Psychopathy: Antisocial, Criminal, and Violent Behavior

edited by Theodore Millon, Ph.D., D.Sc., Erik Simonsen, M.D., Morten Birket-Smith, M.D., and Roger D. Davis, Ph.D.; New York City, Guilford Press, 1998, 476 pages, $60

Gary J. Maier, M.D.

This book is essential reading for any clinician, jurist, or criminologist who will encounter, diagnose, manage, or treat a psychopath. Given both the rise of incarceration in the United States and the increasing interest in civil commitment for sexual predators, many of whom have psychopathy as a comorbid diagnosis, this book is a must. The cast of writers is international and outstanding.

The book is divided into five parts, on history and viewpoints, typologies, etiology, comorbidity, and treatment. In most of the 28 chapters, the authors give their definition of the psychopath for reference within their chapter. These definitions create a sense of redundancy, but given the controversy that has surrounded the diagnosis of psychopathy—even though it is allegedly the "best validated clinical construct in the realm of psychopathology"—the definitions do provide needed clarity.

The definition provided by Robert Hare in chapter 12 appears to be comprehensive and congruent with others: "Psychopathy is a socially devastating disorder defined by a constellation of affective, interpersonal, and behavioral characteristics including egocentricity, impulsivity, irresponsibility, shallow emotions, lack of empathy, guilt, or remorse, pathological lying, manipulativeness, and the persistent violation of social norms and expectations." The definition helps us understand immediately what Cleckley (1) wrote about so clearly in *The Mask of Sanity:* that this diagnosis has a number of defining attributes that have been part of its mystery and are still part of its uncertainty.

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Historically, *DSM-II, DSM-III,* and *DSM-III-R* identified this personality disorder by the use of descriptors. However, the term "psychopath" fell by the wayside in *DSM-III* in 1980, and the diagnosis of antisocial personality disorder arose in its place. In *DSM-IV* seven items were listed as defining adult antisocial personality disorder. They were substantially condensed and simplified from those in *DSM-III-R,* but they were not clinically tested, and they were not validated. Therefore, we have no idea how reliable or valid the current seven-item set is. In the continuum of psychopathy to sociopathy to antisocial personality disorder, the impact of the innate personality disorder shifts from a focus on intrapsychic dynamics to rule breaking and the social cost.

Thus Hare's Psychopathic Checklist—Revised (PCL-R) has come to be the gold standard for making the diagnosis of psychopathy, both in the general population and in prison settings. Because this assessment tool is so important, a brief description of it is warranted. The PCL-R is a 20-item checklist—or, more accurately, a 20-item clinical-construct rating scale—completed on the basis of a semistructured interview and detailed collaboration or file information. Each item is scored as 0, 1, or 2, yielding a maximum possible score of 40. The mean PCL-R scores in North American populations of male and female offenders typically range from 22 to 24, with standard deviations of 6 to 8. Mean scores in North American forensic psychiatric populations are somewhat lower, around 20. For research purposes, a score of 30 is generally considered indicative of psychopathy. The PCL-R now has a shortened version, called the Psychopathic Checklist: Screening Version, that also appears to be valid and reliable in identifying this disorder.

Those who have challenged and checked the internal consistency of the initial Psychopathic Checklist and the later PCL-R have found that the checklist measures a unitary construct that consistently reveals a stable, two-factor structure. Factor 1 consists of items having to do with the affective interpersonal features of psychopathy, such as egocentricity, manipulativeness, and callousness. Factor 2 reflects features of psychopathology associated with an impulsive, antisocial, and unreliable lifestyle or social deviance. In fact, these two factors are guidelines to the polarity of this personality construct. Factor 1 reflects its innate pathology, which later in the book Otto Kernberg describes as part of the intrapsychic dynamic formulation. Factor 2 describes the impact of the personality in terms of rule breaking, which becomes better associated with the personality-trait literature. Some authors do not believe that psychopathy is a valid construct; however, the book, in my opinion, convincingly presents research that shows that it is valid.

While the second part of the book

In this section . . .

