

DSM has ignored the fact that evolution has designed us to have anxieties that may be irrational by current standards (e.g., vicious felines, airplanes, tall buildings). Ignoring this fact, they argue, results in us being quite overinclusive in our diagnoses of anxiety disorders.

The greatest weakness of this overall excellent book is the excess confidence Horwitz and Wakefield display in the correctness of their theory. More self-criticism would have made for a better and a more balanced book. In the spirit of trying to even the playing field for those who go on to read this book, I would emphasize three limitations of their argument.

First, in most cases, we really have no good idea about what evolution has designed our mind/brain systems to do. Furthermore, very rarely can we do experiments to answer these questions. We are therefore at great risk of having competitive “just-so” stories about evolution that we judge on the grounds of plausibility, a slippery slope if there ever was one. If we did not know that long, long ago, felines were very vicious and prone to bite, what stories might have been constructed to explain our fear of them?

Second, Horwitz and Wakefield misrepresent evolution. Their argument depends critically on the assumption that evolution produces a single prototype of human functioning. But evolution works on populations not individuals. We know quite well that humans differ widely from one another in their vulnerability to anxiety disorders at least partly for genetic reasons. Some of us are going to have a lot of risk genes for anxiety disorders and others far fewer. Given this level of genetic variation, the harmful dysfunction theory would seem to lead us into the following rather untenable conclusions:

Individual A has a low genetic liability to feline phobia, yet she develops the condition from some traumatic exposure to an aggressive alley cat. Individual B develops feline phobia from his evolutionarily conditioned set of risk genes that shape his fear circuitry. The harmful dysfunction theory would dictate that we call individual A disordered because her fear system—not naturally tuned to be afraid of vicious felines—is really malfunctioning. Individual B, by contrast, does not have a disorder, since his “feline-detection-fear” circuitry is functioning as designed.

That is, a logical extension of the harmful dysfunction theory given genetic variation is that some individuals with the identical DSM syndrome should be considered ill and others not, depending on whether their “fear circuits” were “doing what they were designed to do.”

Third, it is not at all obvious what to do when the environment in which we evolved and current environments are seriously out of sync with one another. This was of course the point of my largely fictional story about vicious felines. But consider the current epidemic of type 2 diabetes, which could be a result of an evolutionarily selected fat storage system functioning as it should in the age of McDonald's. Do we really wish to then argue, as dictated by the harmful dysfunction theory, that individuals with type 2 diabetes are not disordered and hence should not be eligible for insurance coverage because their metabolism is doing what it was evolved to do?

So the harmful dysfunction model for psychiatric illness has some significant problems. Despite this, however, it is a

coherent, well-argued and thoughtful view about the boundaries we should set for mental disorder. Furthermore, I cannot suggest a much better approach, nor can the psychologist/philosopher Derek Bolton in his own excellent book on this topic (4). While we have our formal definition at the front of DSM, as a field we are actually in the uncomfortable position of not having a clear, philosophically coherent and easily implemented definition of a mental disorder. It is a devilishly hard problem.

For those interested in the fascinating problem of trying to define the boundaries of our disorders, reading this book will be time well spent. Indeed, in our mature moments, we should be glad that our field has attracted critics of such quality.

References

1. Wakefield JC: The concept of mental disorder: on the boundary between biological facts and social values. *Am Psychol* 1992; 47: 373–388
2. Wakefield JC: Disorder as harmful dysfunction: a conceptual critique of DSM-III-R's definition of mental disorder. *Psychol Rev* 1992; 99:232–247
3. Horwitz AV, Wakefield JC, Spitzer RL: *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder*. New York, Oxford University Press, 2007
4. Bolton D: *What Is Mental Disorder?: An Essay in Philosophy, Science, and Values (International Perspectives in Philosophy and Psychiatry)*. New York, Oxford University Press, 2008

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Comprehensive Care of Schizophrenia: A Textbook of Clinical Management, 2nd Edition, edited by Jeffrey A. Lieberman and Robin M. Murray. New York, Oxford University Press, 2012, 464 pp., \$79.99.

For years, I have opened my psychiatry course by asking the students and residents for their thoughts on recovery in schizophrenia, and they always greet me with perplexed and hopeless faces. They would be surprised to know that the outcome is quite better than previously reported; Schizophrenia is no longer necessarily a constricting and life-long diagnosis. Recovery can be a reality for 42%, while 35% have an intermediate outcome, and only 27%, a bit more than one-quarter of the entire suffering people, have a poor outcome (1).

This important textbook provides most of the empirically based information needed in order to achieve the best results for each person, together with convincing data showing that, for some of them, we can pursue the goal of recovery.

