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Book reviews

From Normal Adaptation to PTSD. Edited by M. J. Friedman, D. S. Charney and A. Y. Deutch. (Pp. 551; £96.00.) Lippincott–Raven: Philadelphia. 1995.

This book lists 64 authors and is in five parts. The first is from molecules to behaviour – stress in laboratory animals, then models of the impact of stress on brain function, and human responses to stress, clinical issues, and a summary.

After the introduction by Professor Kolb I turned straight to page 415 and the clinical issues section. There were two reasons for this. The first is that some of the neurobiology is very complex. The second is that the clinical section starts with an epidemiological review by Fairbank *et al*. The epidemiology of post traumatic stress disorder (PTSD) is still poorly understood and this review is good, covering the major studies. One complaint is that they, like most other reviews, comment upon the 'surprisingly consistent' prevalence rates for PTSD although they show a wide range of rates. It would seem appropriate to mention in such a review that there are still problems because of a lack of a gold standard for diagnosis and perhaps in the limits of the diagnosis.

The chapter on co-morbidity is also well written and useful. There is a helpful model demonstrating the overlap and differences between PTSD, generalized anxiety disorder, major depressive disorder and panic disorder. The chapter looks at the clinical utility of laboratory tests for PTSD and, not surprisingly, notes that the most consistent of these is physiological responsiveness.

There is a comprehensive review of drug treatment, which quite reasonably concentrates on the lack of good evidence of the efficiency or otherwise of drug treatment and the need for randomized clinical trials. The reviews of this and other treatments are very good.

All in all the clinical section is informative and helpful. So to the neurobiology…

The section on animal studies is extremely detailed and authoritative. The neuroanatomical chapter is comprehensive. The intracellular signal transduction chapter is erudite but of little relevance to the clinician. The neuroadrinergic response chapter explains the basic science behind potential future diagnostic tests. The amino acid system chapter has little clinical relevance but the stress and sensitization chapter is of theoretical interest. The neuropeptide chapter is not yet clinically relevant. The stress into motion chapter is interesting. The adrenal steroid chapter suggests that repeated stress impairs successful behaviour adaptation by effects on the hypothalamic pituitary adrenal access.

Part II looks at the changes in brain function following stresses and tries to produce models of same. It looks at memory processes neurotransmitters, failure of extinction of memories, kindling theory, the involvement of the hypothalamic pituitary adrenal access and alterations in memory function. These are all features associated with post-traumatic stress disorder in various studies. They are of clinical interest although the detail contained in these chapters is not that for the clinician.

Part III looks at the human response to stress, both adaptive and maladaptive. The first chapter gives the evidence for the psychophysiological changes associated with PTSD and increasingly being used in confirmation of diagnosis. There are chapters on sleep, neurotransmitter and hormone changes, immunology and other physical changes.

In summary, the clinical section of this book is a thorough comprehensive view of the areas covered. However, the neurobiological sections, which comprise by far the majority of the 551 pages, are really the province only of research scientists rather than practising clinicians. The price tag of £96 reinforces the idea that this is probably not a resource book for the mental health professional with an interest in post-traumatic stress disorder or for the average psychiatric training scheme.

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Psychiatric Aspects of Physical Disease. Edited by A. House, R. Mayou and C. Mallinson. (Pp. 110.) Royal College of Physicians and Royal College of Psychiatrists: London. 1995.
Medical-psychiatric Practice. Volume 3. Edited by A. Stoudemire and B. S. Fogel. (Pp. 617.) American Psychiatric Press: Washington, DC. 1995.

Psychiatric disorders are common in the general population and even more so in medical practice. The claiming of under-recognition and under-treatment of these conditions has been a traditional hobby-horse of many psychiatrists. If the general physician would diverge his or her one-sided mechanistic concern for physical disease to the broader holistic concept of medicine, many patients would be treated better. This would result in a better quality of life and a substantial reduction of health care costs. Such are the sweeping claims that are frequently associated with the field of psychosomatic medicine. The history of this discipline is full of the most grotesque examples of the power of mind over matter. Nowadays, these colourful fantasies from the past have been left behind and the field has matured into the more pragmatic discipline of medical or liaison psychiatry. Only sometimes the over-optimistic echo of the former hail message has remained.

