depression on the individual's mental and physical functioning. Issues such as the profound effect of depression on one's judgment and social functioning, heart function (e.g., decreased heart rate variability), overall cardiovascular functioning (blood clotting etc.), newest imaging findings, vascular depression, damage to neurons due to depression and other impact of depression are reviewed through the book.

Peter Kramer is quite passionate in his statement against depression as a disease, which, he hopes, will be eradicated one day, like some maladies of the past. He speaks against the misconception (in his interpretation) of the concept of 'heroic depression,' which has been considered a source of creativity and insight especially in artistic circles. While appreciating the achievements of psychiatric research, he also sees its shortcomings. He feels, probably rightfully so, that, " . . . conceptually, the research of last decade has been pedestrian" (p. 203), and has "mixed feelings about recent research on psychotherapy. It seems limited—not nearly so creative as research on medication, not nearly so important in its contributions to our understanding of what depression is." (I personally do not believe that even the research on medication has been very creative lately.)

The book unquestionably reflects the author's passion, intellectual acumen, vast knowledge and the fact that Peter Kramer is well-read. The reader will probably curiously ask, 'so, is this another great read, as some of the books of the past?' Unfortunately, I do not believe it is. The first issue I would like to raise is my lack of understanding of who the audience of this book should be. Being published by Viking, I assume the book is intended for the general readership. Maybe, but I am not sure how many general readers (I do not mean to offend anyone, I am a member of this group, too) would be able to resonate on the author's intellectual level. I do not mean just regarding the references to the nonfiction literature, but also the research issues. Even the author himself partially appreciates this on page 115, "My impression is that few people outside the research community appreciate the degree to which the scientific understanding of depression has changed in the past decade." Peter Kramer obviously does. But I remain unconvinced that his most recent book is going to make many people appreciate and understand the change of scientific understanding of depression during the last decade. And, surprisingly, some psychiatrists may find the presented review of the depression research incomplete and simplistic.

The second issue is, surprisingly and in contrast to the author's intention I presume, the fairly simplistic concept of depression as a clear-cut disorder, and the relative lack of consideration for despair, existential depression, and "everyday life depression." The author wonders, " . . . whether the spectrum metaphor isn't overdone when it comes to mood disorder. The emptiness, paralysis, and terror of depression have only a modest connection to the sadness of everyday life" (pp. 158–159). I think that some will disagree with this concept.

Thirdly, I was also surprised by the tone of some remarks and characterizations in the book. I would have the reader judge them him/herself. "Reviewing the chart of the depleted inpatients . . . " (p. 20), or "Depression may relate to creativity only in the fashion of quite plebeian diseases and handicaps, like psoriasis or the narcissist's fragile ego." One wonders whether psoriasis is a plebeian disease.

Finally, besides some factual mistakes (e.g., not Marie Asgard, but Marie Asberg is the "most eminent biological psychiatrist in northern Europe" p. 32). Also, it seems to me that reading this book I learned much more about the author himself than I would expect reading in a book about and against depression. I also read many more references to *Listening to Prozac* (1) and what happened due to it than I would really like to know.

The reader is probably going to ask whether my final verdict is that this is a bad book. Is it? Not necessarily. It has positive aspects, some of which I mentioned, including the author's passion, intention, knowledge, and the information he provides us (unfortunately not in a very clear fashion). Maybe I spent a lot of time on the weaknesses. That might be partially a reflection of the fact that *Listening to Prozac* and the importance of fighting depression put my expectations too high. I also read so much "nonspecific" praise on the book's jacket that I probably wanted to put things more in perspective and reality.

Thus, for the staunch fans of Peter Kramer's books: yes, this is another usual Kramer book, which, if you liked all previous ones, you might like. For the rest: this is not *Listening to Prozac*.

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Assessment Scales in Depression, Mania and Anxiety. (Part of the Assessment Scales in Psychiatry Series). By Raymond W. Lam, Erin E. Michalak and Richard P. Swinson; Taylor & Francis (A Martin Dunitz Book), Abingdon, Oxfordshire, United Kingdom; 2005; ISBN: 1 841 84 434 9; $ 69.95 (softcover), 198 pp.

As clinical psychiatry moves to become more evidence-based, the necessity to measure changes in clinical symptoms, outcomes, residual symptoms, side effects, and quality of life, among others, becomes more evident and pressing. Various assessments or rating scales/instrument provide one way to measure these and other clinical variables. As the authors of this volume, Drs. Lam, Michalak and Swinson point out, assessment scales can serve the same role as laboratory tests in other areas of medicine and have similar strengths and limitations.

They also point out that these instruments should not be used in isolation nor should they replace a clinical evaluation, just as one should not treat a laboratory result without considering the clinical status of the patient. Nevertheless, scales are usually an organized, convenient and clear method to track clinical progress.

