Silove then describes the clash between the burgeoning numbers of refugees worldwide and the erosion of governmental protections for asylum seekers, especially in the wake of Sept. 11, 2001. In previous decades, collective shame about the Holocaust spawned enlightened refugee policies throughout the world. Silove notes that a paradigmatic retreat in these attitudes occurred with the "refugee fatigue" toward Indochinese refugees in the 1970s. Successive waves of Vietnamese refugees went from receiving warm welcomes in countries such as the United States to spending long periods in refugee camps, which then became prison-like detention centers. During the past two decades, the number of refugees worldwide has tripled, further straining resources and goodwill. Tragically, "In the public mind, the war against terrorism has become confused with the challenge posed by asylum seekers, a blurring of issues seemingly fostered by political rhetoric" (p. 17).

Several other themes recur throughout the book. It is reassuring to see that all authors emphasize the initial and essential goal of establishing safety for survivors of trauma. Cultural variables receive the attention they deserve. Refugees experience cultural dislocation. So, as Aroche and Coello observe, "culture is both the cause of this pain as well as the pathway to recovery" (p. 55). All of the authors seem to be from Western countries, often treating clients who are fleeing non-Western countries. In the West, we tend to follow the maxim of *de mortuis nihil nisi bonum,* or Don't speak ill of the dead. However, in some cultures, anger at those who have just died is permitted. One widow sarcastically asked her children to put four replicas of female genitalia in her late husband's coffin, "so that he could enjoy adultery in afterlife as he sometimes did [while] alive" (p. 170).

Nonverbal expressive therapies have an important place in treating victims of trauma, since they are especially designed to engage with implicit consciousness and implicit memories. Art, music, and movement therapies have added advantages when therapist and patient do not share a common spoken language. Four chapters effectively describe clinical aspects of expressive treatment. We were disappointed that the authors did not link their treatments with relevant advances in the neuroscience of posttraumatic disorders.

Wilson and Droždek deserve our deep thanks for putting this outstanding book together. Unfortunately, Wilson's own chapters get entangled in overly intellectualized lists, diagrams, and theories. In addition, he sprinkles his chapters with quotations of some of his own most treacly past writing (e.g., "Weary souls displaced from their natural roots. Quietly desperate in a vacuum of loneliness. Their cries are silent. Existence in an abyss of pain and dark uncertainty" [p. 109]). The unadorned facts about these survivors are eloquent enough.

A recurrent theme is treaters' and patients' relationships with administrative and political policies that deeply affect refugees' lives. Realistic anger and frustration with inhumane policies are widespread. A few authors acknowledge that "projecting guilt only on 'the system' can hamper seeking adequate active [solutions] to problems.…Rather than go through the work of mourning…they might prefer to attribute problems to their surroundings" (pp. 493–494). Such projection of all blame onto "the system" is surely a temptation for overwhelmed and vicariously traumatized treaters.

The book's final two chapters address legal and political issues. This perspective is highly germane to the clinical issues with this patient population. Herlihy, Ferstman, and Turner highlight the labyrinthine complexities of legal systems that asylum seekers must navigate. Relevant international laws and treaties offer some protection for displaced persons, but draconian policies and unresponsive bureaucracies all too often interfere with effective and compassionate approaches to traumatized refugees. The book demonstrates that there is a clear need for further bridge-building work at the interface between clinicians and human rights advocates.

This book is an excellent compendium for clinicians in this field, and it helps point the way toward the further work necessary to fulfill our moral obligations to the victims of humanity's darkest side.

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Trauma and Health: Physical Consequences of Exposure to Extreme Stress, *edited by Paula P. Schnurr, Ph.D., and Bonnie L. Green, Ph.D. Washington, D.C., American Psychological Association, 2003, 311 pp., $49.95.*

The premise that a close connection exists between emotional states triggered by stress, particularly episodes or prolonged periods of extreme stress, and a variety of physical ailments has received much attention in recent years. Not that the idea hasn't been around for a very long time. It's just that more studies have been done to establish support for it. Drs. Paula Schnurr and Bonnie Green have obviously devoted considerable time, thought, and effort to compiling very pertinent information on this subject and assembling an outstanding group of contributors. They have produced a first-rate resource, filled with solid documentation of value to anyone wanting to review the work in this field, although not exactly an easy read.

The book is divided into five sections. Part 1 describes the effect of trauma on physical health. People exposed to one or more traumatic events over their lifetime have more physical symptoms and a greater number of chronic health conditions than do nonexposed individuals. Posttraumatic stress disorder (PTSD) is also associated with higher rates of other disorders and may represent a pathway between stressful events and adverse physical outcomes.

Part 2 focuses on psychological mechanisms. For example, evidence for the interplay between clinical depression and coronary artery disease is compelling. So too for PTSD, which may share biological underpinnings with affective disorders. Unhealthy coping methods, such as avoidant and repressive behaviors, have been linked with greater cardiovascular reactivity and impaired immune function. One point deserving greater emphasis is that "how individuals cognitively appraise situations is the primary determinant of how they cope." I think of the Columbine High School students who sought help not so much from crisis interventionists but from the clergy, who they believed were better able to help them achieve a meaningful perspective on the terrible ordeal they'd just been through.