The evolution of antisocial personality disorder and the validity of the construct of psychopathy are among points Gary Maier considers in the lead review. Also on the theme of violent and criminal behavior are books on appraising and managing the risk of violence, on the transformation of Great Britain's "Special Hospitals" for the criminally insane, and on legal issues affecting mentally ill offenders, from a lawyer's viewpoint, plus books on "collective violence" and on community treatment of child sexual abusers. Recent texts on pediatric neuropsychiatry and on posttraumatic stress disorder are also featured.

describes different types of psychopathy, the fourth section, on comorbidity, describes the relationship of psychopathy to schizophrenia, somatization disorders, mood disorders, suicide attempts and suicide, anxiety disorders, other personality disorders, and substance abuse. The chapter by Darwin Dorr focuses on the relationship of psychopathy to pedophilia. Psychopathy as it relates to alcoholism and polysubstance abuse is given a separate chapter, as is the attempt to differentiate psychopathy from the sadist personality in murderers. Each of these chapters is filled with reports of current studies that cogently define the relationship of psychopathy to the specific topic area, with the overwhelming bottom line that psychopaths are at great risk for experiencing comorbid symptoms.

The section on treatment, which starts with chapter 23, may be the most useful and yet the most distressing. With the current state of the art of psychopharmacology, drugs that have an impact on irritability, preaggressive feelings, and impulsivity, especially the selective serotonin reuptake inhibitors (SSRIs), are beginning to show promise. Controlled studies indicate that SSRIs help some psychopaths gain control over emotions like impulsivity and anger that disrupt life.

Kernberg's chapter on the psychotherapeutic management of psychopathic, narcissistic, and paranoid transference is must reading for therapists. The feelings that psychopaths generate in those around them, including therapists, can be quite devastating. Furthermore, psychopaths can generate these feelings in themselves by identifying with the feelings they generate in others. In describing the effects of treatment, Kernberg states, "I believe that the prognosis in the work with such patients depends, in part, on the structural characteristics of their illness and, in part, on developments that can be assessed only during the treatment itself." He is still optimistic that change is possible, but outlines specific guidelines that the therapist must use when approaching such a patient.

A group therapy model and a therapeutic community model are both rated as promising treatment modalities when they are properly designed—that is, when they are structured to include healthy decision makers in the decision-making tree. In another chapter Jeremy Coid addresses the management of dangerous psychopaths in prison. He points out that 75 percent of inmates in English and American prisons qualify for a *DSM-IV* diagnosis of antisocial personality disorder and that, based on the PCL-R, about one-third of those inmates, or 25 percent of the total, qualify as psychopaths. The super-maximum-security prison is now becoming a more standard administrative approach to contain and control recalcitrant and unchangeable psychopaths, who can be devastatingly destructive to the prison system and to individual inmates.

Psychopathy is both an easy and a hard book to read. Although the psychopath has been described in the Bible, in classical and medieval literature, and by Shakespeare, it was not until Cleckley (1) wrote *The Mask of Sanity* in 1941 that we came to realize that pathopathy is a personality disorder that wreaks havoc on personal and societal institutions. As reported in chapter 8, Westman estimates that each sociopath costs society about $50,000 a year.

Whether psychopathy is a product of genetics, neurobiology, or childrearing practices or whether it represents a moral defect in character or is an expression of "evil," we must agree with William Reid, who states in chapter 7, with more passion than science, that for the greater good of society, "We must stop identifying with the chronic criminal and stop allowing him to manipulate our misplaced guilt about treating him as he is: qualitatively 'different' from the rest of us." Amen.

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Violent Offenders: Appraising and Managing Risk

by Vernon L. Quinsey, Grant T. Harris, Marnie E. Rice, and Catherine A. Cormier; Washington, D.C., American Psychological Association, 1998, 356 pages, $39.95

Kirk Heilbrun, Ph.D.

The past decade has witnessed significant advances in the assessment of the risk of violent behavior toward others. Some of the most noteworthy advances include increased research on shorter-term outcomes, a multisite study funded by the MacArthur Foundation and the National Institute of Mental Health using an expanded range of predictor variables and more carefully defined and sensitive outcome measures of violence and aggression, and the development of tools to help clinicians focus on relevant risk factors for violence. Others are the increased use of meta-analysis to assess risk factors for crime and violence, the focus on developing actuarially based tools validated to measure level of risk for future violence and offending, and increased attention to interventions that reduce risk.

