(hormones vs. psychotherapy). Chapter 8, "Treatment of rapid ejaculation—Psychotherapy, pharmacotherapy, and combined therapy provides a standard summary of the treatment approaches to rapid or premature ejaculation. The author points out that the belief that the prevalence of premature ejaculation diminishes with age is not supported by current data and appears to affect a broader range of individuals than erectile dysfunction (p. 220). The important part of this chapter is the discussion of the impact of this dysfunction not only on the man but also on the couple. Chapter 9, "Treatment of delayed ejaculation," emphasizes the paucity of research and of treatment efficacy data in this least common male dysfunction. Sex therapy is not only the treatment of choice here, but probably the only presently available treatment. Chapter 10, "Erectile dysfunction—integration of medical and psychological approaches," deals with a dysfunction which has been receiving the most attention lately, thanks to the availability of the phosphodiesterase-5 inhibitors. These medications seem to be highly effective in erectile dysfunction of various etiologies, but as the author points out, they may be less effective or ineffective if significant relationship issues, partner sexual dysfunctions, medical conditions, desire deficits and other issues are not addressed. The author of this chapter strongly advocates for the integrated approach to male erectile disorder, using both psychopharmacology and psychotherapy.

The third part of this book focuses in seven chapters on special issues in sex therapy, such as sexuality and physical and/or mental illness; sexual dysfunction and childhood sexual abuse; sex therapy with sexual minorities (i.e., gays, lesbians and bisexual individuals); sexuality and culture (including issues such as sexuality and religion; sex therapy and racism, sexism and oppression); paraphilia-related disorders—the evaluation and treatment of nonparaphilic hypersexuality; gender dysphoria and transgender experiences and, finally, "new" sexual pharmacology. All these chapters are quite interesting, informative and clinically relevant.

This book is clearly one of the standard volumes in the field of sex therapy. It brings a wealth of up-to-date information and experience. It emphasizes the integration of all available treatment approaches to sexual disorders. It also has a few weak spots. As almost every treatment textbook in this and other fields (e.g., psychotherapy), it could be more concrete, instructive and didactic in recommending treatment approaches. The content of the book could be a bit more comprehensive and inclusive. Nothing against the inclusion of the relatively rare persistent genital arousal disorder, but why not include a chapter on paraphilias, or infidelity, or a chapter discussing individuals who avoid sex (is it a dysfunction or biological variation?). Nevertheless, this is a very useful book that should become part of the library of every sex therapist and trainee in this field. Even a busy clinically oriented psychiatrist with interest in human sexuality will find this book interesting. I have been annoyed and worried a bit lately by the gradual disappearance of attention to human sexuality from psychiatry. Let's hope books like this will help us spark some interest in sex therapy and sexology, especially among the younger colleagues.

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Half in Love with Death. Managing the Chronically Suicidal Patient, by Joel Paris, Lawrence Erlbaum Associates, Publisher, Mahwah, New Jersey; 2007; ISBN 0-8058-5514-9; $19.95 (hardcover), 224 pp.

Chronically suicidal patients are probably the most difficult and most emotionally taxing ones. I would say that with a few exceptions, most of my colleagues try to avoid them. As Joel Paris, the author of this small book points out, "our greatest fear is losing a patient to suicide" (p. x), because "we entered our profession to help people, not to see them die" (p. 178). Interestingly though, as Dr. Paris repeatedly points out, most chronically suicidal patients do not end their lives by suicide (p. xv). Part of the difficulties we have with managing chronically suicidal patients are several myths regarding chronic suicidality, and the fact that we are not properly trained to handle these patients. We usually do not have a good grip on handling their suicidality. Chronic suicidality is most frequently associated with borderline personality disorder, a notoriously difficult to treat condition.