In reality, the borderland between psychiatry and somatic medicine is characterized by a great variety of complex problems that may, or may not, be solved by psychological interventions. At least four different domains need to be separated. First, and perhaps most frequent, there is the simple concurrent presence of psychiatric and physical disorders, without any causal interdependence. The presence of more than one disease in a single subject will generally complicate the treatment of both. An entirely different problem is the situation where psychiatric disorders occur as an emotional reaction to the stress of physical disease. Lately, it has become more clear that the emotional reaction and the way this is handled may significantly contribute to the outcome of physical disease in terms of quality of life. A third, and altogether different aspect of the relation between psychiatric and physical illness is the field of neuropsychiatry. Many physical disorders may disrupt the functioning of the brain, which may result both in physical and in mental symptoms. Finally, a major shared interest are the unexplained medical syndromes such as chronic fatigue, irritable bowel or chronic pain syndromes. Although it is far from clear that such syndromes are caused by psychological factors it has been repeatedly demonstrated that a psychotherapeutic approach may contribute to the treatment.

The Royal College of Physicians and the Royal College of Psychiatrists have been worried about the unhealthy split between physical and psychiatric care. In joint meetings the two colleges have been exploring ways to improve the integration of psychiatric care in general medical practice. A previous publication resulting from this effort focused on medically unexplained symptoms (Creed *et al*. 1992). A more recent publication, *Psychiatric Aspects of Physical Disease*, explores various aspects of psychiatric disorders that may occur in patients with physical disease. In an additional report the psychological needs and service provision of medical patients are assessed (Royal College of Physicians & Royal College of Psychiatrists, 1995). Together, these three manageable books provide a useful introduction to the complexity and diversity of the field of liaison psychiatry for the uninitiated psychiatrist and physician alike. Through the discussion of selected topics it is clearly illustrated how psychological aspects, in various ways, are of central importance in patients with medical symptoms or disease. The books provide some clear examples of empirically tested management programmes for well defined common problems that are not too difficult to implement in common clinical practice. Such programmes may certainly improve the quality of patient care, but it may be a bit too optimistic to expect that such improvements will result in a reduction of costs. What is perhaps most important about these books is that the collaborative presentations by psychiatrists and other physicians illustrate that the proper care for the common psychological needs of patients is a responsibility of all physicians and not just of psychologists or psychiatrists.

In their clinical practice liaison psychiatrists meet every day with the complexity of psychiatric and medical co-morbidity. To deal with such problems sound psychiatric and medical knowledge need to go together. For some years now

Stoudemire & Fogel in their series *Medical Psychiatric Practice* collect in depth reviews of selected topics in this field. With the third volume of this series the editors add ten more chapters to their previous collection of 36 (Stoudemire & Fogel, 1991, 1993). The topics in this volume are distributed over the major areas summarized above. The first two chapters almost constitute a complete textbook on psychopharmacology, with specific emphasis on patients with physical disease. A separate chapter on the treatment of psychosis in Parkinson's disease provides a good example of the complex interaction between psychiatric and medical illness. Two chapters focus on the psychiatric aspects of serious disease, i.e. HIV and bone-marrow transplantation. Two chapters are devoted to neuropsychiatry with systemic lupus erythematosus and mild traumatic brain injury as the selected topics. Finally, three chapters are devoted to the unexplained syndromes of chronic fatigue, vulvodynia and chemical sensitivity. The last is particularly interesting as a comparatively new star at the firmament. The cumulative index provides easy access to the entire series. With its heavy emphasis on explaining physical disease the series is perhaps most interesting for the specialized psychiatrist who does not feel too comfortable about his somatic knowledge.

It is not very difficult to focus attention on the considerable importance of psychiatric problems in medical patients. It is far more difficult to decide about sensible solutions. No doubt, the liaison psychiatrist can contribute to a satisfactory outcome in individual patients. A series with the detailed information as edited by Stoudemire & Fogel can be helpful here. To solve the large scale problem, however, the direct contribution of psychiatry will be limited. The sheer size of the problem makes integration of psychological care in general medical practice, as is propagated by the Royal Colleges, a more feasible option. The great complexities involved, however, provide little ground for over-optimistic claims of success.

