The Appendices include paper tools such as the Social Rhythm Metric-II- Five Item Version (SRM-II-5); Social Calculation Instructions for the SRM-II-5, Social Rhythm Metric-II-17-Item Version (SRM-II-17); Score Calculation Instructions for the SRM-II-17, An Interview Guide for the Interpersonal Inventory, Therapist Checklist for the Initial IPSRT Sessions; Social Rhythm Stabilization Schedule, Future Stabilization Goals Charts, Mood Disorder Monitoring Chart and list of resources. The use of all of these tools is described in the text, they are an integral part of the IPSRT.

The IPSRT is an interesting, creative, and thoughtful addition to our armamentarium of treatment approaches to bipolar disorder. It probably requires a lot of effort from both the patient and the therapist, but it seems like it would be worth these efforts. It addresses several very important aspects of bipolar disorder — the impact of disturbed diurnal and other rhythms and the importance of interpersonal stressors for worsening or relapse of this disorder. Dr. Frank's book is well written with a lot of empathy and wealth of clinical information. It is not ideological and gives appropriate credit to biological and psychosocial etiological factors and biological and psychosocial treatments. The book is written for therapists, psychologists or social workers, but I believe that clinically oriented psychiatrists will find it very useful, too. It contains many interesting ideas, which could be clinically useful even if used just in parts (that is just my notion, not the author's). Thus, I would recommend this volume to anybody who cares for bipolar patients.

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1. Miklowitz DJ: *The Bipolar Survivor Guide. What You and Your Family Need to Know*. The Guilford Press: New York, New York, 2002

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Modelling and Managing the Depressive Disorders. A Clinical Guide. By Gordon Parker and Vijaya Manicavasagar; Cambridge University Press, New York, New York; 2005; ISBN 978-0-521-67144-6; $55 (paperback); 247 pp.

Most clinicians would probably agree with the authors of *Modelling and Managing the Depressive Disorders*, Drs. Parker and Manicavasagar from the Black Dog Institute, Sydney, Australia, that the DSM based diagnostic and treatment approach to depressive disorders is unsatisfactory, limited, and "has not generated replicable biological changes or correlates at a satisfactory level, and has not been informative in identifying treatment-specificity effects" (p. 5). Drs. Parker and Manicavasagar argue that the DSM model which presents a dimensional or continuum view of depressive disorders, with depression seen essentially as a single condition varying by severity (p. 1), is wrong. They propose a different model, that allows categorical status to certain expressions such as melancholia and psychotic depression, and for the rest of the depressive disorders (i.e., non-melancholic, non-psychotic) they favor a "spectrum" model which views these disorders as multiaxial and reflecting an interaction between salient life stresses and personality style. They believe that their "alternative classificatory model allows that 'depression' can exist as a disease, a disorder, a syndrome, and even as a 'normal reaction,' and therefore requires a mix- and match- model for capturing both categorical and dimensional depressive disorder" (Introduction, p. X). They also suggest something an experienced clinician would also agree with, that no single therapy has universal application.

Most of this interesting volume expands and expounds the authors' concepts of a new classification and management of various subtypes of depression. The book consists of an Introduction, four parts and three appendixes. Part I, 'The current model of depressive disorders and its impact on clinical management,' starts with the discussion of the limitations of the current dimensional model of depressive disorders and the impact on their clinical management. The authors then point out what according to them are the three core features of depression, a depressed mood, a lowering of self-esteem or self-worth, and an increase in self-criticism. Finally, in a chapter on sub-typing depression, they propose a hierarchical model of depression mentioned before, which includes categorical and quintessentially biological depressive conditions such as psychotic depression and melancholia, and a heterogenous, dimensional model including key contributions from personality style and life stressors to the clinical pattern. The authors connect this models to neurotransmitters, suggesting a greater perturbation of dopaminergic function in psychotic depression, a greater perturbation of noradrenergic neurotransmitter function in melancholic depression and a greater perturbation of serotonergic neurotransmitter function in non-melancholic disorders (all neurotransmitter functions being perturbed in each type). They suggest that the following treatment observations support their theory: 1) non-differentiation of most treatments for non-melancholic depressions, 2) greater efficacy of dual-action and broad action antidepressants compared to SSRIs for melancholic depression, and 3) the fact that a combination of antipsychotic and antidepressant medications is more effective than either alone for psychotic depression (p. 27).

Part II, 'The diagnosis and management of melancholic and psychotic depression,' in three chapters reviews the phenomenology and treatment of these two sub-types of depression. The authors view them both as quintessentially biological diseases and therefore preferentially responsive to biological treatments. They also propose that the key specific feature for the diagnosis of melancholia is observable psychomotor disturbance, either retardation and/or agitation (p. 33), together with categorically non-reactive mood, distinct anhedonia and marked concentration impairment. Part II also reviews bipolar melancholic or psychotic bipolar depression.