Part 3 moves on to consider biological mechanisms. Traumatic stressors have effects on the immune system that may

increase susceptibility to infections and exacerbations of other diseases as well. The chapter titled "PTSD, Allostatic Load, and Medical Illness" is a *must* read. "Allostasis" is defined as the organism's ability to achieve stability through change, namely, by expending and directing energy toward challenges. "Allostatic load" is the cumulative cost to the organism of going through repeated cycles of adaptation, and "allostatic support" refers to mechanisms that confer "resilience" on individuals, making them more resistant to PTSD and other chronic illnesses. Biological abnormalities are associated with chronic stress syndrome, and specific medical problems, many of which involve central and peripheral neuroendocrine activity, are associated with both chronic stress syndrome and PTSD. Here is a framework within which new treatment modalities may be discovered.

Part 4 takes on somatization, a pattern of symptoms for which medical help is sought but adequate medical cause is not found after due investigation. Health risk behaviors are also reviewed—poor dietary habits, obesity, tobacco use, excessive use of alcohol, illicit drug use, and imprudent sexual behavior (often complicated by unintentional pregnancies and venereal diseases, most dangerously AIDS).

Part 5 is the least informative part of this presentation. General suggestions for increasing public and professional awareness of the stress-physical illness connection are made, and the call is for an integrated approach to prevention and treatment, echoing recommendations made for decades. It might have been more fruitful to explore the reasons why these have not yet been successfully implemented and consider new ways to make them happen.

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Assessment and Treatment

Clinical Manual for Assessment and Treatment of Suicidal Patients, *by John A. Chiles, M.D., and Kirk D. Strosahl, Ph.D. Washington, D.C., American Psychiatric Publishing, 2005, 333 pp., $39.00 (paper).*

This is a provocative book that approaches the evaluation and treatment of suicidal patients from a learning theory perspective: "That suicidal behavior is problem-solving behavior…is the principle underpinning our approaches to both the assessment and treatment of suicidal individuals" (p. xxi). The authors, a psychiatrist and a psychologist, combine cognitive behavior therapy and dialectical behavior therapy techniques, as well as some approaches of their own, to provide an etiological and therapeutic overview of suicide that may be more familiar to psychologists than to psychiatrists (particularly those trained before the teaching of cognitive behavior therapy during psychiatric residencies was required). When heuristic was an "in" adjective, this book would certainly merit such an appellation.

In these days, when a biological model of depression (and suicide) is often overemphasized, it is helpful to find a book that focuses on a more psychological basis for suicide and for psychological treatment of it. This is the book's strength as well as its shortcoming. It is so devoted to a learning theory approach that other perspectives (including biological as well as other psychotherapies such as interpersonal, psychoanalytic, etc.) are given short shrift. Chronic suicide attempters and suicide completers are not sufficiently dealt with as representing distinct (although overlapping) populations. The authors primarily address chronically suicidal patients who are more apt to suffer from axis II disorders and for whom psychotherapy such as cognitive or dialectical behavior therapy may be indicated as the primary approach. They are less thorough with other groups at higher risk for completion—namely, patients with severe axis I disorders, for whom prompt and adequate pharmacotherapy may be a more appropriate first-line approach. The authors do mention the suicide-reduction effects of lithium and clozapine but are considerably more tepid in their endorsement of other pharmacological agents, such as antidepressants.

I am somewhat concerned by the authors' explicit wish to "normalize" suicidal behavior. From a public health perspective, we should normalize help-seeking from mental health professionals, not suicidal behaviors, which are better off remaining stigmatized. I realize that Chiles and Strosahl here are referring to individual patients in treatment, where a psychological understanding with a given patient who is suicidal may in effect normalize it, but the point should be clarified.

The value of assessing risk factors is disparaged by the authors because we cannot predict from them who is "at imminent risk" of harming himself or herself and because using them leads to an enormous number of false positives. I agree with both premises but believe that the clinician's task (as well as the medicolegal standard of care) is to evaluate the *risk* of suicide and act accordingly. No one expects the clinician to be able to prevent all suicides—the expectation is that he or she evaluate risk appropriately and do what is necessary and possible to prevent harm. If this requires a paternalistic stance rather than a more self-determining approach such as a learning theory model endorses, so be it. The clinical conditions determine what is most appropriate.

The value of inpatient psychiatric care is also questioned by the authors, and, again, this may reflect the issue of discriminating between patients with axis I versus axis II disorders. For the former, inpatient care often is critical. Rather than viewing suicidal behavior as an attempt at problem solving, psychiatrists are more apt to view it as a symptom of a given disease. We protect the patient from the symptom while we treat the underlying disease. In psychiatry, as in medicine in general, if symptoms are severe enough (e.g., a fever of 105°F), we may be forced to attend to them directly (e.g., ice water baths) until the disease (e.g., infection) can be brought under control. Chiles and Strosahl, however, view the disease model as overemphasized because "perhaps as many as 50% of suicidal patients do not meet criteria for any mental disorder."

The book is comprehensive—covering outpatients, inpatients, repetitiously suicidal patients, suicidal emergencies, and special populations—and provides many tables, charts, and appendixes. Each chapter has a Helpful Hints section and its own references and suggested readings. The section dealing with therapists' feelings toward their suicidal patients and the section on ethical issues are especially worthwhile. There is also a useful chapter authored by Patricia Robinson, Ph.D., devoted to the needs of survivors of suicide—including thera-