with intermittent explosive disorder in terms of aggressive behavior that is impulsive on the surface and seriously impairs functionality, specifically, the overlap with antisocial personality disorder and borderline personality disorder. The authors illustrate research criteria for clearly describing and rating the severity of the disorder and present a measurement scale that they developed. As with the other disorders described in the book, there is detailed discussion of the functional effect, comorbidity, epidemiology, and known biology (potential serotonergic dysfunction). The authors conclude the chapter by describing pharmacologic and psychotherapeutic techniques that have been effective in treating intermittent explosive disorder. The one area that I found lacking in this chapter was a discussion of the frequent clinical diagnosis of intermittent explosive disorder in the context of developmental disability. The authors simply do not mention this frequent comorbidity.

There are two companion chapters following the chapter on intermittent explosive disorder, which broaden the social context and flesh out significant functional disabilities related to the disorder and the impact that it can have on individuals. These include a chapter on violence against women, by Drs. Chrisler and Ferguson, and a second chapter outlining, in vivid detail, the epidemiology and prevalence of intimate partner violence, by Drs. McKinney and Caepano. As with the companion sections accompanying previous chapters, these two companion articles broaden the context in which intermittent explosive disorder plays out and outline the problem in a much broader context that must be addressed in order to minimize the effect of this specific impulse control disorder.

Impulse Control Disorders is a significant contribution to the clinical literature and would be a useful addition to the bookshelf of clinicians across a range of specialties, including psychiatrists, primary care physicians, psychologists, dermatologists, and other professionals. It also has a forensic psychiatric correlate in that many of the impulse control disorders, including intermittent explosive disorder, kleptomania, and pathological gambling, can be first encountered in a forensic psychiatric context. The book is easy to read. The uniform chapter formatting allows easy cross-referencing of disorders, making it simple to find similarities as well as phenomenological differences between entities.

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CBT for Psychosis: A Symptom-Based Approach, *by Roger Hagen, Douglas Turkington, Torkil Berge, and Rolf W. Grawe. New York, Routledge, 2010, 296 pp., $31.95.*

This ultimately hopeful book contains far more than its title suggests. In 17 wide-ranging chapters, international experts write about theory, treatments, and research concerning the psychological understanding of psychosis. As is commonly experienced in such collections, this volume has frequent shifts in tone and focus, with occasional repetition or contradiction. Some chapters contain cognitive-behavioral therapy (CBT) in a perfunctory way, or not at all. The case studies are illustrative, though not intended to be instructive. One would need to look elsewhere for a practical treatment approach. Nonetheless, in summary, it is an often illuminating and thought-provoking book.

The book is divided into four broad parts, beginning with a section on cognitive models of psychosis and their assessment. Chapter 1 carries the same title as the book itself and provides an overview of CBT and CBT for psychosis, setting the stage for a dimensional and psychological view of psychosis. Here, two of the editors, Hagen and Turkington, present a concise and logical rationale for treating psychotic symptoms as experiences rather than simply as items that meet diagnostic criteria for a specific disorder. A primary assumption of this model is that psychotic symptoms lie along a continuum of normality. The authors outline key factors in CBT for psychosis, expanded on throughout the book, including rapport building, education, normalization, case formulation, and relapse prevention.

Chapters 2 and 3 look at cognitive models of auditory hallucinations and delusions. Again, these symptoms are emphasized as being part of a spectrum of common human experience not necessarily associated with psychosis. Hallucinations are identified as "misattributed cognitions," while several cognitive models for delusions are presented. Chapter 4 details various symptom measures and basic strategies for the assessment of psychosis.

Part II focuses on the practice of CBT for psychosis. Common factors in psychotherapy are reviewed in Chapter 5. Here, the authors helpfully relate their own experiences to instruct the reader in forming an alliance with patients with psychosis. Chapter 6 highlights the commonality of psychosis as a justification for the use of normalization as a key component of CBT for psychosis. The important topic of early intervention is reviewed in Chapter 7, with an overview of the limited research supporting CBT in prepsychotic or first-episode patients. The treatment outline provided differs little from that for CBT for other psychotic populations, including the focus on individual experiences and meanings (here, often developmental issues). Chapter 8 examines command hallucinations and presents an outline of a manualized cognitive treatment for this distressing symptom, with a corresponding case study. In a remarkably intriguing and complete Chapter 9, Stolar and Grant propose a cognitive model and treatment strategy for negative symptoms and thought disorder, for which pharmacotherapy has limited benefit. They propose that these symptoms arise in part from low expectations of success and pleasure. The negative attitudes, stress of interaction, and limited activity can be addressed by cognitive behavioral techniques. Chapter 10 shifts the focus to relapse prevention and emotional recovery. After mounting evidence and support for the CBT models and their efficacy in a variety of psychotic symptoms and different populations, the final chapter of this section (Chapter 11) discusses barriers to implementation of CBT for psychosis, with a focus on North America.