The authors of *Violent Offenders: Appraising and Managing Risk* have actively contributed to these advances in risk assessment. Indeed, this book describes a research program that began 25 years ago, centered at the maximum-security division of the Mental Health Centre in Penetanguishene, Ontario. After discussing the historical and methodological contexts of the research, the authors describe their work in violence risk appraisal with three populations: mentally disordered offenders, fire setters, and sexual offenders. They appropriately assume that

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risk factors for one of these populations may be different, or arrayed differently, than for others.

The authors next describe the development of the Violence Risk Appraisal Guide (VRAG), a tool designed for the relatively long-term prediction of who will be violent. They offer data and summarize arguments relevant to the VRAG's use, but anyone familiar with the violence risk literature over the past decade will be aware that the VRAG is clearly the tool of choice when the purpose is predicting violent behavior over a relatively long period (a mean outcome period of 88 months for the derivation sample) with mentally disordered offenders.

Violent Offenders also documents another major contribution to risk prediction and reduction. In a chapter on reducing the risk of future violence, the authors present the results of an empirical approach to establishing a treatment program for hospitalized mentally disordered offenders. The approach is more sophisticated than the usual current one of selecting dynamic risk factors (those potentially changeable through planned intervention) from among the predictors in the literature and building a risk-reduction program around them. Instead, the authors' empirical study of risk-relevant treatment needs for the population under investigation yielded the following target areas for intervention: management problems, aggression, anger, substance abuse, life skills deficits, active psychotic symptoms, social withdrawal, and family problems.

Despite the greater methodological sophistication of this approach, the list of target areas is reassuringly similar to what could be derived from a review of the current broader literature on violence. This consistency should serve to remind hospital and agency staff working with mentally disordered offenders that it is currently reasonable to design a treatment program that has a primary goal of reducing future crime and violence. It should also underscore the importance of research questions on risk reduction that must be addressed as the field moves toward implementing such approaches. Issues such as efficacy versus effectiveness in research designs, treatment integrity, sensitivity of outcome measures of crime and violence, and the enrollment of sufficient numbers of participants across sites must be considered if we are to learn what works, with whom, at what level of effectiveness, and in what context in the reduction of violence risk.

Violent Offenders: Appraising and Managing Risk is an important book. Its strengths include the description of a research program on violence with different populations and the derivation of a tool, the VRAG, that is both relatively accurate for long-term predictions of violence for mentally disordered offenders and efficient to use. The book also cogently summarizes the arguments in favor of actuarial prediction, addressing many of the concerns raised by clinicians who have been reluctant to consider such methods, and it describes an empirical approach to measuring risk-relevant treatment needs and designing a program to address them.

The application of this material has limits, which the authors tend to carefully acknowledge. The VRAG would not be applicable as a tool for predicting violence and crime by individuals not involved in the criminal justice system. It places individuals in one of nine overall risk levels, which is useful for considering overall level of risk but relatively insensitive to identifying specific risk-relevant intervention areas or change in risk status; a VRAG level is determined almost entirely by historical and clinical factors that do not change.

Thus clinicians seeking to develop risk-reduction programs or individual risk-reduction treatment plans must use the VRAG in combination with other approaches that address these questions. How a clinician, or a decision maker, can accurately determine when risk has been reduced is not a question that the VRAG can answer—but it remains a crucial area for investigation, perhaps employing strategies such as those described by the authors in their chapter on risk reduction.

Violent Offenders: Appraising and Managing Risk is highly recommended for clinicians, researchers, clinical administrators, judges, attorneys, and all others who must address questions related to the risk of future violent behavior among various populations. It offers a model approach to operationalizing and measuring risk of violence, and it outlines important considerations for the field as it weighs how such material will be applied.

Managing High Security Psychiatric Care

edited by Charles Kaye and Alan Franey; Philadelphia, Jessica Kingsley Publishers, 1998, 302 pages, $39.95 paperbound

Bruce Swartz, Psy.D.

