in specific anxiety disorders such as combat veterans with post-traumatic stress disorder and obsessive-compulsive disorder, as well as specifically in suicidality, eating disorders, pathological gambling, and the dually diagnosed (mental illness and substance abuse or dependence). There is also a chapter about the use of MI in people within the correctional system. Each disorder-based chapter includes a brief discussion of the disorder itself, how MI is applied clinically, some variant of patient interaction or vignette, a description of pilot or initial research, and conclusions, then ends with a listing of references. The final chapter, as is common with "review-of-the-state-of-the-art" publications such as this one, discusses overall conclusions and future directions.

The individual chapters can stand alone if one wishes to read about MI in just one or two conditions. In fact, since many of the chapters are written by contributors without co-authorship by the overall book editors, the book contains some redundancy. This will probably be most noticeable to those who read the entire work in sequential order. Besides the four editors, there are nineteen other contributors from various parts of the United States, United Kingdom, and Canada, and one from Sweden. Most are psychologists, but three are (presumably) psychiatrists.

The book gives sufficient detail regarding the basics of MI so as to be useful to the novice, and the specifics within each chapter will be of interest to those who have some experience with MI in more traditional uses, such as substance dependence, but wish to expand their practice into other disorders with the help of expert advice. Medical students may benefit for example, from the descriptions and definitions in the first chapter, by learning more about listening to patients and approaching treatment adherence issues. Clinical psychology interns and psychiatric residents will find this an excellent introduction to the theory and practice of MI, a technique in which they seem, at least in my experience, to be more and more interested—they've heard about MI, but not all of their supervisors are as yet utilizing it. And practicing psychiatrists and other mental health professionals will find many practical suggestions for extending their use of MI to more patients, with evidence-based support to back up such options.

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Bipolar Disorder in Late Life, edited by Martha Sajatovic, MD and Frederic C. Blow, PhD, The John Hopkins University Press, Baltimore, Maryland; 2007; ISBN 0-8018-8581-7; $50.00 (hardcover); 257 pp.

Is new onset bipolar disorder (BD) in late life a rare phenomenon? Is the pathophysiology or presentation different from BD in younger adults? And most importantly, is treatment any different? These are some of the questions addressed in this book. These are not easy questions as "treating elderly patients means more questions than answers," as Dr. Bruce Pollock (the President of the American Association of Geriatric Psychiatry) correctly pointed out in one of the meetings. He went on to call it a "public health scandal" referring to the fact that the elderly population is commonly excluded from medication clinical trials, leaving very thin data to treat the older and sicker. This is the challenge that any book on that subject must deal with.

The book is published by Johns Hopkins University Press. It is divided into four parts. Part I: Epidemiology and Assessment (Chapters 1–3); Part II: Treatment (Chapters 4–7); Part III, Complexity and Comorbidity (Chapters 8–10); Part IV: Specialized Care Delivery and Research (Chapters 11–13).

Chapters 1 and 5 probably are the core of the book discussing epidemiology and treatment respectively. Chapter 1 is one of the most informative chapters in the book, and probably, the chapter with the most research support. Martha Sajatovic, MD and Frederic C. Blow, PhD challenge the old notion that late-onset bipolar disorder "burn out" over time (p. 7). They discuss that most researchers define late-onset BD at age 50 or more and that "new" late-onset is not as rare as previously thought, ranging from 6% to 11%. It can even "first manifest as late as the eighth or ninth decade of life" (p. 4). The authors discuss that some suggest that late-onset BD is a distinct subtype and is associated with more medical and neurological conditions and less likely of a positive family history of mood disorder. This subtype has been called secondary mania or vascular BD. A remarkable finding by Angst and colleagues is the finding of increased mortality from suicides and circulatory disorders in this population (1), and that there is a 2.5 fold decrease in suicide rate in older adults with BD who are treated with medications.

The end of the first chapter summarizes that there "is no consensus on the best treatment for late-life bipolar disorder" (p. 11). This is due to lack of randomized controlled treatment trials specific to this population.

Chapter 5, "Biological treatments of bipolar disorder in late life" by Christine R. Dolder, Pharm.D et al., is written in a generic way and does have areas with little clinical relevance. An example is mentioning "hypothyroidism > hyperthyroidism" under common side effects of lithium (p. 76). Hyperthyroidism is not considered a common side effect by most clinicians. Also, lumping of "Topiramate/Lamotrigine" together under one small section and presenting them as having more similarities than differences is less helpful to the practicing psychiatrist. It is not clear what the authors mean by mentioning that "the *newer* (italics added) antidepressants as bupropion . . . are considered the preferred alternatives to SSRIs for older adults" (p. 83), as bupropion was approved by the FDA in 1985 and then was re-introduced to the market in 1989, before most SSRIs.

