information available here merits concentrated attention.

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## Personality-Guided Therapy

By Theodore Millon. New York: Wiley. 1999. 776 pp. £41.95 (hb). ISBN 0-471-52807-2

This lengthy and ambitious book is predominantly concerned with the explanation and treatment of the DSM personality disorders of Axis II and much less so with the clinical syndromes of Axis I. Although Millon states that his personality-guided synergistic psychotherapy is conducive to shorter and more effective treatment of the Axis I syndromes, he offers no evidence in this text to support the efficacy of his orientation for either group of disorders. Furthermore, confidence in the many detailed case studies used to illustrate his approach is not enhanced by his admission that many of them preceded the development of his model.

His perspective is purportedly based on his evolutionary model of personality, which presumes that personality and its disorders can be classified and explained in terms of the three polarities of pain–pleasure, active–passive and self–other. Normal individuals show a reasonable balance between each of the polarity pairs. Those with personality disorders are thought to reflect a deficiency in one or more of the three (e.g. the schizoid personality prototype is deficient in both pain and pleasure), an imbalance (e.g. the schizoid personality prototype is strong on passivity and weak on activity), a conflict (e.g. the negativistic personality prototype has a conflict between self and other) and/or a structural defect (e.g. the paranoid personality prototype rigidly compartmentalises each of the three polarity pairs). Fifteen disordered personality prototypes have been identified. In addition, there are various disordered personality subtypes, such as the affectless type of schizoid personality. These subtypes are said to be based on empirical and clinical observation although, as with the personality prototypes, no supporting evidence is presented.

The personality disorders are also described in terms of eight clinical or diagnostic domains, which are shown at one of four levels: expressive behaviour and interpersonal conduct at the behavioural level; cognitive style, self-image and object representations at the phenomenological level; regulatory mechanism and morphological organisation at the intrapsychic level; and mood/temperament at the biophysical level. The salience of these domains for each personality disorder is displayed graphically by ellipses. The relationship between the polarity pairs and these domains is not explained.

Treatment is outlined at two levels: first, in terms of the more general strategic goals of balancing polarities and countering the way in which disorders are perpetuated; and second, at greater length, in terms of the more specific tactics of therapeutic modalities or techniques directed at particular domains, such as the use of social skills training for developing more appropriate interpersonal behaviour in those with schizoid personality disorder. Millon suggests that treatment is more effective when two different therapeutic modalities are administered at the same time in potentiated pairings, when different therapeutic modalities are given singly in catalytic sequences and when potentiated pairings of the therapeutic modalities are presented in potentiated sequences. The relevant criteria for combining treatments in these supposedly synergistic ways and for choosing between them is not made explicit, making it difficult to apply and to evaluate empirically the approach advocated in this book.

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## Delusional Disorder: Paranoia and Related Illnesses

By A. Munro. Cambridge: Cambridge University Press. 1999. 261 pp. £45.00 (hb). ISBN 0-521-58180-X

All psychiatrists will have encountered patients who present only with delusions. Most – after seeing some such patients who are obviously psychotic with persecutory and referential delusions but no other symptoms; others who seem only to have an isolated over-reaction to some perceived injustice; and yet others who are suffering not from imagined persecution but whose beliefs revolve around infidelity, illness or deformity – will have concluded that such patients frustrate all attempts at classification. Some, especially those of us who trained in the past 20 years, will recall consulting the articles by Munro, one of the very few authors who seemed prepared to grasp the nosological nettle of paranoia. He introduced the term monosymptomatic hypochondriacal psychosis. His sustained advocacy played an important part in the renaissance of paranoia as a delusional disorder in the 1980s. He was single-handedly responsible for popularising treatment with pimozide, which, as he notes, now tends to be the most widely used drug in different forms of the disorder.

In this book Munro takes on the whole field of paranoid disorders, not only delusional disorder, but also paraphrenia, standard and late varieties, delusional misidentification syndrome and *folie à deux*. He also reviews disorders which regularly feature in the differential diagnosis of delusional disorder, including reactive psychosis, cycloid psychosis, and paranoid, schizoid and schizotypal disorders. There is a chapter on treatment and many case descriptions.

The section of the book devoted to paranoia/delusional disorder leads off with monosymptomatic hypochondriacal psychosis (now renamed delusional disorder, somatic subtype), a subcategory whose existence Kraepelin was doubtful about, but which has dominated and shaped Munro's thinking. The approach taken with this and the other subtypes is one which will be familiar to those who have read the author's previous publications: lucid description, clear-headed analysis, a solid grasp of the complex background of 'normal' hypochondriasis, jealously, etc., and yet an unsatisfying feeling that the really difficult issues have been glossed over. He uses terms like 'belief' and 'conviction' liberally, but the reader is sometimes hard put to see what makes him decide some convictions are delusional, whereas others are not. Thus, a case of AIDS hypochondriasis is delusional disorder, somatic type, but a superficially similar case where there is a dysmorphic belief is not. The presence or otherwise of referential delusions – which Kraepelin came to the conclusion were present in all cases of paranoia – is hardly touched on. Everything is complicated by use of



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