In Great Britain the notion that individuals who commit violent crimes and also suffer from mental illness are entitled to treatment in a psychiatric facility rather than imprisonment originated 200 years ago. In 1800 James Hadfield was found not guilty by reason of insanity following his attempt to kill King George III. The court ordered that Hadfield be held in strict custody under humane conditions until "His Majesty's pleasure was known."

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Sixty-three years later saw the opening of Broadmoor Hospital, the first of Britain's three currently operating institutions for the criminally insane. Three additional facilities were eventually constructed to meet the growing need for secure psychiatric care. The 1959 Mental Health Act deemed these facilities "Special Hospitals" for individuals in need of "treatment under conditions of special security on account of their dangerous, violent, or criminal propensities." The patient population included those suffering from mental illness, mental retardation, or severe character disorder.

This book documents the brief but significant impact of the Special Hospitals Service Authority (SHSA) between 1989 and 1996 in its mandate to bring about vast organizational and cultural change that essentially elevated the Special Hospitals from custodial to treatment environments. The book's editors, Charles Kaye and Alan Franey, played significant roles in the change process, the former as chief executive of the SHSA and the latter as general manager at Broadmoor Hospital during this crucial period.

Contributors—mental health system and hospital administrators, psychiatrists, nurses, and a hospital chaplain—paint a grim picture of life inside the walls of the institution before the SHSA's emergence. Patients were locked in their rooms through the night with a chamber pot to be emptied the following morning in a ritual graphically termed "slopping out." Methods of physical control, including seclusion, mechanical restraints, and excessive medication, were commonly used. Staff were members of the influential and security-minded Prison Officers' Association. Military-style uniforms highlighted by peaked caps reinforced an atmosphere of authority and control to the exclusion of concepts such as individualized treatment planning and rehabilitative therapy.

The book painstakingly documents the SHSA's evolution over the course of its seven-year existence. The capital improvements, policy initiatives, multidisciplinary treatment concepts, and educational opportunities detailed within embody Mr. Kaye's firmly held belief that "dangerousness is reduced as progress is made towards stabilisation and recovery, and treatment is thus part of security." I came away from this book with a profound respect and appreciation for the contributors' accomplishments in the face of a deeply entrenched culture from within and a fiercely unsympathetic view of the patients.

The organization of the book makes it difficult to obtain a clear sense of the chronology of how the change process unfolded over time. Also, more careful editing might have diminished the reader's experience of traversing the same territory over again. Yet *Managing High Security Psychiatric Care* is an informative book that accomplishes its objective of chronicling how enormously complex systems of care can evolve to better address the needs of patients when the political will and financial resources are present.

The Mentally Disordered Inmate and the Law

by Fred Cohen, LL.B., LL.M; Kingston, New Jersey, Civic Research Institute, 1998, 584 pages, $98.95

Joel A. Dvoskin, Ph.D.

Long before the nationwide rash of class action litigation, Fred Cohen was writing about the rights of prisoners, especially those with diagnoses of serious mental illness. *The Mentally Disordered Inmate and the Law* is Cohen's latest effort in this area, and it is characteristically comprehensive and well written.

The volume is essentially an updated and expanded version of Cohen's well-received *Legal Issues and the Mentally Disordered Prisoner* (1), published in 1988. But the update and expansion were sorely needed, as a great deal has changed in the legal landscape in relation to mentally ill prisoners in the past decade. Several important cases, notably *Coleman v. Wilson, Madrid v. Gomez,* and, to a lesser extent, *Casey v. Lewis,* have expanded and clarified the rights of mentally ill prisoners and the duties of the people who control their lives.

Overall, the book features a highly useful layout and structure, and it is well edited. It is easy to find information relevant to any question, and the citations the author provides are accurate, complete, and up to date.

I especially appreciate Cohen's treatment of *Turner v. Safely,* which was as important to corrections as *Youngberg v. Romeo* was to psychiatric hospitals. Cohen also addresses, head-on, several important dilemmas. For example, an inmate who behaves in an odd and angry manner may be developing a mental illness, aggressing against the prison milieu, or both. Cohen's admonition that "it should not be assumed that this inmate is 'mad' or 'bad'" may seem obvious to clinicians, but it very much needs to be said to judges and lawyers.