Chapter 2 discusses the mood rating scales for old age mania. Again, the authors emphasize that YMRS positively correlated with Hachinski score (index of vascular brain disease). Chapter 3 addresses the comprehensive assessment of BD in long-term care settings and goes into great detail about assessment instruments, assessment protocols and policy implications. Chapter 4 covers the epidemiology, incidence (as chapter 1), etiology,

diagnosis and treatment of secondary mania. Chapters 6 to 10 address the aspects of psychosocial intervention, adherence to treatment, substance abuse, medical comorbidities, and cultural factors that can affect the diagnosis and treatment. Chapters 11–13 focus on specialized care delivery, evidence based treatment, legal and ethical issues in research; addressing issues like advanced directives for research and surrogate consent.

There is overlap and repetition of information between different chapters of the book. On the other hand, the useful side is that the book is drawing attention to the incidence of new onset BD in late life and the fact that it is not as rare as previously thought. Research in this area is important, not only because there is limited data, but also because it provides several unique advantages. After all, studying this population allows for studying a life-long course that has unfolded. It also gives a more complete genetic picture of inheritance, as there will be more data on first degree relatives such as children and siblings.

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Dialectical Behavior Therapy with Suicidal Adolescents, by Alec L. Miller, Jill H. Rathus, and Marsh M. Linehan, The Guilford Press, New York, NY, 2007; ISBN 1-59385-383-1; $40.00 (hardcover); 346 pp.

Dialectical behavior therapy (DBT) sprouted from Marsha Linehan's way of applying cognitive-behavior therapy to individuals with suicidal and self-injurious behavior. Not only has DBT demonstrated efficacy in randomized clinical trials for reducing suicidal behavior and hospitalizations of suicidal patients with borderline personality disorder (BPD), but also there is no other treatment that has such strong data of efficacy in this group of patients.

This book, by Drs. Miller, Rathus and Linehan, developed from Miller and Rathus' application of a modified version of Linehan's DBT for adolescents with suicidal behavior. They used their work to implement a pilot study with inspiring results. This is a very important area since suicides in adolescents have become the third leading cause of death in this population. Whether this modality decreases suicides remains to be determined.

Throughout the book (and in Linehan's own work), sometimes these patients are referred to as "multi-problem suicidal adolescents." It is not intended that they are "problematic" to the therapist, but rather that the risk of suicidality increases with the number of risky behaviors or "problems" these adolescents exhibit.

The book is divided into 12 chapters. The first chapter describes some definitions, specifies the problem behaviors as violence, drinking, illicit drugs, smoking, high risk sexual behavior, disturbed eating, etc. They discuss that suicide risk doubles for one problem behavior, becomes 8.8 for two, and up to 277 for six of these behaviors. They discuss also other risk factors for suicide and the overlap between suicidal behavior and BPD.

Chapter 2 discusses that there is no effective treatment that is well established to reduce risk of suicide other than lithium (1) and clozapine (2), but again, these medications are not usually helpful for individuals with BPD. This is also complicated by the fact that suicidal patients are usually excluded from medication treatment trials. Linehan describes her findings (3,4) that DBT approach reduces suicidal attempts and self-injurious behavior (completed suicides not mentioned) compared to treatment as usual, even without being more effective in reducing depression. This, of course, has favorable clinical and health cost benefits.

Chapter 3 describes that DBT is not only dialectical, as the name implies, but consists of three components: behavioral, mindfulness and dialectical. It also discusses treatment stages, targets and strategies. Chapter 4 describes the structure of the program and how to tailor the original DBT to be helpful for adolescents. Chapter 5 depicts the dialectical dilemmas faced by adolescents and supported by clinical vignettes. Chapters 6 to 12 go through the process of therapy in great detail, from assessing suicide risk and choosing appropriate candidates to orienting adolescents and their families about the treatment. It describes the importance of family involvement, goes though the nuts and bolts of the skill training and the individual therapy, assessing progress and terminating treatment with preparation of a graduate group.

The book is a good outline of the theory and application of DBT in adolescents, which is helpful for psychologists and psychiatrists who treat adolescents with BPD or "multiproblem suicidal adolescents." I believe it would help therapists who already do DBT and would like to learn more about applying it to this specific population, as well as newcomers. This would be specifically helpful to residents and interns. Trainees commonly find these patients fascinating and are eager sometimes to treat a higher share of these patients. BPD can masquerade as a large number of psychiatric disorders and can be challenging to the inexperienced treater. After multiple sessions and/or a long list of psychotropic medication trials, the treater gets frustrated or just gives up or in to the pressure/temptation to prescribe sedatives with little or no scientific evidence for the use of most psychotropic medications. For training purposes, *I Hate You, Don't Leave Me* (5) would be a great complementary book to this one in understanding how these patients feel and the effects of the disorder on family and friends.

One limitation, however, is that most chapters are a little too detailed, especially for the novice, and I believe a