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

focused version would be more useful. Another editorial point is that although this is a great model of treatment which fills the gap in an area where almost nothing else does work, it should be noted that it has not been definitively proved by randomized clinical trials in the adolescents as it has in the adult population, where Linehan's original DBT has proven effective for decreasing suicidal behavior and hospitalizations.

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The Therapist's Guide to Psychopharmacology: Working with Patients, Families, and Physicians to Optimize Care, by JoEllen Patterson, A. Ari Albala, Margaret E. McCahill, and Todd M. Edwards, The Guilford Press, New York, NY; 2006; ISBN 1-59385-328-9; $35.00 (hardcover); 310 pp.

Gone are the days when doctors tell patients the best medication for them in a paternalistic fashion. In the era of patient-centered advertisements, Internet, and online pharmacies, a supermarket kind of interaction, where some patients have specific requests for certain medications, is more prevalent. The physician has to not just agree or disagree, but should provide sufficient information for the patient to be able to make an informed decision and provide informed consent about the available feasible alternative medications, risks, benefits, target symptoms etc. In this era, non-physician mental health professionals (which are the target audiences for this book) should have some basic knowledge of psychotropic medications as stated in the introduction of this book: "to stay current we have to gain rudimentary knowledge about these medications" (p. 2).

Prescribing medications requires medical training specialized not only in medication, but also in physiology, pathophysiology, and medical conditions that can be comorbid with or masquerade as psychiatric symptomatology. As stated in the Hippocratic Oath in the 4th century BC: "I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone."

Specialization was also recognized back in the 4th century BC: "I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners, specialists in this art." The "stones" referred to are kidney or bladder stones. At that time, practitioners who did surgery were officially the barbers.

Nonetheless, some knowledge of psychotropic medications by non-physician therapists and non-medical trainees would be helpful to patients. One benefit is that if the therapist knows that there is some medication to help a certain disorder the proper referral for medication initiation can be done. A second benefit is that the therapist can play a crucial role in improving medication adherence; work with patients and families toward eliminating stigmatization. Studies show that patient education and medication counseling help to decrease the incidence of relapse (1,2). Moreover, this improves collaboration between the psychiatrist and the therapist.

The book is written by two psychiatrists and two family therapists. A useful aspect of the book is the inclusion of multiple illustrative case examples, sample referral letters, and a glossary of common medical terms used in the book, as well as a concise list of references at the end of the book. Another helpful aspect is that the authors tend to talk more broadly of groups of medications rather than a single medication. This makes it easily digestible by teaching the common properties of medications and information that is more resistant to becoming outdated in the face of the ever-expanding pharmacopoeia.

The book is divided into three main sections. Part I: Mind-Body Connection (chapters 1 and 2), starts with a concise presentation of how psychotropic medications affect the brain without going in depth into complicated neurobiological mechanisms and pharmacodynamics. Part II: Psychiatric Disorders and Their Treatment (chapters 3 to 8) discusses medication for common psychiatric disorders, including schizophrenia, mood disorders, anxiety disorders, etc., as well as epidemiology and symptomatology of the disease process. Part III: Creative Collaboration (chapters 9 through 11) discusses the referral process for medication evaluation, collaborative care for patients, and building collaborative relationships for sharing care of patients between the physician and therapist. The last chapter addresses an important issue, which is collaborating with the patients' families. Appendices A and B are especially interesting. Appendix A discusses how drugs are developed and FDA requirements. Appendix B briefly discusses the landmark studies, such as CATIE and STEP-BD, as well as non-pharmacological treatment, such as TMS and VMS.