Joel Paris, an experienced psychiatrists and well published psychiatrist, wrote an interesting, a bit iconoclastic (in a good sense!) and highly readable book to debunk some of the myths regarding chronic suicidality and to propose some guidance on how to manage it. It is important to emphasize that this book deals mostly with *chronic* suicidality in chronically suicidal personality disorder patients, as opposed to acute suicidality in major depressive disorder, schizophrenia and other Axis I disorders.

The book's title is taken from John Keats "Ode to a Nightingale." Its verse "I have been half in love with easeful Death" describes the state of mind of chronically suicidal patients, whose lives are so painful that they feel "half in love" with death (p. ix). The book consists of Preface, Introduction, ten chapters, Summary: Guidelines for therapists and a very good list of references.

In the Introduction, Paris suggests, among others, that giving up the idea of actively saving chronically suicidal patients actually liberates us to understand them and to work on their problems (p. xiii). Most of the time, we are paralyzed by fear of patient suicide and may be actually acting counterproductively (e.g., by hospitalizing the patient). He also lists four major points of his book as follows: 1. The inner world of the chronically suicidal patient is one of pain, emptiness, and hopelessness; suicidality is an attempt to cope with these states of mind; 2. Chronic suicidality is not usually accounted for by depression alone, but is associated with personality disorders;

3. Methods generally recommended for the management of suicidality are ineffective and counterproductive in chronically suicidal patients; and 4. Effective therapy requires that therapists tolerate chronic suicidality while working toward healthier ways of coping (p. xiv). While expanding on these four points, Paris also discusses how he became interested in chronic suicidality ("although research became a major part of my professional life, it did not provide me with guidelines for treating chronically suicidal patients" p. xxi) and summarizes the ten chapters of his book.

Chapter 1, "Suicidality and suicide," discusses the unclear term of suicidality; suicidal ideation and the risk of completion including the fact that risk factors for suicide are not useful in prediction of individual suicide; suicide attempts and the risk of completion; and finally why self-mutilation is not suicidal behavior. Chapter 2, "The inner world of the chronically suicidal patient," focuses on psychic pain, emptiness, hopelessness, and the need for control in chronic suicidality. Dr. Paris points out that in chronically suicidal patients suicide provides a greater sense of control, and that one function of suicidality in these patients is to regulate psychic pain. The text also emphasizes that chronic suicidality does not exist in a vacuum. The next chapter, "Suicidality in childhood and adolescence," focuses on the developmental origins of suicidal behavior, and the fact that patients who are chronically suicidal often date their first attraction to death to their childhood or adolescence. During the discussion of borderline personality disorder in adolescence, Dr. Paris warns us that there is nothing normal about personality disorder symptoms at this point of development (p. 45). He concludes this chapter with a recommendation that, as there is a lack of clear causal links between risk and outcome, therapists should not spend too much time on "working through" childhood traumas but should concentrate on finding ways to improve current life situations. Chapter 4, "Chronic suicidality and personality disorders," examines the relationship between chronic suicidality and personality disorders (mostly borderline personality disorder—BPD). It also contains a great critique of some diagnostic issues. For instance, Dr. Paris suggests that the term "comorbidity" is grossly misleading and it is "actually an artifact of a diagnostic system that encourages multiple diagnoses" (p. 59). He also criticizes the DSM concept of major depression ("it became reified" p. 59) and questions whether chronic suicidality is a result of depression. Two other "pearls" I liked in this chapter were suggestions that "in contemporary practice, both pharmacological and psychological interventions tend to be focused on symptoms rather than the underlying pathological process" (p. 68) and that, "one of the reasons why suicide completions in personality disorders occur at a later age is that they happen when patients fail to recover and when they give up after a series of unsuccessful treatments" (p. 76).

