hopelessness, abandonment, self-hatred, and guilt) were key determinants of short-term risk for suicide. The affective state that was most predictive was desperation. Many people can tolerate living with hopelessness, while desperation indicates that it does not matter whether they can eventually be helped because they cannot wait for relief. One study reported evidence that hopelessness and the other affects turn to desperation in the period before suicide (2). That study highlighted that cognitive-behavioral therapy, the most commonly used short-term therapy, is counterproductive for some suicidal patients who use it to hide emotional conflicts. Interpersonal therapy or psychodynamic psychotherapy is likely to be more effective in such cases.

To be fair, Simon accomplishes what he set out to do. His book is not written for psychiatrists who see suicidal patients in psychotherapy. It seems more directed toward psychiatrists who see suicidal patients for short intervals after they have been hospitalized or who see such patients monthly to renew their prescriptions. For both, safety inevitably becomes a primary concern. However, patient safety needs to be a major concern among all of us. Despite its limitations, I have not read a more thorough compilation of evidence-based studies dealing with suicide risk. I believe that anyone who evaluates or treats suicidal patients could benefit from reading this book.

References

1. Hendin H, Pollinger AH, Maltsberger JM, Koestner BK, Szanto K: Problems in psychotherapy with suicidal patients. Am J Psychiatry 2006; 163:67–72
2. Hendin H, Al Jurdi AK, Houck PR, Hughes S, Turner JB: Role of intense affects in predicting short-term risk for suicidal behavior: a prospective study. J Nerv Ment Dis 2010; 198:220–225

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The author reports no financial relationships with commercial interests.

Book review accepted for publication September 2011 (doi: 10.1176/appi.ajp.2011.11081305).

Integrated Group Therapy for Bipolar Disorder and Substance Abuse, *by Roger D. Weiss, M.D., and Hilary Smith Connery, M.D., Ph.D. New York, Guilford Press, 2011, 224 pp., $35.00.*

Bipolar disorder and substance use disorders are often "co-travelers." The National Comorbidity Survey Replication Study reported that patients with bipolar I disorder are approximately nine times more likely than other psychiatric patients to have lifetime substance use disorders (1). Substance use is related to a number of negative outcomes in bipolar disorder, including poor medication adherence and suicidal behavior (2). In this treatment manual, Weiss and Connery offer session-by-session instructions for conducting a 12-session group cognitive-behavioral therapy for dual-diagnosis bipolar patients who are also receiving pharmacotherapy. They describe the group treatment as "integrated," meaning that the two disorders are treated simultaneously by one clinician who is schooled in both disorders. The book offers a pragmatic, step-by-step approach to treatment that will be useful to many clinicians working with these difficult-to-treat patients. Others may find it lacking in depth in its discussions of patients with heterogeneous illness presentations or of those who are highly resistant to treatment.

The integrated group approach has been validated in two short-term randomized trials of adults with dual-diagnosis bipolar disorder (3–4). In both trials, patients in the integrated groups showed a reduction in alcohol and drug abuse over 3- to 8-month intervals compared with patients in single-focus drug education groups. Paradoxically, in the 8-month trial (4), patients in the integrated groups had higher subsyndromal depression and mania scores at the follow-up assessment than patients in the drug education groups. It is not clear whether reductions in substance use worsened mood symptoms in these patients or, alternatively, whether integrated treatment increased the frequency with which patients recognized and reported their mood symptoms.

The book appears to be written with frontline substance abuse counselors as the primary target audience. The introductory chapters describe the target patient populations and the assumptions of the model. Each of the subsequent chapters covers a specific topic and an associated set of skill training tasks. These tasks include identifying and resisting triggers for substance use, dealing with family members and friends, recognizing early warning signs, practicing "refusal skills," challenging negative or self-defeating thoughts, and adhering to medication regimens. I was dismayed by the amount of redundancy within and across these chapters, leading me to conclude that even though the book is relatively short, it could have been even shorter. The chapters all begin with virtually identical instructions on how to conduct a weekly check-in and then present the core themes of each session twice, once in the form of instructions to the clinician and then in the form of handouts summarizing similarly worded instructions to patients. The handouts are quite text-heavy, which may limit their utility in less educated patient groups.

The order of the sessions (and as a result, the chapters) was at times puzzling. For example, in the final session, the important issue of sleep hygiene is raised, along with the recommendation to keep a written diary of sleep patterns. Given the importance of this task and the difficulty of getting patients to do it regularly (5), I was surprised by its placement at the very end. Likewise, only one session is devoted to medications and adherence, and it is also placed near the end of the section on treatment.

There are two central assumptions of the approach. The first is summarized by the adage, "It's two against one, but you can win!" Patients are taught that bipolar disorder and substance abuse are really one disorder and that they should think of themselves as having "bipolar substance abuse." This may be a useful shorthand for clinicians, but the empirical status of this claim is questionable. Different subgroups of patients show different temporal associations between alcohol and cannabis abuse and depression or mania symptoms, and in up to one-half of dual-diagnosis patients, the course of alcohol or cannabis abuse and bipolar disorder are divergent (6).

The second assumption is the central recovery theme, repeated often in the sessions and handouts and reiterated multiple times throughout the text: "No matter what, don't drink, don't use drugs, and take your medication as prescribed—no matter what!" This is, of course, a wise message from the per-

spective of abstinence and mood hygienics, but I think many readers, and probably many patients, will find it simplistic. Many bipolar patients have had multiple failure experiences in attempting to stop using substances or have had multiple trials of medications with little response or intolerable side effects. There is limited guidance on how to approach group members with different ideas on how to combat their depression, mania, or substance abuse (for example, those who believe in "controlled drinking") or on how to approach those who have already been through multiple 12-step or "just say no" programs without benefit.

