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Preconscious perceptual processing

SIR: Fleminger (*Journal*, March 1992, **160**, 293–303) has argued that abnormal perceptual processing is the cause of delusional misidentification. But a closer look suggests that a failure of preconscious processing underlies *all* perceptual experiences in which the subject makes a faulty interpretation of an external stimulus. Fleminger's argument applies equally to illusions, sensory distortions, delusional misinterpretations and delusional perception.

The traditional distinction between these experiences relies on the notion that the 'properties' or 'qualities' of an object are perceived in a different way to the 'identity' and the 'meaning' of the object. But this is mistaken. As Fleminger notes, perception is an active process of interpretation of stimuli. The ascription of meaning is an integral part of perception. Abnormalities of perceptual processing can occur in 'bottom-up' processing (incoming information) and 'top-down' processing ('expectancies' that predispose the subject to make a particular interpretation). Abnormalities of both kinds contribute to misperceptions.

Psychiatric disorders commonly influence 'top-down' processing. Illusions can arise from 'top-down' abnormalities of mood. For example, a person who is anxious may hear footsteps instead of the rustle of leaves. Sensory distortions can arise from 'top-down' alteration of the perceptual threshold. For example, a patient with hypomania may experience colours with unusual vividness. Delusional misinterpretations can arise from 'top-down' abnormalities of belief, for example, a patient with delusional jealousy may 'see' semen stains on the sheets. Similarly, delusional perception is an abnormal perceptual interpretation which arises from 'top-down' abnormalities of belief and emotion in delusional mood.

We all interpret, and misinterpret, using preconscious perceptual processing. Misinterpretation exists on a continuum encompassing normal experience and pathological symptoms. What distinguishes pathological from normal, perhaps, is not so much that a misinterpretation occurs, but that in 'normals' the misinterpretation is isolated and easily recognised and corrected. At the other extreme, schizophrenia causes such a pervasive abnormality of perceptual processing that all varieties of misinterpretation occur, and keep on occurring.

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Reconquest of the subjective

SIR: In his recent article, van Praag (*Journal*, February 1992, **160**, 266–271) defends the realm of the subjective in psychiatry against prevailing exclusively objective approaches. He strongly opposes the view that the notion of the 'subjective' has come to mean "a qualification incorrectly used as a substitute for 'vague' or 'undefined'" (p. 268), i.e. has become "synonymous with non-operationable, non-measurable, non-quantifiable – a symbol of soft science at best" (p. 268). While we agree with Dr van Praag that subjective symptoms are important for psychiatric theory and practice, we think that his point is blurred by his imprecise and ill-defined concept of the subjective. A clearer conception of the subjective would, we believe, significantly strengthen Dr van Praag's thesis.

According to Dr van Praag, symptoms can be called 'subjective' for two reasons: (a) they are "diffuse" (p. 268) and "confined to the patient's experiential world, not expressed in objective behaviour, and 'atmospheric' rather than 'factual' in nature, that is, not manifesting themselves as delineated mental phenomena and not verbalised as such" (p. 267); (b) they are conceptualised in the mind of the interviewer/observer by means of interpretation (cf. p.268).

It is apparent from the quote (as well as from the given examples) that the first criterion restates the view that the author is opposing in the first place, i.e., that 'subjective' has come to mean something vague, unreliable, soft, unclear, and non-clarifiable (and hence, something which has no place in science). Dr van Praag obviously sees the degree of 'delineation' of mental phenomena as a criterion for their degree of subjectivity. This can further be inferred by his introduction of the category of quasi-symptoms, i.e. symptoms which have not yet been properly operationalised.

If theoretically driven 'constructs' and inferences made by the observer about what is observed are a criterion of the subjective, then all science is subjective. Hence, Dr van Praag's second criterion of the 'subjective' is at best misleading.