imply an improvement or elimination of symptoms and deficit, but rather relates to a learning process that enables people to live with long-term limitations and teaches them how to cope or compensate for them and to participate in community life as actively and satisfactorily as possible" (p. 45).

The authors, a psychiatrist and a psychotherapist, reveal their enthusiasm for the topic of consumer-oriented services throughout the book (and in the postscript, they describe what drew them to the subject). They present a wealth of information from around the world, referenced with care. The book, originally in German, has been beautifully translated and updated for the English-language edition. As we read about consumer-developed recovery programs from the United States, Australia, and several European countries, recovery-oriented treatment systems from Scotland to Ohio, and the global involvement of the World Psychiatric Association, it becomes apparent that the recovery concept has had a significant impact on service delivery in a large number of developed countries, often with government support. America's earlier consumer-driven reform movement, the Mental Hygiene Movement of the early 20th century, did not have this broad an impact. This is something we cannot afford to ignore, particularly since, as with the Mental Hygiene Movement, the stimulus for the recovery concept has been the perception of widespread deficits in the adequacy of psychiatric care.

The authors are not biased reporters, and they deal with each issue with balance and thoughtfulness. They are appropriately cautious about recent attempts to prevent psychosis through early intervention. Issues such as consumer empowerment and involuntary treatment are handled with delicacy from the perspective of both the patient and the clinician. Nor do the authors recommend, as some mental health policy makers have done, that we rely on subjective reports of quality of life or related measures in designing treatment programs, pointing out that subjective and objective data of this type are often at wide variance with one another. They do endorse, however, the expanded use of qualitative research and suggest, somewhat caustically, that psychiatry's emphasis on evidence-based research might be better regarded by consumers and family members if the results of, say, rehabilitation intervention research were more widely adopted in practice.

Although the recovery concept has diffused as a social movement and hence will not necessarily be based on scientific evidence, this book offers ample research data on the central components of the model. We are shown the evidence for the substantial recovery rate from schizophrenia, and we recognize the reason for the optimism that is fundamental to the approach. One of the most robust findings in schizophrenia research since the time of Eugen Bleuler is that a significant proportion of those with the illness will recover completely and many more will regain good social functioning. We learn about the merits of consumer empowerment in improving outcomes from serious mental illness and how we can help it happen. We discover how consumer involvement in treatment benefits both the peer-provider and the recipient. A growing body of research supports the concept that empowerment is an important component of the recovery process and that consumer-driven services and a focus on reducing internalized stigma are valuable in empowering the person with schizophrenia and improving outcomes from the illness.

As practitioners, what should we take from this book? The authors would want us to offer hope rather than unfairly negative prognoses. They would encourage us to eschew paternalism and to partner with our patients in making treatment decisions, offering them choices as a route to empowerment. They would expect us not only to treat our patients with dignity and respect but to insist that our coworkers do so, whatever the setting. And they would want us to bear in mind that psychiatrists have been criticized by a distinguished leader in the field as being sources of "iatrogenic stigma" of mental illness for ignoring some of these very precepts (2).

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The Protest Psychosis: How Schizophrenia Became a Black Disease, *by Jonathan M. Metzl. Boston, Beacon Press, 2010, 288 pp., $27.95.*

The Protest Psychosis is a passionate condemnation of the relationship between psychiatric diagnosis and race. It is deliberately provocative—"the book explores the processes through which American society equates race with insanity"—with the aim, it seems, of shocking readers into recognizing their own underlying racism. The tale it tells is grim. In the early 20th century, "schizophrenia" was a problem of white middle-class women. They needed help, but above all they needed kindness, and the institutions built to house them existed not to protect others from them but to restore them to themselves. Most psychiatrists are aware that DSM-III narrowed the category of schizophrenia. Patients left within it after 1980 were sicker, crazier, and more violent than those who fit within its earlier capacious boundaries. Many may not realize that before the category was narrowed, back in the days when psychoanalysis still dominated psychiatry, African American men came to represent the problem of schizophrenia in popular culture and, arguably, in psychiatry. Advertisements for antipsychotic medications in the psychi-

atric journals showed angry black men or even just African tribal symbols. Metzl attributes this association to civil rights-era anxieties about racial protest, and he insists that with this history, the category of schizophrenia itself is racist: "Diagnosis is an inherently political interaction because diagnostic terminology is inherently politicized…even a correct diagnosis is always already a misdiagnosis." In electronic searches of articles in the *New York Times*, the *Chicago Tribune*, and the *Los Angeles Times* from the late 1950s on, "schizophrenic" and "schizophrenia" repeatedly draw associations with "Negro" and "black."