In a final gift to his readers, Cohen includes extensive relevant portions of the decisions in *Casey, Coleman,* and *Madrid* as well as the actual consent decree in *Dunn v. Voinovich.* These thoughtful inclusions will save any reader a great deal of time, as the cases are essential to an understanding of this area.

Make no mistake about it: Professor Cohen does not pretend to be a clinician, and this book will not tell clinicians how to practice their craft in correctional settings. The book is unabashedly legal, but it benefits others besides lawyers who litigate in this area. It gives clinicians—and, perhaps more important, administrators—a very clear and welcome set of legal rules and structures within which they can practice, with perhaps some degree of assurance that their efforts might be judged fairly by the courts.

It may be ironic to observe that the expansion and clarification of the rights of inmates to mental health services is of great benefit to clinicians and administrators. But it is impossible to practice effectively in correctional settings without knowing the rules of engagement. To that end, *The Mentally Disordered Inmate and the Law* will be of great value to anyone who wishes to work in the rapidly expanding world of correctional mental health.

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Child Sexual Abusers: A Community Treatment Approach

by Jackie Craissati; Hove, England, and Philadelphia, Psychology Press, 1998, 138 pages, $29.95

Marnie E. Rice, Ph.D.

The author of this book aims to provide a guide for practitioners working in community probation agencies, social services, and mental health settings who wish to learn about assessment and treatment of child sexual abusers. The cognitive-behavioral treatment approach described here is based on the author's experience working in the Challenge Project in Southeast London. Throughout, the author uses vignettes from four cases to illustrate treatment principles and the problems that arise in practice.

This short book includes a brief introduction and a very short chapter (ten pages) on assessment; three chapters on treatment, which form the main body of the book; a short chapter on treatment evaluation; and two appendixes, one detailing the assessment measures, and the other summarizing the four illustrated cases.

In the introduction, readers are told that the book includes a careful evaluation of the Challenge Project treatment program, including the follow-up of both treated and untreated child sexual abusers. As a scientist-practitioner who supervises a small treatment program for both hospitalized and community-residing sex offenders, I was eager to skip to the evaluation chapter first, to find out whether the data supported the use of the Challenge Project, before I read the step-by-step details about the program itself.

The evaluation chapter says that before designing a treatment evaluation, one should ask whether one could bear to find out that the treatment does not work. At worst, the author says, a negative evaluation could "dent confidence in a lovingly constructed program." The author seems to be unaware of the more ominous possibility that treatment could cause harm (1,2).

Unfortunately, the promised "careful evaluation" turns out to be a two-year follow-up of 43 men treated in the program. Some untreated men are reported on, but their crimes and offense histories were so serious that they were not offered treatment, and their outcomes are not presented. In the absence of comparison data, the reader has no evidence on whether the outcomes of the treated men (eight of whom were considered "failures") differed from outcomes that would have occurred without treatment.

The detailed, step-by-step description of treatment is useful to readers who want to find out what a contemporary treatment program for child molesters looks like. Although, as the author states, there is nothing unique about the Challenge Project, the book does give a good account of what happens in the treatment sessions.

The strongest aspect of *Child Sexual Abusers: A Community Treatment Approach* is the four clinical cases used to illustrate the application of the treatment methods and the practical problems that arise in working with men who have sexually assaulted children. I recommend this book to those who might be considering working with such men. Those who already provide therapy for sex offenders will find little new material here.

Dr. Rice is director of research at the Mental Health Centre in Penetanguishene, Ontario.

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Collective Violence: Effective Strategies for Assessing and Interviewing in Fatal Group and Institutional Aggression

edited by Harold V. Hall and Leighton C. Whitaker; Boca Raton, Florida, CRC Press, 1998, 721 pages, $134.95

Abraham L. Halpern, M.D.

This massive book is a product of 32 contributors, including two chief editors, two associate editors, and ten consulting editors. The book is divided into three distinct parts. The first part, Foundational Issues, contains six chapters covering violent groups and institutions in the United States, juvenile delinquency and violent crime, and women and aggression. Part 2, Collective Violence by Private Groups and Institutions, contains five chapters whose topics include cults, hate crimes, profiling and criminal investigative analysis of violent crimes, and dealing with large-scale hostage and barricade incidents. Part 3, Collective Violence by Government Institutions, comprises nine chapters providing detailed information on subjects ranging from capital punishment and deadly use of police force to chemical and biological violence and "oppression by science."

