
evaluate the risks and benefits “off-label” use for clinician, parent, and child.

This was not an easy book to read. It required patience, thoughtfulness, reading, and rereading of most of the chapters. Perhaps this is due to the thoroughness of the material presented so ably in this volume. Drs. Geller and DelBello must be commended for presenting the latest medical and research findings with regard to the treatment of bipolar disorder in children and adolescents. I would echo the reviewers who have commented that this book is an invaluable resource for clinicians and researchers who work with children and adolescents.

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Dialectical behavior therapy. By Michaela A. Swales and Heidi L. Heard, 167 pp, ISBN 978-0-415-44458-3, New York, Routledge, 2009.

Dialectical Behavior Therapy is the seventh book in “The CBT Distinctive Features” book series edited by Wendy Dryden. Other CBT approaches covered in this series include behavioral activation, Beck’s cognitive theory, constructivist psychotherapy, metacognitive therapy, mindfulness-based cognitive therapy, and rational-emotive behavior therapy. Forthcoming titles will cover acceptance and commitment therapy, schema therapy, and compassion-focused therapy. This exciting new series invites the leading practitioners and theorists of the main CBT therapies to highlight 30 distinctive features--practical and theoretical--of their particular CBT approach in accessible, simple, and brief texts.

This little gem of a book is no exception. Michaela Swales is a lecturer-practitioner in clinical psychology at Bangor University and a consultant clinical psychologist in the North Wales Adolescent Service of the National Health Service Trust in the UK. She is

the Director of the British Isles DBT Training Team. Her coauthor is Heidi Heard, a senior trainer and international consultant for BehavioralTech in the USA, which is the organization founded by Marsha Linehan, the developer of Dialectical Behavior Therapy (DBT). Both authors are therefore uniquely qualified for the task of distilling the 30 distinctive features of a complex and multifaceted treatment like DBT.

In recent years, DBT has become the leading psychotherapeutic approach designed particularly to treat the problems of chronically suicidal individuals with borderline personality disorder (BPD). It was the first psychotherapy to show effectiveness in treating BPD in controlled clinical trials, and while it is no longer the only therapy to have shown effectiveness in controlled trials (e.g., Bateman & Fonagy, 2001), it has currently the largest evidence base with several randomized controlled trials to support its effectiveness (Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Koons, Robins, Tweed, Lunch, et al., 2001; Linehan, Armstrong, Suarez, Allman, & Heard, 1991; Linehan, Tutek, Heard, & Armstrong, 1994; Verheul, Van Den Bosch, Koeter, De Ridder, et al., 2003).

Perhaps part of the DBT success is the fact that, like most CBT approaches, DBT can be taught to clinicians across a variety of backgrounds and training due to its clear theoretical principles, its transparent treatment targets, strategies, and structure, and its skill-learning components. This is not to say that DBT is not a complex treatment. Indeed, a possible second reason for its success is its integrative treatment approach, which is exemplified in the treatment's name--that is, as Swales and Heard point out in Chapter 2, DBT is integrative in the dialectical and developmental sense of the word so that therapy changes continuously as new developments become incorporated rather than avoided. It is integrative in the sense that it cuts across biological and environmental models of psychopathology; it balances change with acceptance; it integrates the principles of behaviorism and Zen; and finally, it integrates a variety of treatment modalities (individual therapy, skills training, phone consultation, team consultation, and groups work) into a single, unified psychotherapy, thereby finding the synthesis that the dialectic ("dialogue") in the treatment name suggests.

Given the complex and multifaceted nature of this treatment approach, it is therefore no small task to distill the 30 essential features in a concise manner, but Swales and Heard do so beautifully.

In common with all the books in this series, the volume has two parts. Part I is dedicated to the theory underlying DBT, and Part II is devoted to its practice. Part I begins with two chapters highlighting the fact that DBT is principle driven (as opposed to protocol driven) and integrative (as discussed above). Chapter 3 then discusses the first theoretical foundation DBT is based on, namely, the dialectic philosophy. Chapters 6-8 deal with the second theoretical foundation (behaviorism) in a discussion of learning theory, while Chapter 8 introduces Zen principles (mindfulness and acceptance) as the third foundational underpinning for DBT. Chapters 4 and 5 both explicate the transactional bio-social theory of the aetiology of affect regulation problems associated with BPD. Most chapters are 3-4 pages long and summarize the core features of each of the pillars on which DBT rests in a concise and wonderfully clear manner.