Fortunately or unfortunately, there are hundreds of scales available in psychiatry. I say fortunately, because they allow us to focus on measuring almost every aspect of the mentioned variables, frequently with great attention to detail. I also say unfortunately, because it is quite difficult to figure out which instrument to use and when, how to get it, find a good reference to figure out whether it is validated and what the properties of that instrument are. Compendia of scales may provide a solution, at least a partial one, to this problem. It is interesting that so far, there have been so few good compendia of rating scales/instruments available.

The publishing powerhouse Taylor & Francis decided to help clinicians to address the lack of good comprehensive compendia of rating instruments with the introduction of the "Assessment Scales in Psychiatry Series." *Assessment Scales in Depression, Mania and Anxiety* is the second volume of this series, the first one being *Assessment Scales in Old Age Psychiatry*. The volume on depression, mania and anxiety scales was conceived as "a practical clinical resource for psychiatrists, family physicians, other mental health practitioners and for students." It intends to be a quick reference and also a tool for selecting an appropriate instrument for clinical use, or for reviewing a particular instrument while reading an article referring to this instrument.

The book is divided into five chapters and two appendices. In their introduction to this volume the authors "identified relevant instruments using a comprehensive search through the literature, focusing on scales that specifically relate to the measurement of severity and outcome rather than on diagnostic or screening tools." A few scales are included for historic reasons but otherwise they chose "to include only those scales that we considered useful in current clinical practice." The first chapter briefly reviews the reasons for using assessment scales in psychiatry. It points out the rise of evidence-based medicine, emphasis on patient self-education and self-management which includes self-monitoring, and the increasing recognition of the importance of residual or subsyndromal symptoms as predictors of poor outcome. This chapter also discusses the necessity of training for the proper administration of some scales, the fact that some scales must be purchased because they are copyrighted, while other scales are in the public domain, and that interviewer-rated scales users must consider issues such as inter-rater reliability and whether scoring rules are followed.

The following four chapters review the assessment scales/instruments in specific areas: Chapter 2 in depression and mania, Chapter 3 in anxiety, Chapter 4 in related symptoms, side effects, functioning and quality of life, and Chapter 5 in special populations. The introduction to each chapter briefly reviews the specific issues for each area, namely the symptomatology of disorders, syndromes or variables. Then each of these chapters reviews the assessment scales in each particular area. The review of each scale contains the following information: name of the scale, main reference, whether the scale is self-reported or clinician administered, what is the administration time, what is the main purpose (e.g., "to assess the level and nature of anxiety in adults"), what is the intended population (adults, children), brief commentary about the scale, brief discussion of scoring, available versions (e.g., Chinese, Danish, Spanish), additional references, and, importantly, the address for correspondence (including phone numbers and e-mail addresses). Most of the scale reviews also include a full version of the scale/instrument. Chapter 2 reviews 28 scales for depression and/or mania, from Bech-Rafaelson Mania Scale to Zung Self-Rating Depression Scale, including three "Hamiltons" (Hamilton Depression Inventory, Hamilton Depression Rating Scale, and Hamilton Depression Rating Scale, 7-item version). Chapter 3 discusses 28 scales for various anxiety disorders and symptomatology, from Adult Manifest Anxiety Scale to Zung Self-Rating Anxiety Scale. The following two chapters, in contrast to the first two, do not mean to be a comprehensive selection of scales, but rather a review of a few selected scales for the most important residual symptoms, side effects and populations. Chapter 4 presents 25 scales of related symptoms, side effects, functioning and quality of life, such as the Abnormal Involuntary Movement Scale, Arizona Sexual Experience Scale, Sheehan Disability Scale or Symptom Checklist-90-Revised. Finally, Chapter 5 discusses 13 special population instruments, such as the Calgary Depression Scale for Schizophrenia, Cornell Scale for Depression in Dementia, Children's Depression rating Scale-Revised, and Worry Scale for Older Adults.

The two appendices are a very useful part of this volume. Appendix 1, "which scale to use and when" is basically a large summary table listing the assessment scales by areas (depression-general, depression-subtypes, suicide, anxiety-PTSD, older adults etc.), their abbreviation, whether they are self- or clinician-rated, population, purpose, whether a rating sheet is reproduced in the book and which page is the scale reviewed on. Appendix 2 is an alphabetical listing of the scales and their pages in the book. This volume is certainly a very useful brief compendium of the most frequently used assessment scales in the areas of depression, mania and anxiety with related symptoms, side effects, functioning and special population scales. The book is well organized and structured and easy to use. It has a few minor and understandable weaknesses, such as the fact that not all selected scales are printed in the book due to copyright issues, or lack of the discussion of the Scandinavian, yet widely used UKU (Udvalg for Kliniske Undersogelser) Scale for side effects of medications. The book is also a selected compendium, not a collection of all available scales (which would be an almost impossible task). Nevertheless, the selected scales are the most frequently used, most well-known and the most useful ones. We are far from introducing the

rating scales to routine practice of all psychiatrists and mental health practitioners. Nevertheless, the introduction of assessment scales/instruments into clinical practice is growing and will probably become inevitable. This book presents a useful and practical tool for those novices interested and invested in this exciting, important, and innovative development.

