diagnosis of substance abuse. And the Johns Hopkins Press' resident grammarian seems to have nodded as the odd solecism ("a couple of years younger than him") sneaked into print. Overall, however, a noble effort, one that fills a hole previously unoccupied in the psychiatric literature. For the optimism and the life stories, request a copy for your department—and watch the Amazon ranking soar.

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Standardized Evaluation in Clinical Practice. Edited by Michael B. First; American Psychiatric Publishing, Inc., Washington, DC; 2003; ISBN 1585621145; $34.95 (softcover).

Not long ago I inflicted upon a few colleagues what may be the least scientific survey of my carrer. What I wanted to know was, other than when doing a drug study, how often do practicing clinicians use a standardized interview to evaluate a new patient? The answer was both shocking and unsurprising: hardly ever. Most of my clinician friends gather their diagnostic information the good old-fashioned way, probably the same way that you (and I) use: they wing it.

That's the basis for much of what you'll read in this important book. Unfortunately, it may go largely unread, judging by the Amazon.com ranking of over 1.4 million (no, that isn't the number of copies sold). The five chapters are readily summarized; in fact, Michael First's introduction has précised them neatly enough that you could almost skip the rest of the book altogether.

Monica Basco reviews the studies that demonstrate how much you will improve diagnosis when you use a structured interview. No surprises here. For primary care doctors, the psychiatric diagnosis agreement with "gold-standard" research evaluations was low, and if patients are diagnosed by mental health clinicians, it doesn't improve much. In a 2000 study, clinical psychiatrists had missed all but 41 of 223 comorbid diagnoses in a sample of 200 psychiatric outpatients.

In Chapter 2, Mark Zimmerman first retreads some of the same ground, then moves on to an excellent review of the development of the Psychiatric Diagnostic Screening Questionnaire (PDSQ), a self-administered interview that can help pinpoint areas that should be covered more thoroughly by a clinician during the initial interview. For years, when I was in private practice, I filled out a standard questionnaire for each new patient I saw. It didn't include many diagnostic criteria, but it did remind me to interview more thoroughly in a variety of areas that I might otherwise have neglected. In so doing, I was never aware of any problems with rapport that such a process might have introduced. Rather, I believe it actually improved rapport by gaining me greater knowledge of my patients right from the beginning than I would have had otherwise. This is the real meat of the book, and I only wish that the questions for the PDSQ had been reprinted here. Alas, it is a proprietary document, so you'll either have to come up with your own set of questions or plunk down over a hundred dollars at Western Psychological Services.

Christopher Lucas' Chapter 3 does for child and adolescent psychiatry what previous chapters have done for the adult interview, though his solution focuses on the computerized version of the Diagnostic Interview Schedule for Children.

The two final chapters cover rather more specialized material, and they have a somewhat added-on flavor, as if to bulk out the book. Maria Oquendo and others report the less-than-astonishing finding that we don't do very well when it comes to evaluating risk of suicide. After decades of trying, we still haven't advanced much beyond guesswork in determining imminent risk of suicide, the patient on the 12th story ledge notwithstanding (so to speak). The assessment of lifetime risk may be somewhat more accurate, but even that is pretty hazy at best. The bottom line is still: the best predictor of risk for a suicide attempt is a previous attempt. In the final chapter, Van Stone et [many] al. describe how the VA implemented use of the GAF in the waning years of the previous millennium.

Just about everyone who has studied the issue of interviewing patients agrees that structured and semi-structured interviews can greatly enhance diagnostic accuracy. Whether clinical improvement necessarily follows has not been adequately studied, though if diagnosis has any meaning at all, the answer must be yes. In the end, the issue isn't whether we can improve diagnosis, but whether we have the will.

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Anxiety Disorders in Adults: A Clinical Guide. By Vladan Starcevic Oxford University Press, New York, New York; 2005; ISBN 0195156064; $59.50 (hardcover), 423 pp.

I read this book about anxiety disorders over a series of lunch hours on a covered dock on the bank of the Arkansas River. The flowing water, tall bluffs, and darting swallows provided a calm oasis from office life. The contrast between the pastoral setting and the titled book title struck me. The serene setting was sufficient that an uninformative book would be put down or a dull dense book might induce sleep. To my surprise, this unassuming single authored small book kept me focused and impressed. After reading the first chapter, I looked forward to subsequent readings along the river.

The book is written by an academic psychiatrist who has been on the faculty at the University of Belgrade in Yugoslavia and now on faculty at the University of Sydney, in Australia. He is from a wide global experience and writes with an obvious wide clinical and research experience in anxiety disorders. The author writes clearly and simply and shows his breadth of knowledge from both published literature and personal experience from evaluating patients.