It is demonstrably true that even in recent decades, psychiatrists misdiagnose African Americans with schizophrenia when they would be more properly diagnosed with affective disorder. It is also demonstrably true that our jails are our largest psychiatric hospitals and that many housed within them are African American. *The Protest Psychosis* tells the story of Ionia State Hospital for the Criminally Insane, an old psychiatric institution that shifted from the care of presumed-harmless white women to the care of presumed-dangerous African American men to a prison, a trajectory that Metzl understands to represent the broader American understanding of our most devastating mental illness.

There is, however, another dimension to this story that Metzl does not tell. For the past 20 years, psychiatric epidemiology has gathered evidence that stress and trauma increase the chances that someone will develop schizophrenia. Being born poor increases one's risk of schizophrenia, as does living in an urban setting, being retarded, and being an immigrant. If one has a dark skin, one's risk of schizophrenia increases as one's neighborhood whitens, a disturbing finding known as the "ethnic density" effect. The risk of developing schizophrenia among African Caribbeans who have migrated from Jamaica to the United Kingdom is as much as *15 times higher* than that among the local whites; the effect holds true for black-skinned Surinamese who have immigrated to the Netherlands. Recent research has found an association between trauma and schizophrenia so powerful that some European psychiatrists argue that trauma lies behind every psychosis. (These robust data are summarized in a recent collection edited by Morgan et al. [1]). There is something about social defeat that gets under the skin and—in those who are vulnerable—can literally drive someone crazy.

Why would a good liberal not consider this dimension of the story? Metzl simply ignores the research. "From the perspective of contemporary psychiatry, it makes no sense that schizophrenia is over-diagnosed in African Americans." This is not a problem unique to him. I have a student conducting an ethnographic study of the African Caribbean community in the United Kingdom, and again and again, academics in this country explain to her that the rate is the result of clinician bias—an explanation that even members of that community do not believe. The African Caribbeans in London attribute their high rates of schizophrenia to the experience of living in poverty with a history of racism and slavery. Why is it that racial prejudice—which certainly exists—seems so much more palatable as an explanation for high rates of illness than the effects of social inequality?

Perhaps the explanation is that it is so morally distressing to confront the costs of human social life. This, after all, was the story of the 1965 Moynihan report—a report that documented the real challenges of African American life in the inner city and was roundly criticized as racist and dismissed. Racial prejudice, after all, is something that readers of a book like this can act on or at least believe they can alter. Deep social inequality that leaves its marks on the body and mind is far more difficult to uproot. There is little doubt, however, that those marks are real.

Racism may be a problem for psychiatric interpretation. But it is also a psychiatric problem for those who struggle beneath its burden.

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Note: An example of a study that specifically examines heritability of cognitive impairment in African Americans with schizophrenia is published in this issue (Calkins et al., pp 459–472).

Modern Management of Perinatal Psychiatric Disorders, *by Carol Henshaw, John Cox, and Joanne Barton. London, Royal College of Psychiatrists, 2009, 294 pp., $35.50.*

Historically, fear of adverse fetal effects, medicolegal concerns, and the once accepted myth of "maternal bliss" during pregnancy dictated treatment decisions for pregnant women with psychiatric disorders. Depression in pregnancy was often discounted or neglected; frequently the customary rule for treating a depressed pregnant woman was not to do so. Increasing knowledge has made us more accountable when treating patients of childbearing age.

In this comprehensive work, Drs. Henshaw, Cox, and Barton provide an extensive review of the identification, treatment, and prevention of perinatal mental illness from the time of conception through breast-feeding and early mothering. Given that a significant number of our patients are women of childbearing age, it is essential for us to understand the biopsychosocial model of psychiatry as it relates to childbirth and as it is presented in this exceptional book.

In the book's foreword, the authors suggest that maternal mental health issues are the "core businesses of psychiatry and maternity care." Childbirth is unique in psychiatry as a major provoker of mental illness that comes with 9 months' warning. Psychiatrists are challenged to be knowledgeable about treatment decisions for women in all phases of childbearing, including pregnancy, the postpartum period, and lactation.

The most prominent work on postpartum mental illness was by Louis-Victor Marcé in 1858, yet the condition was also recognized at the time of Hippocrates as having a biological explanation. Despite the abundance of literature in the 19th and 20th centuries, there is no formal classification of puerperal psychiatric illness in ICD-10 or DSM-IV-TR.