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REFERENCES

Creed, F., Mayou, R. & Hopkins, A. (eds) (1992). *Medical Symptoms not Explained by Organic Disease*. Royal College of Psychiatrists and Royal College of Physicians of London: London.

Royal College of Physicians and Royal College of Psychiatrists (1995). *Psychological Care of Medical Patients: Recognition of Need and Service Provision*. Royal College of Physicians and Royal College of Psychiatrists: London.

Stoudemire, A. & Fogel, B. S. (eds) (1991). *Medical-psychiatric Practice. Volume 1*. American Psychiatric Press: Washington, DC.

Stoudemire, A. & Fogel, B. S. (eds) (1993). *Medical-psychiatric Practice. Volume 2*. American Psychiatric Press: Washington, DC.

Eccentrics. By D. Weeks and J. James. (Pp. 198.) Weidenfeld and Nicolson: London. 1995.

Neither mad nor sad, nor bad. Eccentrics owe Weeks and James a debt of gratitude for their rehabilitation in the reader's mind. To their credit, as a class, eccentrics probably do not care what other people think.

But what do eccentrics think about themselves? And, more to the point, how do they think? How many of them are there? How might we define eccentricity? Weeks, a clinical neuropsychologist, is probably correct in his insistence that you will nowhere find a rigorous and consistent (i.e. scientific) account of eccentricity. So he set out to construct one, and published the findings in the *Proceedings of the Royal College of Physicians of Edinburgh*. But specialist technical journals do not reach the public domain, hence this book, which is co-authored by James, a North American journalist.

Eccentrics, we are told, tend to be non-conforming, creative, curious, idealistic, obsessive, intelligent, opinionated, non-competitive. Each of these qualities is soft to the point of liquidity. Serious-minded academics have surely come to blows arguing about hard definitions and validated assessment scales for such character traits. Thus, their description in a book written for an intelligent lay readership requires subtle precise prose, and an exceptionally careful construction. Weeks and James succeed handsomely with the prose. The construction begins with an excellent introduction and a fascinating first chapter that describes the design and conduct of Weeks's study. The authors then insert four chapters about eccentrics in history, followed by chapters 7, 8 and 9, which describe aspects of the psychology of eccentrics. These latter chapters, full of surprises, left me wanting more, while the historical chapters, brimful of charming anecdotes, are entertaining but less illuminating. I suspect that a non-medical

readership might reverse this judgement, elevating entertainment above instruction, and that the authors were correct to expand their book into the anecdotal past. And, there is a delightful spin-off. Readers can indulge in the game of feigned outrage at inexcusable omissions. (You know how it goes – 'What! Battleship Potemkin in your all time top ten but not Citizen Kane?') In the chapter on eccentric scientists, for instance, Nikola Tesla (1856–1943) is missing. He invented the alternating current induction motor in 1888, and later constructed a giant metal tower on Long Island intended to harness the ionosphere for both telegraph and 'star wars' purposes. He failed, and bankrupted himself, a typical consequence (the book tells us) of eccentric obsession. And yes, the US military continue to research his ideas.

To qualify for inclusion in the pantheon of historical eccentricity the subject needs a biographer who will highlight their poignant peculiarities. Thus, the dreary Mitfords get a lengthy mention mainly, I suspect, because they chose to write about themselves, at length. Edmund Backhouse (1873–1944), a secretive man, is nowhere to be seen however, despite Hugh Trevor Roper's magnificent biography (*Hermit of Peking*, Penguin, 1976), which exposed Backhouse as an outrageous forger, fraud, deviant fantasist and true eccentric expatriate in early twentieth century China.

Weeks also repeatedly insists that doctors know nothing about eccentrics, in terms that suggest that either they should, or that they think they do when they don't. This is of course unfair, since (as the book tells us) eccentrics enjoy good health, and avoid doctors. Clinical research about eccentrics would need to start with a case series, and case definitions derived therefrom. Which clinician has ever seen such a series? Which patient ever presented with a complaint of eccentricity? Pankratz & Kofoed (1988) did describe a particular type of eccentric – the Geezer, and a fine account of their incompatibility with conventional clinical care. Asher (1972) profiled a type of female eccentric – the Lucy syndrome – in a brief note in his essay on malingering. This stereotype of The Proud Lonely Person, who uses 'illness as a comfort' never caught on, while his description of the Munchausen syndrome (based on only three case histories) thrives and survives.