In addition, appendixes totaling more than 100 pages include chapters discussing misuse of psychological techniques under U.S. government auspices, atrocities that took place during the Vietnam War, and assessment of dangerousness using handwriting characteristics. A unique and valuable feature of this book is that almost every chapter has an excellent annotated bibliography summarizing the most significant works on the subject of violence.

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The chapters on hate crimes, deadly cults, and antigovernment terrorists are especially thorough and fascinating. The book will surely be of interest to persons wishing to understand institutional and government-initiated violence. However, I cannot see many individuals purchasing a personal copy of this astronomically priced book. Nor would a library permit anyone, even a speed reader, to borrow it for the extended period necessary to read it in its entirety.

An important objective of this huge text, not hinted at in the title, is to propose principles and methods useful for inhibiting group and institutional lethal aggression. In this, the volume succeeds admirably. But even so, with the possible exception of the chapter on cults, most mental health professionals would not find the book of value in their clinical practice.

In sum, *Collective Violence* is an absorbing book, but not a useful one for busy mental health professionals seeking to improve their therapy skills.

The Older Adult Psychotherapy Treatment Planner

by Deborah W. Frazer, Ph.D., and Arthur E. Jongsma, Jr., Ph.D.; New York City, John Wiley & Sons, 1999, 269 pages, $39.95 softcover

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Betty C. Moore, L.C.S.W.

Like other books in the publisher's Practice Planners series, *The Older Adult Psychotherapy Treatment Planner* is a valuable resource for clinicians attempting to use a structured, goal-oriented approach to providing mental health services. The focus is on psychotherapy for older adults. The book uses a model for treatment that is consistent with practice standards and compatible with the documentation requirements of Medicare, managed care, and other third-party payers.

Mental health providers are increasingly called on to justify treatment and to measure outcomes. The book outlines a treatment planning process that will facilitate a focused approach with behaviorally stated objectives and measurable goals. For each of 27 problems that can cause functional impairment in older people, the book offers problem definitions, long-term goals, short-term objectives, and suggested interventions. Problem areas covered include anxiety, deficits in activities of daily living, depression, memory impairment, paranoid ideation, sleep disturbance, and substance dependence. Several possible axis I diagnoses are suggested for each problem.

The book could be a very helpful resource for social workers, psychologists, and others working with independent, community-dwelling elders who have few medical problems. It could be particularly helpful to beginning clinicians who are still learning to think in terms of behaviorally stated objectives and measurable outcomes.

However, while the information is sound, it is also limited. The book is written from a nonmedical perspective. Consulting a physician is mentioned in many chapters as part of a list of possible short-term objectives. But because older people tend to have multiple acute and chronic medical problems, it is important to rule out treatable medical problems before dealing with what appear to be psychological problems. It would have been useful if the book had been coauthored or reviewed by a geriatrician or geriatric psychiatrist in order to make clear the important link between the medical and the psychosocial aspects of the complex problems of older people and their treatment.

Mental health problems often are not identified until older people find themselves admitted to a hospital or nursing home. Thus social workers, psychologists, and other therapists in hospitals and nursing homes who use the book would need to work closely with physicians, clinical nurse specialists or nurse practitioners, and other nursing staff to understand the complex interactions of illness, medications, and psychosocial problems.

What background and expertise the authors have in the area of geriatric mental health is not clear. Clinicians who work with older people need to be well grounded in both the medical and the psychosocial aspects of aging.

The book's bibliotherapy section lists many helpful resources. Additional reading might include *New Techniques in the Psychotherapy of Older Patients,* edited by Myers (1), and Spar and LaRue's *Concise Guide to Geriatric Psychiatry* (2).

The reviewers are affiliated with Geriatric Partners, Inc., in Knoxville, Tennessee.

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Textbook of Pediatric Neuropsychiatry

edited by C. Edward Coffey, M.D., and Roger A. Brumback, M.D.; Washington, D.C., American Psychiatric Press, 1998, 1,566 pages, $150

Kamlyn Haynes, M.D.
Sheldon Benjamin, M.D.

