disorder', Lewis & Appleby (1988) comment on the difficulty inherent in defining mental illness. Indeed, this issue is crucial as regards the nosological status of personality disorder. DSM–III (American Psychiatric Association, 1980) does not offer a concise definition of mental illness, but the "conceptualisation" offered in the Glossary of Technical Terms makes it difficult to exclude PD if that diagnostic and classification system is used, viz.: "A mental disorder is conceptulised as a clinically significant behavioural or psychologic syndrome [Parameter 1] ... associated with ... impairment in one or more areas of functioning [Parameter 2] ... not only in the relationship between the individual and society [Parameter 3]." Trait cluster techniques satisfy the first parameter, and impaired interpersonal relationships, the second. Parameter 3 is an expedient rider that permits the exclusion of "voluntary" criminality and political agitation. The classic concept of psychopathy (DSM–III category 301.7, Antisocial personality disorder) qualifies as a mental disorder on these grounds.

The key to possible solution is referred to by Blackburn (1988) in his review of the moral implications of the psychopathy concept. He notes that the DSM–III requirement that clinicians make diagnoses on both Axis I (clinical syndromes) and Axis II (personality disorders) makes it explicit that different criteria are involved in these two sets of disorders, and that symptoms of major syndromes differ in kind rather than degree from the traits that define personality disorders. However, DSM–III makes no allowance for this, as only one tentative definition of mental disorder is offered. Criteria that are arguably appropriate for the definition of *intra*personal mental disorders, as per the traditional medical model, inappropriately subsume *inter*personal disorders, better understood using a bio-psycho-social model. Personality disorder is a diagnosis given to an individual, yet it relies on external referents (other persons) to become manifest. A mental disorder should result in distress or disability in an affected individual when he/she is observed in social isolation. One possible discriminator would be the 'Desert Island Test', i.e. a statistically valid syndrome must reliably result in distress or disability if a putatively affected individual were to be marooned alone on a desert island. This test would exclude PD from being classified as a mental disorder. Were he a candidate for the PD label, Robinson Crusoe would have only shown signs of disturbance once Man Friday appeared. In keeping with the empiricism underpinning DSM–III, PDs should be relabelled 'Interpersonal disorders', and their nosological status considered more akin to the V Codes (conditions not attributable to mental disorders that are a focus of attention or treatment) than to the clinical syndromes.

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SIR: Blackburn (*Journal*, October 1988, **153,** 505–512) contends that "the current concept of psychopathic or antisocial personality remains 'a mythical entity'." Although I find myself in agreement with the author's assertion that a psychiatric syndrome defined largely or entirely on the basis of social deviance (e.g. DSM–III antisocial personality disorder) is likely to be aetiologically heterogeneous, I find the empirical basis for several of his arguments concerning the nosological status of primary (i.e. Cleckley) psychopathy wanting.

Blackburn asserts that: (a) the evidence for the construct validity of Cleckley's (1976) criteria for psychopathic personality is relatively weak and inconsistent, (b) Cleckley's criteria include items tapping both personal and social deviance, and thus define a 'hybrid' construct; and (c) Cleckley's criteria do not identify a homogeneous group of individuals. Below I address each of these points in turn.

(a) Despite Blackburn's contention that the accumulated research suggests that Cleckley's psychopathic personality "remains a speculative construct" (p. 505), it could be argued that the laboratory findings concerning primary psychopathy are as replicable and coherent as that for any psychiatric disorder. For example, primary psychopaths have consistently been found to exhibit poor passive avoidance learning, diminished spontaneous skin conductance fluctuations, a slow recovery rate of the electrodermal response, slow electrodermal classic conditioning to aversive stimuli, diminished electrodermal and augmented cardiovascular activity to impending aversive stimuli, and excess theta waves during resting EEG (Hare, 1978; Lykken, 1984).

Moreover, many of these findings appear to accord well with a physiological model of diminished behavioural inhibition (Fowles, 1980).

(b) Blackburn is correct in stating that Cleckley's criteria comprise items tapping both personal and social deviance. Nevertheless, Cleckley's criteria are weighted heavily in the direction of personality characteristics, and the extent to which the presence of a few social deviance items results in aetiological heterogeneity remains an empirical question. Although there is admittedly little research on this issue, the results of at least one investigation suggest that Cleckley-defined psychopaths with relatively low rates of social deviance resemble those with higher rates of social deviance on a number of psychometric, clinical, and familial variables (Widom, 1977).

(c) The only evidence that Blackburn cites in support of his third contention is a cluster analysis (Blackburn & Maybury, 1985) in which criminals satisfying Cleckley's criteria fell into two groups, both characterised by a lack of empathy and affection, but differing in their degree of aggression and impulsivity. Nevertheless, heterogeneity at the phenotypic level does not preclude homogeneity at the genotypic level, and there is no evidence that these two clusters are distinguishable on external or biological validating variables. Moreover, as the authors themselves point out (p. 385), the less impulsive and aggressive group was considerably older, raising the possibility that the two clusters were an artefact of the decline of psychopaths' criminal behaviour with age. This 'burn-out' phenomenon has recently received empirical support (Hare *et al*, 1988). Finally, Blackburn points out that because some of Cleckley's criteria overlap with those of several DSM–III personality disorders (e.g. histrionic and narcissistic), Cleckley's construct is probably broader than that of antisocial personality disorder. Although this may be the case, this does not necessarily imply that Cleckley's construct is aetiologically heterogeneous. An equally plausible alternative is that the DSM–III taxonomy of personality disorders has failed to "carve nature at its joints", and that a single diathesis underlies several Axis II syndromes (Lilienfeld *et al*, 1986).

By referring to psychopathic personality and DSM–III antisocial personality disorder as "synonyms" (p. 505), Blackburn may unintentionally give readers the mistaken impression that the former is generally operationalised in terms of socially deviant behaviour. In fact, the most influential criteria sets for psychopathic personality, particularly that of Cleckley, rely primarily on personality characteristics, and are thus largely immune from the criticisms that Blackburn raises. Moreover, Cleckley's criteria yield a syndrome with theoretically meaningful and well replicated psychophysiological correlates. Finally, Blackburn's assertion that individuals identified on the basis of Cleckley's criteria are aetiologically heterogeneous has yet to be demonstrated. Thus, Blackburn's proclamation that the concept of psychopathic personality is "ill-conceived" and "should be discarded" (p. 511) is premature and misleading.

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Positive Symptoms of Schizophrenia

SIR: We are pleased that our paper suggesting an approach to the neuropsychology of schizophrenia (Frith & Done, *Journal*, October 1988, **153**, 437–443) has proved a stimulus sufficient to drive some to put pen to paper. Lo (*Journal*, March 1989, **154**, 414–415) has presented a most interesting account of certain ways in which the dopamine system might break down in psychosis. Since, however, he does not relate these mechanisms directly to symptoms, we feel unable to give useful comments on his account.

As is only to be expected, most writers have readily identified the weakest part of our account, as regards the positive symptoms of schizophrenia. We can explain quite well positive symptoms concerning action (e.g. delusions of control, passivity experiences), but not nearly as well, symptoms concerning communication (delusions of reference, third person