The book is divided into seven chapters, starting with an introductory chapter and following chapters on the conventional anxiety disorders (panic disorder, generalized anxiety disorder, social anxiety disorder, specific phobia, obsessive-compulsive disorder and posttraumatic stress disorder). Each chapter covers the clinical features, differential diagnosis, etiology, prognosis, and conventional pharmacologic and psychological treatments. The author is well informed and clearly describes topics where knowledge is certain as he succinctly describes points of contention or uncertainty. Each of the anxiety areas is covered in good balance and described from a practical office perspective. The chapters are appropriate in length, their length determined by the amount of evidence accumulated. The longest chapters cover panic disorder and post traumatic stress disorder.

Phenomenology is emphasized far more than etiology, and the author clearly understands the clinical presentation and internal experience of the patient with anxiety disorders. He describes all of the relevant manifestations as well as the overlap between anxiety and mood disorders. The book emphasized common areas of clinical confusion and co-occurring problems in each of the anxiety disorders. For example, there is regular discussion about how to distinguish between anxiety disorders and how to evaluate for comorbid mood disorders and addiction among patients with anxiety disorders. He also gives practical suggestions about elaborating symptom phenomena from patients. For example, regarding compulsions in obsessive compulsive disorder he writes, "If patients do not reveal spontaneously that they perform mental compulsions, it is useful to ask how they cope with a particular obsession or what they do to alleviate the distress about having such an obsession." The discussion about treatment is balanced, including pharmacologic and non-pharmacologic treatments. He combines findings from clinical trials along with rational clinical experience in treating patients. Hence, the findings from clinical trials are not simply summarized, but they are put in the perspective of the scenarios commonly seen in clinical practice. For example, he gives that common sense advice for treating patients with panic disorder "it is important to start an SSRI at one-quarter to one-half of its initial antidepressant dose . . . This phase of treatment is often critical . . . dropout rates are highest during this period."

The sections covering course and prognosis are generally brief and adequately summarize the natural history of the anxiety disorders. These sections could have been a bit longer. The sections of etiology and biology are somewhat longer, but not excessively long, and they do not get bogged down in the excessive detail of some books that struggle over minor differences in study methods and findings. In the etiology section the author pays respect to several theoretical backgrounds. Biological theories and findings are balanced by discussion of psychological theories and findings.

There is nothing new here, but the author synthesizes well-known information soundly. Many artists may paint a landscape, but only a few will capture it and sustain your attention, make it come alive. His writing is lucid and a pleasure to read. A seasoned clinician will find himself nodding his head in appreciation, and a novice should widen his eyes with new understanding. This small text should find a space on any outpatient clinician's bookshelf. It is an excellent refresher for practicing clinicians and would be fine reading for residents learning outpatient psychiatry.

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A Historical Dictionary of Psychiatry. By Edward Shorter: Oxford University Press, New York; 2005 ISBN: 0-19-517668-5; hardcover, $ 49.95 (hardcover), 342 pp.

In trying to make sure we do not lose sight of key concepts from psychiatry's past that are still part of current trends, Dr. Shorter has compiled this unique volume. Dr. Shorter is very clear that his book does not contain or address all of the field's history. But he has chosen as carefully as possible to define what remains obviously relevant from the past and how it relates to our current understanding of the field.

The dictionary is arranged alphabetically by topical area, such as "Andreasen, Nancy Coover," "Feighner Diagnostic Criteria," or "Freudian Doctrine of Hysteria." However, there is also an index to help the reader toward a briefer and more efficient search, with listings such as "Davis, John M.," and "Computed tomography (CT) scanning." This is due to the fact that some issues and persons are subsumed under more general topical listings within the main body of the dictionary and one might not be able to access them simply by looking up the term alphabetically in the dictionary section.

This is a book best used as a reference to look up specific names, theoretical movements, techniques and concepts. The major difference from an ordinary dictionary is that, rather than a simple, numeric listing of meanings and pronunciations, this book gives a succinct historical vignette with occasional subheadings for related or intertwined concepts. However, where Dr. Shorter believes a pronunciation is difficult or may have been lost in the shrouds of time, he does provide it. He also lists, at times, other topical segments of the book to which one may move should additional, related information be desired.

The introduction on pages 3 through 16 contains its own highly abridged history of psychiatry, along with a set of source notes. And toward the end of the book, just prior to the index, there is an essay on conducting research in the history of psychiatry, as well as a bibliography of other psychiatric historical texts. Each is subdivided into specific areas, such as "France" as a source of historical material, or books about "Psychiatrists: Autobiographies and Biographies," respectively. This book could be especially useful to psychiatrist educators (as a way to increase historical references and issues, or make sure of their accuracy, for any course or lecture), other medical historians (as a concise guide to a large number of