acts to reduce the apparent incidence of schizophrenia, one would tend to increase, whilst the other diminish, the apparent incidence of other psychotic disorder.

The authors admit they are at a loss to offer a plausible mechanism for their interpretation, although they are evidently aware of its potential repercussions, especially in terms of the allocation of health services. In this regard, timely cuts from Occam's razor are less harmful than future cuts in already compromised services for the mentally ill.

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DE CLÉRAMBAULT'S SYNDROME—A NOSOLOGICAL ENTITY

Dr Ellis and Professor Mellsop's article (*Journal*, January 1985, **146**, 90–95) is a salutary exercise in diagnostic stringency. I would agree with them that it is likely that most cases described as erotomania are, in fact, suffering from a wider disorder such as schizophrenia, but I do not accept that the existence of primary erotomania can be summarily dismissed.

In my work on monosymptomatic hypochondriacal psychosis (MHP), I have encountered a similar situation. Many cases of delusional hypochondriasis prove to be secondary to other conditions, and when I began searching for primary cases I was told that they were excessively rare to the point of non-existence. Since there is now a growing literature apparently confirming the reality of the primary type, I am fairly satisfied that my recognition of it is not entirely delusional!

Several years ago, I was struck by the great similarity of the clinical picture in both MHP and pathological (paranoid) jealousy: the main difference lay in the delusional content. Again, paranoid jealousy may be seen in the "pure" or "primary" form, or may be secondary to other psychiatric illnesses. Two of my former residents and I have separately presented single case accounts in which primary paranoid jealousy responded well to pimozide, similarly to many cases of MHP (Dorian, 1979; Pollack, 1982; Munro, 1984).

More recently, after a long search, two colleagues and I identified two cases of primary erotomania, and successfully treated these with pimozide. Once more, the clinical picture is very like that of MHP, but this time the delusional content is one of erotic preoccupation. These patients are described in an article to be published by the *Canadian Journal of Psychiatry* (Munro, O'Brien & Ross, in press).

Cases of primary MHP, paranoid jealousy and erotomania fit very closely with Kraepelin's description of paranoia (Kraepelin, 1921). After his death, many psychiatrists denied that such a condition existed, but it has been rehabilitated and vindicated in recent years (Kendler, 1984) and I think that, until our present nosological system improves, we should place these three disorders under the rubric of paranoia. Incidentally, "primary" proves to be a relative term: I do my utmost to exclude cases with evidence of schizophrenia, affective disorder, organic brain disorder, obsessive-compulsive disorder, etc., but even so, I find that a history of substance and alcohol abuse (often non-current) is so common that I suspect that this may be an aetiological factor even in the primary presentation.

Dr Ellis and Professor Mellsop do us a service in encouraging us to be more careful in an area of diagnosis that remains tentative, but I do not accept as proven that cases of primary erotomania do not exist, although for the time being I shall accept that they seem rare.

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THE PSYCHIATRIC INTENSIVE CARE UNIT

DEAR SIR,

I was interested in the article by Dr Goldney *et al* (*Journal*, January 1985, **146**, 50–54), describing a Psychiatric Intensive Care Unit in Adelaide, Australia, as I carried out a similar study of a new Psychiatric Intensive Care Unit at the North Wales Hospital, Denbigh, in 1982. The study looked at the admissions during the unit's first six months, using a questionnaire and microcomputer database. The

stated aims of the unit were to provide assessment and treatment of patients with a personality disorder and amenable to treatment, and mentally ill patients, who for a time require intensive nursing care under conditions of medium security.

The number of admissions during the six month study was 292 patients, compared with 1132 in three and half years, in the Adelaide unit. The latter was however a smaller unit (8 versus 24 beds). The mean length of stay in the Adelaide unit was shorter—4.8 days against 12 days. The two units had no significant differences in the mean age of admissions, or male:female ratio. There was a higher proportion of first admissions in the North Wales unit, and patients tended to be admitted more from other wards in the hospital. In Goldney *et al's* study there were significantly more admissions referred from police/courts, and other hospitals, whereas there were fewer referred directly from the community. There were no significant differences in the proportions of patients diagnosed as affectively disordered or with substance-induced organic mental disorder, but a significantly greater proportion of the Adelaide admissions were schizophrenic (40.3% versus 21%). There were no significant differences in the ratio of patients admitted for reasons of violence, but there were slightly more admitted in the North Wales unit as they were potentially suicidal. There were no differences found in the proportion of patients discharged directly into the community. A significantly higher proportion of the North Wales unit's admissions were informal (50% versus 3.5%).

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CORRECTION

In the paper by Dr Singh *et al* (*Journal,* February, **146,** 127–131) reference is made on page 129 to a Table which was, in fact, deleted during editing.

British Journal of Psychiatry (1985), **146,** 562–570

Book Reviews

Handbook of Psychiatry. Vol. 4. The Neuroses and Personality Disorders. Edited by G. F. M. RUSSELL and L. A. HERSOV. Cambridge: Cambridge University Press. 1984. Pp 500. £40, £17.50 (paperback).

This work, the 4th volume of the *Handbook of Psychiatry,* was eagerly awaited. The themes of neurosis and personality disorders have always received poor treatment in general texts of psychiatry and the General Editor, in the Foreword to the book, describes how the formation of the Editorial Board of the *Journal of Psychological Medicine* played an important role in the conception that available British books on psychiatry, arising from a variety of academic and clinical departments were lacking in authority. This realisation led to the need for rectification: a comprehensive, authoritative, multi-authored handbook representing all that is best in British psychiatry: the 'Maudsley Approach' to psychological medicine. The sub-editors of this part of the whole *Handbook,* have recognised the need, not only for academic instruction but also for clinical information. Their stated aim has been to produce a book which will not only instruct the teachers but will be read with profit by the clinical workers. They express the hope that the workers who will profit will include, not only psychiatrists and general practitioners, but also nurses, psychologists, social workers and occupational therapists. In order to encourage this wide readership sections are included written by members of all these professions.

Herein lies the flaw in the design: the multiplicity of authorship, there are 43 who have contributed sections, results in a failure of cohersion and a lack of that authority which was its aim. Certainly there are some excellent sections written by authors who have the credentials to provide the required authoritative review of their subject but the requirement that so many others should also be allotted space, has denied them the chance for excellence of contribution. A somewhat curious editorial decision was to invite one contributor to provide eight sections, five of which were con-