Chapter 5, "Myths of suicide prevention," dispels the myth that suicide can be prevented using current methods of prevention. Dr. Paris emphasizes that suicide cannot be predicted and cannot be really prevented, "the evidence is just not there" (p. 81). We can establish a statistical risk for completion, which does not apply to an individual case. The sobering text also states that despite all the efforts, "the psychological interventions of mental health professionals have never been proven to save lives" (p. 81). Dr. Paris also argues that hospitals present an illusion of safety and that hospitalization for chronic suicidality does not really help but rather reinforces the very behavior that therapy is trying to extinguish (p. 89). He quotes personal communication from Marsha Linehan, who suggested that, "if a patient must be hospitalized, the environment should be made as *unpleasant* as possible" (p. 88). The last great quote from this chapter is a suggestion of one of Dr. Paris' American colleagues, "the best thing that ever happened to patients with BPD is managed care, because it prevents psychiatrists from prescribing treatment that is bad for them" (p. 94). Chapter 6, "Psychotherapy research and chronic suicidality," emphasizes that psychotherapy is the treatment of choice for patients with chronic suicidality. However, this chapter also suggests that continuous therapy is not always the best choice and that therapists should consider an intermittent course of treatment for chronically suicidal patients (p. 107). This chapter also reviews psychoanalytical psychotherapy for BPD and some of its newer modifications, dialectical behavioral therapy and other forms of CBT for BPD and how to carry out intermittent therapy. Chapter 7, "Pharmacotherapy and chronic suicidality," suggests that there is a lot of pharmacological mismanagement of chronic suicidality (including polypharmacy) and reviews various pharmacological modalities used in this indication. Dr. Paris writes that psychiatry, after its long infatuation with psychoanalysis "is in the grip of a new set of myths and has taken on a quasi-religious belief in the value of pharmacological methods" (p. 109).

Chapter 8, "Tolerating chronic suicidality," emphasizes the crucial aspect of therapy with chronically suicidal patients, which is the need for therapists to tolerate and accept the option of suicide. The two main reasons for the acceptance are the fact that tolerating suicidality prevents us from being distracted from our job by anxiety, and that tolerating suicidality acknowledges the communication of distress while respecting choice (p. 131). This chapter reviews again the vicious circle of repeated hospitalizations and regression and suicidality. Chapter 9, "Managing chronic suicidality," discusses issues such as alliance building and help rejection, handling suicidal crises, the pros and cons of telephone contacts, boundary maintenance and suicidality, and emotion regulation in terms of tolerating, decentring and reappraising emotional dysregulation and suicidality. It also includes a discussion on managing impulsivity and "getting a life" for chronically suicidal patients (which requires a meaningful goal—"commitment to work and relationships are the primary context of psychological treatment," p. 166). The last chapter, "Suicidality and litigation," again emphasizes that, "in the practice of any mental health professional, suicide is always a possibility" (p. 177). It focuses on conditions under which therapists are sued after a suicide and makes suggestions as to how to make litigation less likely.

The summary present guidelines for therapists regarding suicide and chronic suicidality, and discusses research directions in this area.

This is clearly a great small book that would be very much appreciated by all clinicians treating chronically suicidal patients. It dispels many practiced myths regarding the management of chronic suicidality (e.g., that hospitalization helps). It advises us that chronic suicidal patients have to be handled differently than acutely depressed patients, because if they were managed the same way, it would not be management, but rather mismanagement (p. 130).

The book is critical of the existing "evidence" regarding the outcome and management of chronically suicidal patients. The combination of a broad and critical review of literature and the vast clinical experience of the author makes this volume especially useful. It is written in a highly readable style and filled with many pearls, some of which I mentioned.

Hopefully, this important book is going to help us with our fears in managing chronically suicidal patients, and in learning to tolerate suicide and accept it as an option and choice. Only then will we be able to help our chronically suicidal patients.

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Bipolar Depression. A Comprehensive Guide, edited by Rif S. El-Mallakh and S. Nassir Ghaemi, American Psychiatric Publishing, Inc., Washington, D.C.; 2006; ISBN 1-585562-171-4; $46 (paperback), 269 pp.

