

re-analyse our data in collaboration with Dr Evans and his group (including the alprazolam data) to see whether factor analysis can give us new insight and thereby decrease the fear of illusion. We also hope that the results can be published in this journal.

HAMILTON, M. (1977) Standard criteria for clinical assessment in psychopharmacology. In *Evaluation of New Drugs in Clinical Psychopharmacology* (eds A. Bertelli, G. B. Cassano, P. Castrogiovanni *et al*), pp. 101–105. Barcelona: J. R. Prous.

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The meaning of insight

SIR: Drs Markova & Berrios provide an adequate historical account of the search for a definition of insight (*Journal*, June 1992, 160, 850–860). However, it seems to us that their attempt to be all-inclusive means that their conclusions offer little guidance to the clinical psychiatrist. ‘Insight’ in clinical psychiatry will not mean the same as in philosophy, and need not mean the same as the psychodynamic use of the term to indicate a deep level of self-knowledge. The authors appear to recognise this, and state that “whether insight itself is adequately defined may not be as important as reliably measuring perhaps only aspects of the concept”. Furthermore, they feel that “it would seem appropriate to grade the level of ‘insight’ ”.

In the context of a diagnosed psychiatric disorder, we propose a pragmatic and hierarchical definition of insight whose predictive validity is amenable to testing:

Level 1: the patient is aware of change in perceptual experiences, cognitive processes, emotions, or behaviours

Level 2: the patient has a feeling of disease engendered by these changes

Level 3: the patient gives verbal recognition that the changes causing disease are pathological, i.e. they amount to an illness

Level 4: the patient acts on this in a manner appropriate to his/her intellectual and cultural background by seeking treatment, or complying with treatment, from a psychiatrist.

This schema would seem to us to offer a practical and testable alternative to previous attempts at a clinically useful definition of insight (e.g. McEvoy *et al*, 1989; David, 1990). It accommodates, for example, the patient with a psychotic disorder who develops a delusional system to account for perceived unpleasant changes, and whose insight is therefore assessed at level 2, and the patient with a neurotic disorder who self-deceives by denying the psychological nature of the illness, and whose insight is therefore assessed at level 3.

By qualifying the definition “in the context of a diagnosis of psychiatric disorder” we exclude the purely neurological conditions described by Drs Markova & Berrios. It is possible that the study of these conditions will ultimately cast light on the mechanisms of insight, but they have little practical relevance in routine clinical psychiatry.

DAVID, A. S. (1990) Insight and psychosis. *British Journal of Psychiatry*, 156, 798–808.

MC EVOY, J. P., APPERSON, L. J., APPELBAUM, P. S., *et al* (1989) Insight in schizophrenia. Its relationship to acute psychopathology. *Journal of Nervous and Mental Disease*, 177, 42–47.

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Benzodiazepines with ECT

SIR: In the article by Cohen & Lawton (*Journal*, April 1992, 160, 545–546) they mentioned that they gave electroconvulsive therapy (ECT) using an Ectron duopulse constant-current machine at waveform 2 with a stimulus lasting for 1.5 seconds. In the table about stimulus delivered by machines by Russell (1988), a duopulse machine giving waveform 2 for