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

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.