Weeks and James choose not to include Munchausen syndrome 'sufferers' in their study. Indeed, Weeks and James conclude that eccentrics are happy, creative and healthy. As Weeks relates in the introduction, he approached the subject of eccentricity in a positive frame of mind, believing his study might 'help the rest of us to be more creative, more original: better at being ourselves'. As he began his project he hoped (but failed) to find an account of eccentricity 'that carefully distinguished the syndrome from other, harmful forms of mental aberration'. Such an approach disbars those who are narrowly, self-destructively or unhappily eccentric. So, 'no' to Munchausen 'sufferers'. and 'yes' to a subtle but powerful selection bias. This is perhaps the major weakness of Weeks's study, but a forgivable one. For the first serious research on this subject he needed a sympathetic approach, the trust of his paradoxically shy subjects, and a strong counter to the inhibiting description of eccentricity as 'a form of predominantly inadequate or passive psychopathy'. The authors estimate that there is approximately one eccentric per 10000 of the population, or a total of 5000 in Great Britain. So eccentrics are commoner than professional footballers, Members of Parliament and consultant psychiatrists, but less visible and less well understood. This book part redresses the balance.

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REFERENCES

Asher, R. (1972). *Talking Sense*. Pitman Medical: London.

Pankratz, L. & Kofoed, L. (1988). The assessment and treatment of Geezers. *Journal of the American Medical Association* 1988; **259**, 1228–1229.

Personality Disorders: Recognition and Clinical Management. By J. Dowson and A. Grounds. Cambridge University Press: Cambridge. 1995.

In 1935, Dr Richard Cabot started his epic randomized trial of the effect of counselling and social worker support on more than 500 both 'difficult' and 'average' young males. Dr Joan McCord's equally heroic 30-year follow-up of these subjects was reported in 1978 (McCord,

1984) (it showed that the treatment was associated with negative effects as measured by 'criminal behaviour, death, disease, occupational status and job satisfaction'). Both the length and completeness of follow-up and the randomized protocol provide benchmarks of methodological quality against which later studies of 'personality disorder' (PD) can reasonably be judged. Thus, it was with great interest that I opened this book, hoping for a summary of the evidence on two key points. First, what is the evidence for the existence of the various PDs? Which subjects have been studied, for how long, with what loss to follow-up? What was the reliability and validity of instruments employed, and what end points were used? Secondly, with regard to management, what interventions have been proved to work in randomized trials, in whom, for what outcomes, for how long, at the expense of what cost and unwanted effects?

These two questions form the background to my review of Dowson and Grounds's book. It was no surprise to find that most studies reviewed here fall far short of the standards of Cabot and McCord. However, poor quality messages should not necessarily be grounds for 'shooting the messengers'. Nevertheless, it is worrying that the authors do not seem to have used clear standards against which to assess the studies reviewed. Neither is there any description of how they identified studies for inclusion: one suspects this was not done systematically, leading to some surprising omissions, for example Bowlby's juvenile thieves, not to mention McCord's article, surprisingly little known although indexed on *Medline*.

Dowson and Grounds of course quote the ICD definition of 'deeply ingrained maladaptive patterns of behaviour, *generally recognized by the time of adolescence or earlier and continuing throughout most of adult life*' (my italics). Such patterns of behaviour can be recognized and, to some extent, agreed upon in classification systems, and Dowson and Grounds open with various PDs recognized in ICD and DSM. However, all behaviours and symptoms seen in PD occur in other conditions (including normality); there is a continuum between PD and normal personality on the one-hand, and between PD and mental illness on the other: any precise cut-off points can only be arbitrary. Permanence is, therefore, PD's main distinguishing feature, and accordingly the evidence on this point must be the foundation of the book.

Indirect support for the permanence of PD would come from evidence that normal personality itself was stable through time; there is a psychological and a sociological as well as a medical literature on this topic, which the authors do not review: a search on *Medline* using the term 'personality and stability' yields more than 200 articles for 1991–4 alone. Their four pages (pp. 5–9) on the topic are so incomplete as to have been, perhaps, better left out altogether. There is not even very much discussion of the currently fashionable, though highly debatable, notions that some aspects of personality may be so stable as actually to be heritable (e.g. the work of Plomim).

