diagnosed as 'schizophrenics' for more than a decade. Both of them had multiple suicide attempts, self-mutilations, were unemployed, and had numerous psychiatric admissions. After their correct diagnosis of MPD, both patients are again working and are finally coping with their lives in an adequate way.

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AUTHOR'S REPLY: Drs Novello & Primavera find historical and anthropological parallels with secondary personalities. Their observations are of interest. Dr Fraser, on the other hand, wishes to reject historical data, while Dr Putnam offers Hacking's 19th century cases to prove the existence of MPD in Britain. The additional British cases were the patient of Dyce (Dewar, 1823) and those of Dunn, Ward and Browne. Dyce's patient reflects the quite conventional trance states of the period and the other three, as documented by Hacking (1992), are similar. Hacking presents them to emphasise the 'cascade' effect whereby one report in the literature in turn produces several more – just like today.

Dr Putnam asserts that it is specious not to explain why two or more alter personality states should be so tractable to suggestion or contamination effects. Hysterical symptoms are so notoriously prone to suggestion that Babinski even wanted to change the name to Pithiatism, meaning an illness due to a suggested idea (Babinski & Froment, 1981, p. 26). Hypnotism is institutionalised suggestion and, even if he is not using hypnotism, Dr Putnam overtly recommends procedures which are an open invitation to his subjects to dissociate into secondary personalities. Not surprisingly, once the breach is made, patients and practitioners feel free to enlarge the numbers. From her original three, sanctioned by her doctors, Eve went on to 22. The practice hardly existed at first, and now has the approval of DSM–III–R for up to 100 'personalities' or fragments thereof. Dr Putnam is a leading member of the committee which recommended this and seems to accept the result as realistic.

The lurid popular accounts seem to me to be quite close to the position which Dr Putnam adopts with lots of 'personalities' occurring in only one person. Fraser (1991) bases part of his techniques on one of them, Billy Milligan. There is a more important issue in this respect, in that when the consequences of the current definition seem to be under pressure, we are offered a new formulation, which talks about interventions directed "towards specific alter personality states associated with pathological behaviours", gliding away from the reified constructs with which the behaviour is propagated, although even this latest formulation could still hardly come into being without the DSM–III–R concept.

Dr Fraser suggests that making an alternative diagnosis would leave out dissociative symptoms and provide "absolutely no management of the trauma . . ." This assumes that some aspect of a case has to be in the diagnosis in order to be treated. We need only look at concern with suicidal ideas, which rarely figure in a diagnostic label, to realise the *non sequitur*.

Dr Putnam defends the scientific standards of modern MPD by reference to "increasingly sophisticated studies, published in reputable journals". If that is a logical position, we should never submit another article to a reputable journal in order to correct or advance previous positions. Tom Fahy (1988), in his critical paper in this journal, found little value in that literature and, in my reading, it has not changed. We need not dispute that the "syndrome" can be found reliably with agreed criteria. An actor's performance of specific parts will be highly reliable repeatedly, in front of hundreds of people, but will not establish a fictional character as an individual who lives or who has lived. Nor can the problems of other diagnoses release the proponents of MPD from their difficulty.

I pointed out in my article, ". . . it is reasonable to reject those diagnoses which most reflect individual choice, conscious role playing, and personal convenience." The conditions which Dr Putnam cites as receiving media attention, were all recognised repeatedly before now and have not been found to be misleading initial creations, as I have found MPD to be (which does not mean that some, such as anorexia nervosa, are unlikely to be increased by publicity). Dr Putnam's claim that MPD is not created by reading *Sybil* or seeing *Eve*, can be left to readers to

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evaluate, taking note that at least the dramatised stories of Eve were presented as truthful expansions of Thigpen & Cleckley's 1954 article.

Dr Putnam raises a more interesting dilemma with regard to hallucinations in schizophrenia. Careful practitioners try to elicit hallucinations indirectly, or merely to confirm what has been reported independently and spontaneously. The nature of hallucinations, if declared, is tested by non-directive questions, for example, about content and the nature of the voices. With ruminations – as perhaps everyone agrees – the problem is not suggestibility, but a lack of it combined with reticence. In substance, the elicitation of MPD is irremediably flawed. I would again draw the attention of the reader to Dr Putnam's description of his procedure. To me, it reads much like the interview in Spanos *et al*'s (1986) experiment which Dr Fraser says is non-standard. When Dr Putnam does not get a direct acknowledgement of feeling like more than one person, he asks the patient, "Do you ever feel as if there is some other part [side, facet, etc.] of yourself that comes out and does or says things that you would not do or say?" or "Do you ever feel as if you are not alone, as if there is someone else or some other part watching you?" He also recommends that, in certain circumstances, a clinician can ask whether it would be possible to meet with another part. "Can this other part come out and talk with me?" Spanos asked his intended artificial subjects to play someone called either Harry or Betty who is accused of murder and is going through a full psychiatric interview. Subjects were told the following, "I've talked a bit to Harry (Betty), but I think that perhaps there might be another part of Harry (Betty) that I haven't talked to, and I would like that other part to come to talk to me. Would you talk to me, Part, by saying 'I'm here'?" This was taken from a direct report of the interrogation of an accused (and subsequently convicted) murderer. The subjects were further asked:

(a) Part, are you the same as Harry/Betty, or are you different in any way?
(b) Tell me about yourself.
(c) Do you have a name I can call you by?
(d) What is your function within Harry/Betty?" etc.

I do not understand how Dr Fraser can suppose that there is not a great similarity between these two procedures, apart from the fact that one was understood to be experimental. I might also note that Dr Putnam (Putnam, 1989, p. 86) approves of another extreme technique, that of Richard Kluft, who stresses suspected MPD patients by extended interviews of several hours. Dr Fraser (1991) himself recommends hypnosis, or that patients be invited to imagine being at a table with empty chairs and to fill the chairs with their other personalities. All this speaks for itself in terms of the overt message that is being given to the patient and the degree of suggestion which distinguishes this label from others.

Currently, neither Dr Putnam nor I can predict the survival or demise of MPD, but it is salutary to recall that, at the end of the 19th century, MPD extended prominently to spiritism (see Hacking, 1992) which declined into scientific disrepute because of the excesses of its supporters. This risk is inherent in a diagnosis which is driven by enthusiasm and unrestrained by realistic limits.

Like Drs Fraser and Putnam, Drs Martínez-Taboas & Francia have overlooked my relativist position about diagnosis (Merskey, 1986) to which I drew explicit attention in my *Journal* article. But a relativist position does not mean that all conceptual elaborations have the same value or utility. Drs Martínez-Taboas & Francia are, of course, to be congratulated on the good results they have obtained after rescuing two patients from a wrong diagnosis, as I hope they will congratulate others on improved treatment after the re-diagnosis of supposed MPD.

My most important point in this discussion has remained unchallenged. If MPD is so very susceptible to artificial production, how can we ever know that it is veridical? We cannot, but since we now may recognise that those early cases, which might have been credible MPD without the help of suggestion, are also either immensely unreliable, or clearly something else, there is no point in this magical, doxogenic diagnosis.

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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.

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