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The Psychiatry of AIDS: A Guide to Diagnosis and Treatment. By Glenn J. Treisman and Andrew F. Angelino; Baltimore, Johns Hopkins University Press; Baltimore, Maryland; 2004; $42.50 hardback (ISBN 08018-7970-1), $19.95 paper (ISBN 08018-8006-8), 217 pp.

How often have you seen a monograph title and asked, What does this have to offer that I can't find in a standard textbook? So, we turn to "Neuropsychiatric Aspects of HIV Infection and AIDS" in *Comprehensive Textbook of Psychiatry*, and lo!—the chapter was written in part by the two editors of the book currently under review. Here, then, is a terrific opportunity to compare what someone writes in large with the boiled-down, textbook version.

The two versions have a lot in common, especially as they relate to the diagnosis and treatment of AIDS-related disorders such as depression (Chapter 2), schizophrenia and dementia (Chapter 3), personality disorders (Chapter 4), and substance use issues (Chapter 5). In an exegesis a tad too Aristotelian for my taste, both versions dredge up the four humors, melancholic, choleric, phlegmatic, and sanguine, to illustrate how unstable extraverts—choleric types—are the most vulnerable to HIV high-risk behavior. I was also somewhat puzzled to find that patient D, whose interesting and poignant history is reported in Chapter 4, was called an antisocial personality, though his long history of substance use calls into question whether that diagnosis is warranted. Whereas I am not, as a rule, a stickler for exact criteria, any disorder with implications as serious as ASPD (or schizophrenia or dementia) demands that they be met rigorously. Anyway, the outcome was gratifying: D improved markedly over the course of many months and stands as a tribute to the patience and therapeutic innovation of this treatment team.

Indeed, it is the case examples in this monograph, missing entirely from the textbook chapter, that I treasured in this volume. They are presented in detail full enough to make the problems of these individuals live for the reader. The first of these recounts the inspirational history of A, a young woman with major depression, personality disorder, substance misuse, a history of childhood hyperactivity—and AIDS. An unmarried mother of two who had served three prison terms, she abused heroin and cocaine and had such severe obstructive lung disease that she couldn't climb a flight of stairs. She required active intervention when she tried to sign out of the hospital against advice, and responded, over the course of seven years, by becoming nearly drug-free and working to help others with similar problems. There must be many more patients who do well in treatment, but we often know far too little of them. The authors do us a real service by presenting them in detail here.

Some material in the 25-page textbook chapter is barely touched upon in the book. This especially includes such neurological complications as toxoplasmosis, cytomegalovirus, cryptococcal meningitis, and others. Fatigue, which rates four paragraphs of discussion and differential diagnosis in the textbook, is covered in three sentences here. Each of these topics is of interest to a clinician practicing in the field, and deserves full coverage in a monograph.

Other than case histories, what added value can you expect for your 20 bucks? In its life story approach to HIV, Chapter 7 offers us an opportunity to understand the context of illness in the DSM-IV era. Many depressed HIV patients are in reality demoralized, a "psychological state of loss, grief, sadness, and despair that accompanies psychological injuries." The authors equate this to bereavement, and state that psychotherapy must be optimistic and based on experience.

Almost the entirety of Chapter 6, "Sexual problems and HIV," has no counterpart in the textbook. Although it discusses gender identity disorder, homosexuality, and sexual dysfunctioning, the bulk of the chapter concerns the paraphilias, which it likens to an addiction. (At least as written in DSM-IV, paraphilia is no more an addiction than heterosexual intercourse.) Sexual behavior has fueled much of the AIDS pandemic, and as such, it is highly worthwhile to examine it carefully. But when you consider the relative rarity of paraphilias, I wonder if the emphasis has been misplaced. The chapter seems something of a missed opportunity to discuss not only prevention, but identification and treatment in vulnerable populations.

Of course, the focus of this text is on diagnosis and treatment, but even so, I would expect greater emphasis on prevention, if only from the standpoint of explaining, for example, how to approach a patient to create a list of sexual contacts. But in their final chapter, "How to fight AIDS," the authors describe the role of the physician, the organization of the clinic, managed care, and the at times necessary use of paternalism (come on, isn't it time we switched to the anagrammatic, slightly older *parentalism*?). From their vantage point of many years of field experience in treating HIV, they have encountered dozens, hundreds of instances where a clinician could apply the ounce of prevention. I'd have been glad to see more about needle sharing, the development of vaccines, and the clinician's contribution to case-finding, for example. Sadly, there isn't much information about prevention in the textbook chapter, either.

It's an under-appreciated fact that book reviewers only get paid once they've reported misprints and other errors in the text. My beefs include an erroneous definition: it takes two or more instances of behavior in a year, not one, to qualify for a