Direct evidence for the permanence of PD would obviously be provided if PD itself was reliably and validly measured as stable over time. We can attempt to assess longitudinal stability of PD retrospectively, looking back into the past of a person diagnosed with PD, but there are tremendous problems in this approach, including recall bias, selection bias of index 'cases' and the difficulty in choosing appropriate controls. 'I did what I did because of the situation I was in – he did what he did because that is the sort of person he is,' as the adage runs.

Prospective longitudinal evidence must be the cornerstone; that quoted is strongest for childhood conduct disorder/antisocial personality disorder. But Dowson and Grounds do not convince that they have summarized the existing literature objectively and adequately: a *Medline* search using the terms 'personality disorder' and 'follow-up or prospective' yields more than 200 articles for 1991–4 alone, including for example, among many others not cited, a 20 year follow-up of conduct disorder children form Norway (Storm & Vaglum, 1994).

Further support for the existence of antisocial PD only comes from the evidence (p. 15) of a possibly discontinuity or 'point of rarity' in the continuous distribution of these traits between PDs and normals. However, this offers no succour to the other proposed PDs ('paranoid, schizoid, schizotypal, avoidant, dependent, obsessive–compulsive and passive–aggressive')

for which their evidence of prospective longitudinal stability consists of a mere handful of references (pp. 178–179).

More evidence seems available for 'borderline' and 'schizotypal' PDs, though it is unconvincing as presented. For example, 'five studies reviewed by Perry (1993) found that a mean of 8·7 years 57% of patients still received the borderline PD diagnosis', which is not impressive: what of the 43% who had been given a supposedly lifelong diagnosis? These 'PDs' are comparatively recently described entities, which remain much more readily diagnosed in the US than elsewhere, perhaps especially at (p. 164) private clinics with a psychoanalytical bias. Perhaps the proper context in which to consider them is as a possible replacement for excess of schizophrenia formerly diagnosed in the US, or even as culture-bound syndromes.

I turn now to the arguments presented in favour of lumping together two groups of conditions, which for practical purposes seem to have more differences than similarities: that is, antisocial personality disorder, with its forensic aspects and supporting evidence, and all the others, which fall mainly in the domain of psychiatry and medicine, and for which the evidence seems much weaker. An inherent and fundamental paradox in the concept of PD is not discussed: on the one hand, most PDs are cited as reason for discharge from mental health care systems on the grounds of untreatability; on the other, a diagnosis of antisocial PD is a passport out of the criminal justice system and into forensic psychiatry, if it is felt to be treatable!

The scope of the book is disappointingly blinkered, with little consideration of possible historical, social or political perspectives on the concept of PD and its development. For example, after defining PD by behaviour, they then use PD to explain (p. 4) 'the origins of various social phenomena with serious consequences to society', without considering the circularity of the argument, or considering its possible origins, such as secular trends towards the medicalization of marginalized members of society. Furthermore, after quoting Blackburn's view of PD as 'little more than a moral judgement masquerading as a diagnosis' (which here has to stand duty for the whole school of thought critical of labelling or stigmatization), they offer no arguments whatsoever in response, just a bald assertion (p. 13) that 'criticism of the concept of PD should be directed at clinicians and health care workers, rather than to the relevant concepts and classificatory systems'.

Regarding treatment, as previously indicated, the 'gold standard' study by McCord is not cited. Drug treatments are discussed, but again, the authors seem to lack perspective: for an allegedly lifelong condition, waxing and waning in severity, can anything really be learnt from non-randomized studies? Even randomized trials of the typical few weeks' duration can only look at the treatment of super-imposed episodes of illness.

On psychological treatments, they give an account of ten or more different kinds of individual psychotherapy, but reasonably conclude by quoting Andrews's influential 1993 review on the better value represented by 'good clinical care' as 'more effective, cheaper and less harmful than dynamic psychotherapy'. Some of the other advice given is of dubious practicality: for example, on how to cope in an interview that seems to be getting so heated as to threaten violence by 'moving the body's weight to one leg and placing one hand on the chin' seems unlikely to achieve desired outcomes (p. 287). Quoting received analytical authority, e.g. 'What these patients need is an experience, not an explanation' (Fromm-Reichmann, p. 262) is surely obsolete.