Only in recent years has the field of neuropsychiatry, which was reborn in the 1980s, turned its sights toward children and adolescents. In the context of such a young field, the scope of the *Textbook of Pediatric Neuropsychiatry* is awe inspiring. Drs. Coffey and Brumback have coordinated the work of more than 100 authors to gather in one place overviews of neurobiological issues in development, child neuropsychiatric

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examination techniques, reviews of neuropsychiatric aspects of the principal psychiatric and neurological syndromes of childhood, and literature reviews of treatment.

As a psychiatric resident planning to enter a child psychiatry fellowship and a neuropsychiatrist who directs a psychiatric residency program, we read this textbook from the vantage points of trainee and teacher. Generally the information is encyclopedic and provides "one-stop shopping" for information about most conditions. For each of almost three dozen syndromes or disorders of children and adolescents, the authors include coverage of neurobiology and diagnosis and, in most cases, treatment. The final section, on more global principles of treatment, takes treatment considerations further in such areas as neuropsychopharmacology (four chapters), electroconvulsive therapy, psychotherapies, family interventions, community treatment, forensic issues, and genetic evaluation and counseling.

Many chapters in the book are outstanding for both trainee and practitioner. The chapters on neuropsychological testing, cerebral palsy, electroconvulsive therapy, tic disorders, and genetics are a few excellent examples. We could think of few topics in pediatric neuropsychology that are not covered. It is notable that in all five sections of the text, the material is presented with a uniformity and an evenhandedness that does not slight certain topics or overplay the presentation of others.

We were surprised to find that solid, practical coverage of normal neurobehavioral development and clinical assessment is followed by rather esoteric chapters on imaging and electrophysiology. They present research topics at the expense of basic instruction on when to order tests, what findings to expect in various neuropsychiatric conditions, and how to use results to inform treatment decisions.

Similarly, a few otherwise excellent chapters have occasional lapses in consistency of coverage. The chapter on medical diseases does a fine job of discussing issues common to many conditions, then focuses on nine particular conditions without explaining why others, such as asthma, are not covered. An otherwise excellent chapter on anxiety disorders mentions posttraumatic stress disorder only briefly. The chapter on dyslexia and language-based learning disabilities is among the most reader friendly and best written we've seen, yet no mention of treatment is made. An extensive collection of literature-based psychopharmacology algorithms is presented, but in some areas, such as depression, the algorithms sometimes do not reflect common practice. Despite these minor issues, which will no doubt be addressed in future editions of the book, the majority of chapters are comprehensive and quite well crafted by acknowledged authorities.

It is impossible for one text to serve as an all-inclusive reference for all readers, yet the authors have created a resource that is accessible to pediatricians, pediatric neurologists, and child and adult psychiatrists alike. The topic overviews address the key concepts in each area and are useful for both specialists and trainees. The research-focused chapters reflect the state of the art and are thorough enough for advanced readers. The scope of the book is more comprehensive than previous works in this area. Drs. Coffey and Brumback are to be commended for opening up the field of pediatric neuropsychiatry with this groundbreaking text.

Posttraumatic Stress Disorder: A Comprehensive Text

edited by Philip A. Saigh, Ph.D., and J. Douglas Bremner, M.D.; Boston, Allyn & Bacon, 1999, 434 pages, $87

Kenneth E. Fletcher, Ph.D.

The editors of this text have managed to compile a truly comprehensive overview of our understanding of posttraumatic stress disorder (PTSD). Although the book does not address every possibility under the sun, it does cover a wide range of the most relevant topics. Prominent experts discuss each topic in a detailed but readable manner, basing their information on the latest empirical data.

The concept of posttraumatic stress has a particularly interesting history of development. Social acceptance of the concept has tended to ebb and flow in a manner reminiscent of the symptomatology of the disorder, in which bouts of intense attention to the traumatic experience alternate with periods of denial. The first chapter sketches the troubled history of the concept, building on previous histories while supplying new information and fresh insight.

The range of topics covered in the following chapters is impressive. It is important that the subjects of prevalence, risk factors, and comorbidity are given as much emphasis for children and adolescents as they are for adults. The impact of a variety of traumatic stressors, including combat, disasters, and criminal victimization, is also covered thoroughly.