At times, the approach is "one size fits all." There is little discussion of 1) how patients who mainly smoke marijuana should be approached differently from patients who regularly use methamphetamine, cocaine, or heroin or, for that matter, alcohol; 2) how these different substances affect manic versus depressive symptoms (or the course of bipolar I versus II disorder); or 3) the different needs of male and female patients. The book would have been strengthened by the addition of case vignettes illustrating how different patients respond to the psychoeducational materials and, in turn, how clinicians can mold the approach to patients with different attributes.

The chapter titled "Dealing with Family Members and Friends" glosses over the many relational issues associated with dual-diagnosis disorders, such as how to cope when a spouse also has a substance use disorder (and with whom refraining from use may have relational consequences) or how to negotiate with a parent who, rightly or wrongly, has become overly vigilant for early warning signs of recurrence. I also wondered why, given the focus on environmental triggers for relapse and the emphasis on considering others' points of view, family members are never invited to any of the group sessions.

Despite these limitations, the practical approach offered in this book will be useful as a framework for clinicians who treat comorbid bipolar patients and practice in settings that include group treatment. The educational and cognitive-behavioral materials may also be adaptable to individual therapy or pharmacological management sessions.

References

1. Merikangas KR, Akiskal HS, Angst J, Greenberg PE, Hirschfeld RM, Petukhova M, Kessler RC: Lifetime and 12-month prevalence of bipolar spectrum disorder in the National Comorbidity Survey replication. Arch Gen Psychiatry 2007; 64:543–552
2. Jaworski F, Dubertret C, Adès J, Gorwood P: Presence of comorbid substance use disorder in bipolar patients worsens their social functioning to the level observed in patients with schizophrenia. Psychiatr Res 2011; 185:129–134
3. Weiss RD, Griffin ML, Greenfield SF, Najavits LM, Wyner D, Soto JA, Hennen JA: Group therapy for patients with bipolar disorder and substance dependence: results of a pilot study. J Clin Psychiatry 2000; 61:361–367
4. Weiss RD, Griffin ML, Kolodziej ME, Greenfield SF, Najavits LM, Daley DC, Doreau HR, Hennen JA: A randomized trial of integrated group therapy versus group drug counseling for patients with bipolar disorder and substance dependence. Am J Psychiatry 2007; 164:100–107
5. Frank E, Kupfer DJ, Thase ME, Mallinger AG, Swartz HA, Fagiolini AM, Mallinger AG, Thase ME, Grochocinski VJ, Houck PR, Kupfer DJ: Two-year outcomes for interpersonal and social rhythm therapy in individuals with bipolar I disorder. Arch Gen Psychiatry 2005; 62:996–1004
6. Strakowski SM, DelBello MP, Fleck DE, Arndt S: The impact of substance abuse on the course of bipolar disorder. Biol Psychiatry 2000; 48:477–485

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The author reports no financial relationships with commercial interests.

Book review accepted for publication September 2011 (doi: 10.1176/appi.ajp.2011.11091354).

Developing an Evidence-Based Classification of Eating Disorders: Scientific Findings for DSM-5, *edited by Ruth H. Striegel-Moore, Ph.D., Stephen A. Wonderlich, Ph.D., B. Timothy Walsh, M.D., and James E. Mitchell, M.D. Washington, DC, American Psychiatric Publishing, 2011, 429 pp., $65.00.*

The process of preparing for the release of DSM-5 has created opportunities for reconsideration of the validity of symptoms used to substantiate specific diagnoses. DSM-IV was initially published in 1994 and revised in 2000. DSM-5 is expected to be released in 2013. This edited volume includes data gathered and reviewed by leading clinicians and researchers in the field of eating disorders and provides a thorough discussion of the literature related to symptom specificity and profiles associated with different eating disorder presentations. The 23 chapters explore the challenges and questions prompted by some of the existing criteria or clusters of symptoms attributed to diagnoses, many of which are not as specific as they seem on close examination, are difficult to measure or validate, or are specific to certain cultures, ages, or genders. The level of detail in some chapters may exceed what the nonspecialist is interested in, but for providers and researchers who are focused on research or clinical care of individuals with eating disorders, the chapters encourage the reader to think beyond the limits of DSM-IV.

The book is organized into four sections. Part 1 is titled "Improving the Definition of Symptoms and Syndromes of Eating Disorders." Part 2 includes more statistically oriented work and is titled "Empirical Approaches to Classification: Methodological Considerations and Research Findings." Part 3 is focused on and titled "Eating and Feeding Disorders in Childhood and Adolescence." Part 4 explores, as titled, "Cultural Considerations in the Classification of Eating Disorders."

Many of the chapters throughout the book attempt to provide alternative approaches to clarifying the residual eating disorder not otherwise specified category. One of the most significant problems with DSM-IV has been that as many as 60% of eating disorder patients fall into the eating disorder not otherwise specified category. The chapters in section 1 explore the limitations of the current criteria for eating disorder diagnoses, including disordered cognitions, fear of weight gain, and frequency thresholds of behaviors for diagnosis. In chapter 4, Hilbert et al. explore the validity of binge size in binge eating disorder and examine objective bulimic episodes relative to subjective bulimic episodes. The experience of loss of control while eating is discussed by Field et al. (in chapter 6) as a critical factor in binge eating disorder and bulimia nervosa. They also discuss the likely lowering of the threshold from twice a week to once a week for binge eating disorder and bulimia nervosa episodes. The second section