The open-minded first chapter, by van Os, Murray, and First, conveniently offers a commented and updated

interpretation of the literature on the diagnosis and natural history of schizophrenia and the correlation between diagnostic construct and course. There are at least eight categories in studies in the European Union and 12 in studies in the United States to be listed: combining categorical and dimensional approaches sounds like the most adequate approach to face this complexity.

Each clinician is a translation scientist committed to real-time translation of bench science to bedside clinical practice. The chapter by Girgis and Abi-Dargham on neurobiology presents the implication of this translational reasoning in terms of assessment procedure and provides the right basis for the treatment chapters, while also introducing the experimental probes.

Then there are two fascinating chapters on child and adolescent schizophrenia (by Rapoport and Frangou) and the problem of early detection of schizophrenia. The fundamental distinction between nonpsychotic premorbid and prodromal symptomatology is clearly stated.

The concept of the clinical staging model with different foci—ultra-high risk, first episode, and the recovery or critical period of the first 5 years after the diagnosis (2)—is of crucial importance in this new framework of schizophrenia, considering that about 75% of those who develop a first episode of psychosis will progress to a schizophrenia diagnosis (3).

I think the clinical staging model that considers the degree of extent, progression, and biological impact may represent the “state-of-the-art” approach to the complexity of the phenotype. The potential benefit of staging would be the better coordination and definition of the treatment, either pharmacological or behavioral, including family interventions.

Since we have multifunctional drugs, the two chapters on treatment—two textbooks themselves with about 300 references included—teach all you need to know about the everyday use of these drugs and new compounds, presented with the necessary support to decide the specific target dimension for each of them.

The next four chapters address the real-world issues of cognitive-behavioral therapy for schizophrenia patients, rehabilitative intervention, community treatment, and non-adherence to treatment, while at the same time covering the importance of dissemination to population-based community interventions.

This book approaches two other central issues: the clinical management of both suicidal behavior and aggressiveness/violence, followed by the analysis of substance abuse behavior. This vulnerable population is prone to polydrug abuse at the rate of 40%–60%, making the issue of substances one of the major problems of today.

The chapter on comorbidity is also a very helpful section, now that we are aware of the importance of the prompt recognition and assessment of it, as it has been a too often neglected side of the clinical psychopathology of major psychosis. Medical comorbidity is an arising issue because as psychiatrists, we need to care about the whole person, and our work must be directed toward an increase in the quality of life as well as of the life expectancy itself in this population already prone to illness.

The issue of gender difference is a very recent acquisition of psychiatry, and this textbook brilliantly highlights its major

aspects. As for the genetics contribution, we know that we are not far away from including genetic information in the assessment process.

Economic matters in the age of the Patient Protection and Affordable Care Act are closely connected with the empowerment and perception of the suffering, and I found it very appropriate that the chapter on economic matters was placed close to the first-person account section. We have learned that a better outcome is not directly correlated to a higher rate of spending, rather the personalized treatment would assess all the faces of the phenomena, with interventions that have to be timely and coordinated, not necessarily the most expensive.

In addition, we still need a fundamental shift in our thinking from pessimism to a reasonable optimism (chapter 4, by McGorry and Addington). One central message is that we should dedicate more time to disseminating this new knowledge to population-based community interventions. We must listen to but also study the people who have recovered from schizophrenia, as well as their caregivers: they have a lot to teach us, and this volume states it.

Next year, I will open my course by asking my students and residents to give this excellent book a close read, but it is also valuable reading for professionals, researchers, and laymen: the sum of the chapters make up a new culture for the care of schizophrenia patients.

References

1. Menezes NM, Arenovich T, Zipursky RB: A systematic review of longitudinal outcome studies of first-episode psychosis. *Psychol Med* 2006; 36:1349–1362
2. McGorry PD, Hickie IB, Yung AR, Pantelis C, Jackson HJ: Clinical staging of psychiatric disorders: a heuristic framework for choosing earlier, safer and more effective interventions. *Aust N Z J Psychiatry* 2006; 40:616–622
3. Yung AR, Phillips LJ, Yuen HP, Francey SM, McFarlane CA, Hallgren M, McGorry PD: Psychosis prediction: 12-month follow up of a high-risk (prodromal) group. *Schizophr Res* 2003; 60: 21–32

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***Suicide: Global Perspectives From the WHO World Mental Health Surveys*, edited by Matthew K. Nock, Guilherme Borges, and Yutaka Ono. Cambridge, United Kingdom, Cambridge University Press, 2012, 404 pp., \$120.00.**

Suicidal behavior is a major public health concern worldwide for which culturally appropriate interventions are desperately needed. Almost 3 years ago, I lost two individuals in my social network across two continents to suicide in a space of 6 months. I was devastated to say the least. I accepted to review this book because I have many unanswered questions about