The neurobiology and genetics of PTSD are explored in detail. The chapter on neurobiology is one of the most readable and comprehensive explanations I have read of the current issues in this area. The genetics of the disorder is discussed in a separate chapter, and the relationship of gender to PTSD is explored in another.

Assessment issues are covered in several chapters. One chapter outlines the assessment process for children and adolescents, and another for adults. Many currently available

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assessment tools are critically reviewed. Techniques of psychophysiological assessment are discussed separately. Two other chapters consider forensic assessment of traumatized youth and traumatized adults.

Current approaches to treating PTSD are presented in detail in five separate chapters. One describes prevention strategies that can be implemented immediately after exposure to noxious stressors. Other chapters consider pharmacological treatment, behavioral treatment of children and adolescents, cognitive-behavioral treatment of adults, and group and milieu therapy for veterans with complex PTSD.

One notable chapter explores the socioeconomic consequences of traumatic stress. Although this topic is infrequently considered in the field, it has important public health policy implications, and the chapter deserves close reading for that reason alone.

This text's broad coverage of the field, coupled with the readable, in-depth discussions by leading experts, recommends it as a worthy addition to the library of anyone with an interest in posttraumatic stress disorder. In fact, it would make a useful reference work in any public library. I believe it would serve as an excellent college text as well.

Mismanaged Care: How Corporate Medicine Jeopardizes Your Health

by Michael E. Makover, M.D.; Amherst, New York, Prometheus Books, 1998, 300 pages, $24.95

Ellen R. Fischbein, M.D.

Whenever I hear someone claim to have a sound, workable solution for a problem an entire nation has been unable to fix, I think that person either must be another Einstein or has a bridge in Brooklyn to sell on a Web site. Although Michael E. Makover's *Mismanaged Care* is a nonfiction book, it will elicit a full range of emotions from physicians and other clinicians who may recognize scenarios familiar in their everyday practice.

An internist who repeatedly states that he has never been a provider in a managed care health plan, Dr. Makover writes extensively on the details of how the managed care system works and does not work. A large portion of the book details the inequities, injustices, inadequacies, and ineffectiveness of our current health care system. As a physician who proclaims his practice to be unaffected by encumbrances of managed care, Dr. Makover is somewhat self-aggrandizing in his claim that caring physicians such as he, who give high-quality care, spend an average of an hour with each patient.

Let us be honest. Managed care companies were not the first to introduce clinicians to the concept that more patients per hour means more income per hour. One reason the public embraced the early concept of managed care was that not all doctors were more dedicated to their patients than to the bottom line on the day's ledger sheet. A significant portion of the public felt their doctors did not give them enough time or concern. They looked to managed care to ensure that they received both and that they were charged a "reasonable" fee for it. One cannot disagree with Dr. Makover that the system is not only not working the way patients and some clinicians hoped it might, but that it is plainly messed up.

The author makes one point that cannot be overlooked: the patient must share more fully in the responsibility for deciding when to obtain care. When copayments are low, patients tend to be indiscriminate about going to their physicians for minor complaints. It is the patient's undoing, according to Makover, that managed care companies reinforce this behavior by readily covering "minor" problems but then by heavily managing care for serious problems.

The essence of the book is found in the final section, where Dr. Makover presents and discusses his health care plan. The basis of his plan for rehabilitating our ailing health system is the assumption that people are more careful about "buying" care when the payment comes out of their own pockets. He suggests instituting a combination of a medical savings account for "less serious" illnesses and catastrophic insurance with a high deductible for "major" illnesses. For his plan to work, insurance companies would have to forget about being nearly autonomous and unregulated. The plan would establish diverse boards of honest individuals who would arrive at fees the public and the physicians would accept. Patients would seek care only when they really needed it. (No small feat in this "give me—I want it now" society.)

A nonclinician reader might find some of the descriptions about our current system difficult to assimilate but interesting. *Mismanaged Care* inspires us to use our energy and ingenuity to look at an alternative system that might serve both provider and patient better. It provides stimulation to not just accept the problems with our current system, but to look further to see what might actually work better.

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