Part III concentrates on conditions that commonly cooccur with psychotic symptoms. Both theoretical and clinical aspects of the evolving understanding of the relationship between trauma and psychosis are expertly written about in Chapter 13. The authors encourage us to sensitively inquire about trauma in our patients with psychosis to enhance

understanding. They use case studies to show how trauma-focused CBT can help alleviate distress associated with psychotic symptoms. Chapter 12 (substance misuse) and Chapter 14 (family treatments) provide good overviews of general approaches, though without specific mention of CBT. Chapter 15 looks at psychological interventions to improve work outcomes, including one CBT approach.

Finally, Part IV gives attention to bipolar disorders, based on the idea that these may exist on a continuum of psychotic disorders. Chapter 16 begins with a discussion of bipolar symptoms in psychological terms and ultimately presents an integrated biopsychosocial model to understand these illnesses. The final chapter of the book provides cognitive models of bipolar disorder and evidence supporting their use in treatment.

This book provides a compelling case for a psychological view of psychosis that can influence current treatments and future research. I suspect that many of these ideas will be new to mental health professionals in the United States. The chapters need not be read in succession or in total, as many provide a succinct overview that can stand alone. Though lacking in cohesion, this book offers a considerable breadth of information that could be useful for both clinicians and researchers.

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Psychiatry's Contract with Society: Concepts, Controversies, and Consequences, *edited by Dinesh Bhugra, Amit Malik, and George Ikkos. Oxford, United Kingdom, Oxford University Press, 2011, 288 pp., $54.95 (paper).*

This book provides a predominately British perspective on the social contract between psychiatry and society (21 of the 26 authors are from the United Kingdom, two from Canada, two from Australia, and one from Denmark). The 18 chapters trace the changing nature of the role of British psychiatry while documenting British society's discontent with doctors' behaviors and delineating some of the reasons behind the regulatory changes that have taken place over the past decade.

As might be expected from a compendium of articles, there is some unevenness in the writing from author to author and also some duplication of concepts and explanations. The chapter by Cruess and Cruess, titled "Medicine's Social Contract With Society: Its Nature, Evolution and Present State," is arguably the defining chapter of the book. The authors report on the historical context of the social contract, describe some examples (both in the United Kingdom and the United States) where practitioners have fallen short and of the ebb and flow of responses and counter responses between medicine and society, and argue for the role of doctors to enter the political process to negotiate more of the terms of the contract. They present several examples of how physicians and patients used legislative initiatives to overturn restrictions imposed by commercial interests on doctors' responsibilities for their patients. One example was when doctors were proscribed from explaining to patients the range of therapeutic options covered in their insurance plans and another was the attempt to limit obstetrical delivery hospital stays to 24 hours.

Cruess and Cruess place the concept of the social contract in its historical context, dating back to philosophers such as Rousseau, Locke, and Hobbes. While not a legal contract in any formal sense, the social contract does attempt to define the relationship between citizens and the state. In the instance of medicine in general and psychiatry in particular, a social contract provides a conceptual framework to examine the complex relationship our field has with both our patients and the larger society and helps to define our professionalism.

Society trusts that psychiatrists will use their expertise to look after the mental health of its citizens. We are expected to be objective, to maintain high standards of conduct, to be altruistic, to not seek monetary gain, and to avoid conflicts of interest. In exchange, we will be able to regulate ourselves, establish our own work standards, and regulate recruitment, training, and credentialing as well as earn a comfortable living. Failure to act in this fiduciary role results in society taking action to reduce our autonomy.

U.S. psychiatric history is replete with examples of how society has responded to the field of psychiatry not fulfilling its obligations in the social contract. The profession's failure to vigorously respond to the occurrence of patient-therapist sex resulted in state legislatures criminalizing the act. Failing to choose the lowest-cost effective medication resulted in the restriction of prescribing independence by requiring psychiatrists to obtain prior authorization and limiting therapeutic choices to preselected formularies. Accepting gifts, dinners, consultantships, etc., from pharmaceutical companies has resulted in congressional investigations, with demands for greater transparency, the Physician Payment Sunshine Act, and even criminal prosecutions.

This book uses the social contract to discuss in greater detail the role and demands of professionalism in clinical practice. Its focus on circumstances in the United Kingdom and the changes in its national health system does limit some of the applicability to issues in the United States. Yet the difference in perspective also permits a more distanced reflection on concerns that do overlap between the two regions.

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