Part III, 'An introduction to non-melancholic depression,' focuses on several features salient to the authors' concept or model of non-melancholic depression, such as self-esteem, personality style and functioning, stress, resilience and vulnerability, and psychological interventions for non-melancholic depression. This model assumes less of a primacy of biological perturbation in the non-melancholic depression than in melancholic and psychotic depression (p. 53). The authors connect their model to neurotransmitters and propose a concept of "psychotransmission," which, for instance, "uses the analogy of the neurotransmitter system to help explain how an individual's self-esteem acts as a barometer of mood state" (p. 59). This model provides a "metaphorical illustration of how aethiological factors and risk factors may interact with personality style to promote the development of a non-melancholic depressive disorder" (p. 62). Very interesting is the discussion on the influence of personality style on vulnerability to depressive disorders, exposure to lifestyle and environmental stressors, symptom patterns of non-melancholic depressive episodes, coping responses to the stressors and to depressed state, and response to different treatments. In their discussion of stress, the authors, interestingly, argue for salience, as against severity, being the more commonly relevant construct for considering acute reactive disorder (p. 86). The chapter on psychological interventions emphasizes the active ingredients common to any psychological intervention — patient characteristics, therapist characteristics, therapy characteristics, and interactive effects between all these components.

Part IV, 'Modelling and managing the non-melancholic depressive disorders,' consists of 12 chapters, most of them discussing "sub-types of non-melancholic depression as outlined by the authors: acute stress-related non-melancholic depression; acute stress-related non-melancholic depression: 'key and lock' model; chronic stress-related non-melancholic depression; the perfectionist personality style and non-melancholic depression; irritability and non-melancholic depression; anxious worrying and non-melancholic depression; social avoidance and non-melancholic depression; personal reserve and non-melancholic depression; rejection sensitivity and non-melancholic depression; self-focused personality style and non-melancholic depression; and self-criticism and non-melancholic depression. The last chapter reviews the natural and alternative treatments for non-melancholic depression. This part is quite useful and well organized. The chapters dealing with specific sub-types are organized in a similar fashion, illustrated with case-vignettes, and contain suggestions of intervention strategies, discussion of psychological intervention principles, sorts of therapists, building resilience, barriers to effective intervention, and the role of medication in each sub-type. I found the distinction between social avoidance related depression and personal reserve and depression very interesting and useful. The chapter on natural and alternative treatments contains alphabetical lists of lifestyle and behavior changes (from acupressure to improving sleep), non-prescription medicines (from fish oils to vitamins) and dietary changes (from alcohol avoidance and reduction to sugar avoidance and reduction), most of them either unlikely to be of primary benefit or lacking evidence of any benefit. Unfortunately, the authors do not always mention their potential risks (e.g., kava-kava and liver damage).

The three appendices briefly discuss three measures, The Depression in Medically Ill (DMI), the CORE system for measuring psychomotor disturbance, and T&P, the temperament and personality measure.

I found only two "flaws" in this thought-provoking volume. First, the authors are a bit too apologetic for being "provocative." I don't believe they are too provocative and even if they were, there is nothing wrong with being too provocative, especially regarding such an important topic as depression and its treatment. The other issue is the lack of discussion of the overlap between the otherwise very useful concepts or models of various subtypes of non-melancholic depression. One can hardly imagine "pure" types such as described and can rather see some of described clinical features of several subtypes in one person. Well, that is a problem of almost every psychiatric classification.

Nevertheless, I found this volume very interesting, innovative, and clinically useful. It provides a new, a bit refreshing view of depression, its classification and treatment. It is well-written, practical, and thoughtful. I believe that it could be recommended to all clinicians caring for depressed individuals.

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Oxford Textbook of Psychotherapy. Edited by Glen O. Gabbard, Judith S. Beck and Jeremy Holmes; Oxford University Press, New York, New York; 2005; ISBN 0-19-852064-6; $110 (hardcover); 534 pp.

Good textbooks are hard to find, they are also hard to put together. There are probably hundreds and hundreds of books on psychotherapy and psychotherapies, but not many solid psychotherapy *textbooks*. It has been about ten years since the publication of a major textbook of psychotherapy (1) (my apologies to the ones I missed or don't quote; I am not a psychotherapist and do not profess a great knowledge of the field). Thus, I viewed the arrival of *Oxford Textbook of Psychotherapy* as a major publishing event. I hoped that reading the book would confirm my preconceived ideas of a major event.

The editors (Glen Gabbard, Judith Beck, and Jeremy Holmes), esteemed psychotherapists or therapists themselves put together a great team of 100 writers from several countries (Australia, Germany, Italy, the Netherlands, Norway, United Kingdom, and United States), though most of the authors are from the United States. That itself is a major editorial task. The book follows the outline of major textbooks from other areas — first focusing on major modalities and principles, followed by treatment of major disorders and special areas.