Part II gets down to the nuts and bolts of the practice of DBT, starting with a discussion in Chapter 10 of how DBT is unique in that it makes use of multiple therapeutic modalities to effect change. More specifically, it provides guidance to clinicians in how to juggle different modalities by providing a structure for treatment. Chapters 11-17 teach the principles and strategies employed in DBT to comprehensively address the capacity and motivation to regulate emotions through multimodal, staged treatment that targets the full range of comorbid disorders in a hierarchical manner. These include telephone coaching (Chapter 11), team consultation (Chapter 12), structuring of the treatment environment in which the DBT program operates (Chapter 13), the stages of treatment (Chapter 14), strategies for strengthening commitment in pre-treatment (Chapter 15), and the organization of clients' problems around a hierarchical list of treatment targets (Chapter 16). Chapter 17 deals with one of the hallmarks of DBT (validation strategies), concluding the first set of practical features of DBT.

The stage is then set for Chapters 18-24, which highlight the cognitive-behavioral treatment (CBT) components of DBT. These "problem-solving" chapters start with a chapter on how to do behavioral analysis (Chapter 18) and continue on to other CBT strategies, including solution analysis (Chapter 19), skills training to facilitate skill acquisition, skill strengthening, and skill generalization (Chapter 20), exposure to affect (Chapter 21), contingency

management (Chapter 22), and cognitive restructuring (Chapter 23).

The last few chapters of Part II each highlight further distinctive features of DBT. For instance, Chapter 24, which is called “Being Dialectic,” explains how the process of rebalancing between acceptance and change permeates through the treatment. The therapist achieves this by interweaving change strategies with acceptance strategies--that is, balancing problem-solving with validation. Next, the two styles of communication in DBT are reviewed, namely, self-disclosure to facilitate reciprocal communication (Chapter 25) and irreverence (Chapter 26). Chapter 27 describes the DBT principles for case management to assist the therapist to manage interactions among the various therapeutic interventions clients receive or among the treatment providers delivering interventions. Chapters 28 and 29 deal with treating therapy-interfering behavior in the client and the therapist, respectively. The volume concludes with a review of the studies supporting the effectiveness of DBT in patients with BPD and related conditions.

This volume in particular, but also the book series as a whole, is essential reading for psychotherapists, counselors, clinical and counseling psychologists, nurses, and psychiatrists of all orientations who wish to learn more about the range of new and developing cognitive-behavioural approaches. It is of particular value for early career clinicians or students who may benefit from reading a distilled version of more dense DBT handbooks. Marsha Linehan’s (1993) *Cognitive-Behavioral Treatment of Borderline Personality Disorder* remains the classic in this regard and should be read before, alongside, or after Swales and Heard’s summarized version. Therefore, as a stand-alone for training, this volume will not do, but as an accompaniment to more detailed texts, it provides wonderful assistance to understand not only the core features of DBT, but also those features that distinguish it from other therapies.

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The Millon inventories: a practitioner's guide to personalized clinical assessment (2nd ed.). By Theodore Millon and Caryl Bloom. 732 pages. New York: The Guilford Press, 2008.

This substantial volume updates research findings and clinical applications of the Millon inventories. A broad spectrum of clinical psychologists and psychiatrists have become familiar with these inventories of whole personality profiles, especially in the form of the Millon Clinical Multiaxial Inventory (MCMI). The present edition expands the scope of the variations of the primary inventory directed to the evaluation of more specific patient populations--as, for example, the Millon Behavioral Medicine Diagnostic (MBMD), the Millon Adolescent Clinical Inventory (MACI), and the more recent

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CAE Reading and Use of English Part 1. For questions 1-8, read the text below and decide which answer (A, B, C or D) best fits each gap. There is an example at the beginning (0). Changing Typefaces. A situation event moment occasion. putting themselves in danger. They will risk life and 2. limb blood bone flesh. in an emergency when they are 3. A barely hardly merely scarcely. read this book as an alternative to actually going, use it as the 8. base cause origin source. of inspiration for your own trip, a useful guide once youâ€™re there and a stunning reminder on your return.