Although it is far beyond the scope of this brief commentary to present a comprehensive view of what may be called a proper account of the meaning of 'subjective', it must be mentioned that Descartes' distinction, though frequently attacked, still underlies most of our concepts and differentiations relevant to the point in question. The difference between 'signs' and 'symptoms', for example, is based on the fact that there is a large difference between my pain and anybody else's pain, as well as between pain and pain behaviour. Contrary to what some Wittgensteinian philosophers want to make us believe, we all have an intuitive grasp that our sensations and thoughts are accessible to us in a different manner than they are to somebody else. In fact, the clinician – whether practising internal medicine or psychiatry – is particularly aware of this difference. Every clinician struggles against this 'epistemological barrier' when trying to obtain a clear picture of any particular symptom.

Just as pain remains a (subjective) symptom when rated on a scale by the patient or by the observer, hallucinations and delusions remain (subjective) symptoms. Moreover, talking about pain or hallucinations does not make the pain or hallucinations intersubjectively more accessible. Their presence has merely been communicated. For example, why are we suspicious of studies claiming to have successfully 'treated' patients with auditory hallucinations by negative reinforcement using self-administered electric shocks? Obviously, because we distinguish not reporting hallucinations from not experiencing them. In short, neither rating a symptom, nor talking about a symptom, 'objectifies' it.

In our view, the acceptance and proper appreciation of the patient as experiencing subject is important to psychiatry and to medicine in general. The view that 'subjective' means 'atmospheric' or 'not delineated' does not help to achieve this goal. Nor does the relating of 'diffuse' and 'subjective' help in getting rid of the diffuseness. Only a clarified concept of the subjective as the realm of what is actually experienced by the patient, in Dr van Praag's words, will help to "expand and refine diagnostic concepts and corresponding psychometric instruments" (p. 270). Without a clear view of the subjective, "we end up with a severely coarsened psychiatry obsessed with the obvious [and] detached from the experiential realm" (p.270).

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AUTHOR'S REPLY: My remarks on subjective psychopathological phenomena were pulled out of context by my critics. I reasoned that the prevailing psychiatric classification system based on the DSM–III caters to an overly objective approach, neglecting the realm of the subjective experiences. In that context I described subjective phenomena as those that are confined to the patient's experiential world, not expressed in observable behaviour, and 'atmospheric' rather than 'factual' in nature, that is, not manifesting themselves as delineated mental phenomena and not verbalised as such. Hence, they are largely disregarded in the present psychiatric taxonomy. I did *not* state that the degree of 'delineation' of mental phenomena is a criterion for their degree of subjectivity, nor did I infer such opinion in my exposition on quasi-subjective symptoms.

A second group of psychopathological phenomena I called subjective are those that are not communicated by the patient as such, but are inferences made by the observer/interviewer – "concepts" construed by incongruous observations. As an example I mentioned the meaning of a particular type of behaviour or utterance. I did *not* state that theoretically driven constructs are per definition subjective.

My paper did not, by any means, pretend to give a definitive description of the term 'subjective', yet my definition of what is nowadays called 'subjective' in (research) psychiatry seems to me accurate. The dissertation of Drs Spitzer and Schwartz does not provide evidence to the contrary.

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Guilt or morbid remorse?

SIR: In their interesting discussion of the phenomenology of psychological guilt (*Journal*, June 1992, **160**, 781–787), Berrios *et al* appear to use the word 'remorse' either as a defining component of the phenomenon or as a synonym. I would submit that these words have a different meaning; 'guilt' implying a consciousness of having committed a wrong, and 'remorse' implying an emotion of regret for the consequences of the wrongful act. I would further submit that the term 'morbid remorse' is a more accurate description of what is encountered in major depression.

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