Although the book is billed as being by Dowson and Grounds, it is organized in an unusual way – all of the chapters are by Dowson, except for the last chapter, on 'Management of Offenders with PD', which is by Grounds. This last chapter is brief and to the point and stands, of course, in the shadow of Dolan and Coid's (1993) recent book, quoted on p. 326 'there is still no convincing evidence that psychopaths can or cannot be successfully treated'. Had Grounds co-authored the whole book, it might have been better.

There is no catholicon. In order to accept the notion of PDs in addition to antisocial PD, we need a review of long-term prospective follow-up and treatment studies. Existing reports need to be searched for systematically, tabulated and analysed in a structured and reproducible way. In short, what the book most fundamentally

lacks is a Methods section. It is regrettable that so much effort should end up as little more than an example of the decline and fall of the traditional narrative review.

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REFERENCES

Andrews, G. (1993). The essential psychotherapies. *British Journal of Psychiatry* **162**, 447–451.
Dolan, B. & Coid, J. (1993). *Psychopathic and Antisocial Personality Disorders*. Gaskell: London.
McCord, J. (1984). A thirty year follow-up of treatment effects. *American Psychologist* **33**, 284–289.
Storm, M. A. & Vaglum, P. (1994). Conduct disorder patients 20 years later: a personal follow-up study. *Acta Psychiatrica Scandinavica* **89**, 416–420.

Forensic Psychotherapy. Crime, Psychodynamics and the Offender Patient. Edited by C. Cordess and M. Cox. *Vol. I. Mainly Theory*. (Pp. 313.)/ *Vol. II. Mainly Practice*. (Pp. 715.) Jessica Kingsley: London. 1996.

This nicely-boxed two-volume work is the product of a publisher who has done much to encourage forensic psychiatry. It is an achievement of excellence, and the theories and explanations that it expounds have a lasting quality. The authors are from a variety of nationalities, disciplines, and belief systems and the editors are to be congratulated for achieving both balance and cohesion. The book is packed full of telling two-liners of the 'When sorrows come, they come not single spies, But in battalions' variety, which have become the signature of one of the editors, to the extent that the whole of his discourse is in danger of becoming an extended quotation.

Not having been in personal therapy I decided to learn what I could about my favourite perversion, sadomasochism. Felicity de Zulueta writes of Fairbairns' interpretation of Freud: that both sadistic and masochistic relationships can be subsumed under the category of a dynamic dinosaur, the death instinct. So far, so good.

Nick Temple begins by warning that forensic psychotherapy presents many difficult tasks, a central one being the powerful counter transference set up in response to the patient's transference. The next sentence is more obscure 'The predominance of sadomasochistic pathology makes this particularly difficult'. It seems then, that my selecting sadomasochism was not pure chance, but why 'particularly difficult', I wondered? Temple explains that through projective identification the therapist comes both to believe that he is sadistic (the cruel internal figure of the patient), and to retaliate sadistically (that harsh internal conscience figure being the patient's superego); transference, and retaliatory counter transference may explain the inherent sadism of some penal institutions, and the exorable treatment of sex offenders; by identifying with the patient's projected submissive and masochistic parts the therapist becomes a victim of the patient's sadism. Phew!

The choice, it seems, is between becoming sadistic in return to the patient (the devil), or masochistic, in accepting the role of victim (the deep blue sea).

There is more to come – sadomasochism is closely connected with that other defence mechanism, projection, which allows the assailant to get rid of a very disturbing and upsetting internal experience into the victim, allowing him (or her) to feel omnipotent and sexually excited by their triumph. Donald Campbell describes this very clearly in his contribution on delinquency in adolescence: the tendency to project internal conflict generates a vicious, self-fulfilling prophesy. We have all seen that happen. In the context of sadomasochism, Campbell also warns of the twin traps of both colluding in a wish to forget the offence, and gratifying the underlying sexual fantasy through a pre-occupation with punishment.

There you have it. Of course, there is even more but to give you the whole story would be stealing others' thunder and you must read it for yourself. That is what psychotherapy is all about.

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