reliability between observers for positive and easily defined symptoms is low. While standardised interviews do improve inter-rater reliability, the vast majority of ordinary psychiatric assessment is done on a more *ad hoc* basis and clearly insight is open to misinterpretation in this setting.

Secondly, the concept of pseudo-insight seems an important one. The hermeneutic value of an intellectual explanation of mental illness is important, but the form of an individual's appraisal of his mental disorder seems more significant than the content. Accepting treatment is one aspect of this, but perhaps an allowance needs to be made for the manner in which acknowledgement of medical illness comes about. There is a world of difference between the patient who says "I must be mad because you say so" and the resigned statement "you're right doctor, I'm breaking down again".

A third aspect relates to the psychiatrist's knowledge of mental disorder. His or her knowledge is generally by description (as opposed to by acquaintance). As insight is ultimately a clinical judgement of a patient by a doctor, what happens is for descriptive knowledge to be used to assess an experience that is classified as knowledge by acquaintance. There may not be a problem in this regard, but if knowledge by acquaintance is the route to insight, there seem no grounds on which to contradict a patient who tells his doctor "I have insight" when in reality he does not.

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Reference

KREITMAN, N., SAINSBURY, P., MORISSEY, J., *et al* (1961) The reliability of psychiatric assessment: an analysis. *Journal of Mental Science*, **107**, 887–908.

SIR: We agree with David's contention (*Journal*, June 1990, **156**, 798–808) that insight is best regarded as a multi-dimensional phenomenon. We would support Dr David's view that one such dimension is the ability of the patient to 'relabel' unusual mental events as pathological. However, we take the view that compliance with treatment should be seen not as a dimension of insight, but rather as a related phenomenon – as Lin *et al* (1979) have demonstrated, the correlation between insight and compliance is limited. This suggests that the schedule proposed by Dr David, which allows compliance itself to carry considerable weight, overemphasises the contribution of this variable to the core phenomenon.

The mechanisms underlying diminution of insight remain obscure, but are receiving increased attention. Insightlessness may be regarded as: (a) a normal phenomenon, insofar as many people demonstrate limited awareness of certain characteristics of their personality and behaviour; (b) a defence mechanism (denial); (c) a delusional phenomenon; (d) a feature of the schizophrenic defect state; and (e) a specific defect of cognition.

We have been attempting to operationalise the concept of insightlessness in schizophrenic patients. Given that direct measurement of the components of insightlessness is not possible, our proposed scale attempts to derive an overall measure, based on a semistructured interview. The scale distinguishes between attitudes to overall management and those to compliance with physical methods of treatment. Additionally, the scale permits measurement of behaviour in response to changes in psychopathology, perhaps the most important indicator of insight. An assessment of attitude to previous episodes of illness is included, an element which varies considerably between patients. Allowance is made for those subjects who reject the philosophical concept of mental illness, since it would be inappropriate to necessarily regard those as insightless. The scale measures insightlessness rather than insight, since the former has greater and more relevant clinical utility. (The schedule and score sheet are available from the authors.)

A pilot study of 13 patients fulfilling diagnostic criteria for schizophrenia indicates that scores derived from use of the schedule correlate well with global clinical impressions of insightlessness. In many of these patients, the degree of insight was not obviously correlated with the extent of delusional conviction.

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Reference

LIN, I. F., SPIGA, R. & FORTSCH, W. (1979) Insight and adherence to medication in chronic schizophrenia. *Journal of Clinical Psychiatry*, **40**, 430–432.

AUTHOR'S REPLY: I am delighted that Dr Culliford finds my discussion on insight in accord with his clinical practice. The point about one patient's insight into another's delusions is a fascinating one as it suggests that the basis mechanisms of logical inference leading to a delusional misinterpretation may be