

Book Reviews

Treating Bipolar Disorder. A Clinician's Guide to Interpersonal and Social Rhythm Therapy. By Ellen Frank; The Guilford Press, New York, New York; 2005; ISBN 1-59385-204-5; \$35 (hardcover); 212 pp.

The management strategies for bipolar disorder have for a long time been limited to biological interventions. Psychotherapy and other psychological and social modalities have been considered not useful, or an outright exercise of futility. However, it seems that psychosocial management strategies for bipolar disorder are coming of age. Not necessarily as a sole management approach, but either as a useful adjunct strategy of managing the acute and subacute phase of this illness, or an important part of the overall maintenance management plan. For instance, “self-management” and family involvement have been used in managing bipolar disorder in some centers (1). The newest example is the interpersonal and social rhythm therapy developed by Ellen Frank, a well known researcher in the area of mood disorders from Pittsburgh, Pennsylvania.

According to Dr. Frank (and certainly others), there are likely to be three paths to new episodes of illness in bipolar patients maintained on mood stabilizers: 1) nonadherence to medication, 2) stressful life events, especially interpersonal ones, and 3) disruption in social rhythms (p. 43). “Interpersonal and social rhythm therapy is essentially a prophylactic treatment for a chronically recurring disorder. The goal of therapy is primarily to prevent new episodes of illness or, at least, to extend the interval between episodes” (p. 43). Interpersonal and social rhythm therapy (IPSRT) specifically addresses each of the three mentioned potential pathways. One of the basic tenets of the theory behind this management approach is the assumption that “individuals with bipolar disorder benefit from a higher level of stability than that ‘required’ by persons with no history of affective illness” (p. 93).

Dr. Frank's book on IPSRT consists of Introduction, 14 chapters and 10 appendixes. In the Introduction Dr. Frank describes how she got the idea of developing the IPSRT (basically a combination of interpersonal therapy and social rhythm regulation treatment) during a meeting of the National Depressive and Manic-Depressive Association. She also argues that major mood disorders reflect, among others, serious disruption in circadian and social rhythms. The first three chapters summarize some of the clinical knowledge, empirically supported theories of bipolar disorder and its etiology, and empirically supported therapies for bipolar disorder. These chapters also

further conceptualize the link between the environmental changes, disruptions in circadian rhythms and mood disorders, and explain the terms zeitgebers and zeitstorerers. Besides the evidence for usefulness of biological treatments, the author reviews the available and empirically tested psychosocial approaches to bipolar disorders, such as psychoeducation, group therapy, cognitive-behavioral therapy, marital and family therapy and IPSRT (tested in two controlled studies). The first three chapters basically are an extended introduction to the clinical management of bipolar disorder, and serve as a basis for the following chapters describing and discussing the IPSRT.

The following 11 chapters (4: A brief overview of IPSRT; 5: Assessment of bipolar disorder and common comorbidities; 6: The individualized case formulation: history taking and the Interpersonal Inventory; 7: Orienting the patient to treatment and individual treatment planning; 8: Symptom management: stabilizing social rhythms and behavioral activation; 9: Intervening in interpersonal problem areas; 10: Intervening: other useful interventions; 11: Monitoring progress and enhancing treatment adherence; 12: The therapeutic relationship in IPSRT; 13: Poor outcome and how to handle it; and 14: Tapering or concluding treatment) present a detailed clinically oriented description and outline of IPSRT. The text is richly “illustrated” by very good and relevant case examples. Dr. Frank masterfully weaves together the major elements of Klerman's interpersonal therapy (grief, interpersonal role disputes, role transitions, interpersonal deficits, and an added element — grief for the lost healthy self) and regulation of social and diurnal rhythms using various schedules and charts (which are reprinted in appendices, see below). She makes clear that in bipolar I patients, the IPSRT is intended to be used along with appropriate pharmacotherapy, that patients have to be motivated, that full remission should be the goal of the combined treatment, and that depression treatment is likely to take much longer than treatment of mania. The IPSRT could be used beyond the acute and subacute phase of bipolar disorder and extended to the maintenance phase.

Interesting and useful is the newly conceptualized element of interpersonal therapy in bipolar disorder patients — the grief for the lost healthy self. As Dr. Frank notes, bipolar patients tend to divide their lives into two: before their diagnosis and after their diagnosis, and frequently see themselves this way as almost two different people.

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.

REFERENCE

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 multi-axial 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.