Bipolar depression has received a lot of attention lately. It is not clear why. Maybe it is because of a renewed interest, as interest in various topics during interest's natural course waxes and wanes. Maybe it is really because depression is the most common presentation of bipolar (I still prefer manic-depressive) disorder. Maybe, as some may cynically or realistically suspect, it is because of the introduction and marketing of lamotrigine (interestingly, this book is given to physicians as a compliment of the lamotrigine maker). I suspect that the reason for the recent increased attention to bipolar depression is a bit of all of these three. Nevertheless, a comprehensive and updated guide to this part of manic-depressive illness could be an important help to all of us. Rif El-Mallakh and Nassir Ghaemi, both devoted bipolar disorder researchers and authors, gathered an international group of authors to put together such a guide.

The book is divided into four parts (Diagnosis, Biology, Special topics, and Treatment and prevention of bipolar depression) and consists of 11 chapters. Chapter 1, "Diagnosis of bipolar depression," reviews important diagnostic issues and touches on the bipolar spectrum and some diagnostic controversies. I was a bit surprised by the lack of scholarship at times here (e.g., the statement that antipsychotics alone are largely ineffective in depression is supported by a four-year-old abstract from the APA Annual Meeting; or that the work of Kraepelin is not cited from the original source). Chapter 2, "Neurobiology of bipolar depression," suggests that, "Understanding the biology of bipolar depression should increase the effectiveness of its diagnosis and treatment" (p. 37), but informs us that "…our ability to study the biology of bipolar depression is limited by our imperfect ability to describe the phenotype of bipolar disorder" (p. 55), and that we have not yet reached the point of understanding the biology of bipolar depression. Chapter 3, "Genetics of bipolar disorder," mostly reviews high-index associations and linkages to various chromosomes. Though "numerous regions have at least some support as putative susceptibility loci in bipolar disorder" (p. 84), it is not totally clear how to conduct genetic research in bipolar disorder. "No one approach has emerged as clearly superior in bipolar genetics research" (p. 84). The authors conclude that bipolar disorder is "a highly heritable condition, as demonstrated by twin, family, and adoption studies that consistently suggest a strong genetic component to the disorder" (p. 88). The evidence from linkage studies is confusing at best.

Chapter 4, "Pediatric bipolar depression," is a brief summary of an area and topic that needs much more research. Chapter 5, "Suicide in bipolar depression," emphasizes that bipolar disorder is probably the most lethal mental illness with a suicide rate for untreated cases 30 times that in the general population and with the lifetime rate of suicide around 19%. The chapter reviews the risk factors for suicide in bipolar disorder (phase of illness, clinical course, early onset of illness, psychosis, rapid cycling, comorbidity), and treatment interventions (lithium, antidepressants, anticonvulsants, antipsychotics, psychotherapy). Lithium clearly helps to decrease the rates of suicide in bipolar patients, while there are almost no data available to judge whether any anticonvulsants used in the treatment of bipolar disorder have a prophylactic effect against suicidality (p. 133).

The treatment part of this volume continues in presenting uneven writings. Chapter 6, "Lithium and antiepiletic drugs in bipolar depression," briefly reviews lithium, lamotrigine, valproic acid, carbamazepine, oxcarbazepine, topiramate and a few other antiepileptic drugs (gabapentin, tiagabine, pregabalin, leviracetam). Interestingly, nothing on familial responsiveness to lithium known from the work of Paul Grof and associates is included. Chapter 7, "Antidepressants in bipolar disorder" starts with saying that "This chapter does not represent a systematic review of the literature on antidepressants in bipolar disorder," but rather "an attempt to express our perspective on this complex field" (p. 168). It briefly discusses the efficacy and then delves into the safety of administering antidepressants in bipolar disorder (= risk of switch). This part misses a discussion about the risk of switch to mania with bupropion vs. selective serotonin reuptake inhibitors. This discussion is not well addressed anywhere in the literature and would be very useful. Is the low risk of switch with bupropion lore myth or reality? That would be a useful discussion for a clinically oriented reader. Chapter 8, "Antipsychotics in bipolar depression," is a