prerequisite definition of insanity. And so the pillars of present-day psychiatry are founded on this quicksand of a concept. From the time of Lewis and Jaspers, the great and the good have in turn struggled to explore and redefine our thinking on insight. The crystallisation of this is contained within the pages of this eminently readable book, which manages to keep its subject grounded while encompassing huge scope.

I found the first edition of this book useful, and the second edition is undeniably an improvement. It is a treat to dip into and out of when one wants to raise one’s head and contemplate just what it is we do day to day. The second edition has been comprehensively restructured and updated, and every chapter shows signs of rework. Most chapters are self-contained and many begin by exploring a definition of insight.

Divided into four parts (phenomenology and psychology; neuropsychology; insight, culture and society; and clinical and personal implications of poor insight), there is balance here and the editors have clearly resisted the temptation to weight the contents too much in favour of the neuropsychological. New chapters include Beck & Warman’s ‘Cognitive insight: theory and assessment’, which adds the weight of heavy guns behind the increasingly popular idea that psychological assessments and treatment have a core role to play in schizophrenia. Also of value in keeping the work grounded are the personal perspectives eloquently portrayed by Frederick Frese and the topical views on mental health law in Ken Kress’s new chapter.

Priced very reasonably, bordering on cheap, and now in paperback with a snazzy health law in Ken Kress’s new chapter.

It is a compliment to the author’s understanding of her subject that the book is written in such a way that it is also very accessible to the person with autism. She writes in a forthright, direct manner without ambiguity. This narrative style allows the reader to gain insight into the way individuals with autism communicate, and provides food for thought about how we, as clinicians and potentially in our personal lives, can adapt our own communication methods when encountering people with autistic-spectrum disorders.

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**Brain Stimulation in Psychiatric Treatment**


There was a time when ‘physical’ treatments in psychiatry implied electroconvulsive therapy (ECT) and psychosurgery, but during the past 20 years some alternatives have been developed. The aspirations are that the new treatments are less invasive or reversible, and result in fewer side-effects while being as efficacious.

Transcranial magnetic stimulation (TMS) is the best-known of these methods and there is a growing body of research trial data in depression and schizophrenia. It is thought to work by inducing subconvulsive electrical activity in brain areas of interest. Magnetic seizure therapy (MST) is a logical development of TMS and uses focal magnetic fields to induce seizures in the anaesthetised patient. The localised application and the use of magnetism rather than electricity are seen as possible benefits over ECT. Deep brain stimulation (DST) requires the implantation of electrodes in the brain area of interest which are connected by wires to a pulse generator implanted subcutaneously in the chest wall. In the field of psychiatry, DST has so far only been used to treat a handful of people with intractable obsessive-compulsive disorder. Vagus nerve stimulation (VNS) was first developed as a treatment for intractable epilepsy, but its use has now been