Schizophrenia Bulletin vol. 34 no. 6 pp. 1200–1210, 2008
doi:10.1093/schbul/sbm136
Advance Access publication on January 3, 2008

The Concept of Psychosis: Historical and Phenomenological Aspects

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The historical development of the concept of psychosis and its increasing differentiation from the neuroses up to the modern classification systems, *Diagnostic and Statistical Manual of Mental Disorders* and *International Statistical Classification of Diseases*, is initially presented. In portraying this development, the struggle surrounding the clinical relevance of concepts on the one hand and their reliability and validity on the other are reflected. Thus far, diagnostic reliability has primarily been improved by focusing on externally observable symptoms in connection with expression and behavior. The identification of disease-specific symptoms, however, is principally achieved through the differential description of subjective experience. How this experience is to be explored and assessed remains for the most part unclear. With reference to its founder Karl Jaspers, the phenomenological method is presented as the decisive instrument for the assessment of experience. It is shown that a return to the legacy of phenomenology and a reformulation of the long-standing question concerning the specific symptoms of the schizophrenic psychosis are currently in progress. The revival of historical knowledge and a focus on direct clinical phenomena continue to provide inspiration for further advancement in modern psychiatry.

Key words: psychosis/neurosis/history/phenomenology/schizophrenia/specific symptoms

Introduction

At the start of the 20th century, Jaspers introduced the phenomenological method to psychiatry and laid the foundations for the scientifically grounded diagnostics and nosology which have permeated modern classification systems. In Germany, the phenomenological line of research dominated up to the middle of the 1970s, before being displaced by a more biologically oriented psychiatry. Although considerable progress has been made over the last few decades with respect to the therapy of mental illnesses (in particular for psychoses) and insight into their biological underpinnings, research has continued to visibly reach the limits of its own nosological premises. *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) and *International Statistical Classification of Diseases* (*ICD*) have above all contributed to an improvement in the reliability of psychiatric diagnostics and helped to abolish the "Babylonian confusion of tongues" which had prevailed in the field. Nonetheless, guidelines based on disease-specific symptoms continue to be necessary for an adequate systematization of the wealth of neurological findings which range from molecular genetics to functional and spectroscopic imaging. While current diagnostics are modeled on symptoms relating to expression and behavior, the differentiated assessment and description of subjective experience has led to increasingly sophisticated and specific diagnostics over the course of history. The phenomenological method is the prerequisite for the assessment of pathologically modified experience. Through the incorporation of historical knowledge and continual clinical application, this method can potentially further refine and deepen diagnostics and clinical competence.[1,2] It is hoped that the current call to reconsider the legacy of phenomenology will provide new momentum in psychopathological and biological research.[3–6]

The present article will trace the historical development of the concept of psychosis up to modern-day classification systems. In appreciation of the significance of the subjective experience in psychopathology and nosology, this will be followed by a description of Karl Jaspers' phenomenological method including the philosophical roots and the reception of the method. The article concludes with a kaleidoscope-like portrayal of the current significance of the method in the search for specific symptoms of schizophrenia in positive, negative, early, and core symptoms.

The History of the Concept

Origin and Attempts at Differentiation

In 1841, Canstatt[7] introduced the concept of psychosis into the psychiatric literature, a concept which he used

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synonymously with the term *psychic neurosis*.[8] While the concept of neurosis was initially used to refer to all diseases of the nervous system,[9] Canstatt thus emphasized the psychic manifestation of a disease of the brain.[10,11] For a considerable length of time, Feuchtersleben[12] was credited with first employing the term psychosis in 1845. In using psychosis as a synonym for psychopathy, Feuchtersleben emphasized both the change in the entire personality and the interaction between physical and mental processes. It was not until 1891 that Koch[13] narrowed down Feuchtersleben's broad conceptualization of psychopathy to the *psychopathic inferiorities*, which he considered to be equally subject to congenital and acquired influences and which were later termed *abnormal personalities* by Schneider.[14] Canstatt and Feuchtersleben viewed the etiology of psychoses as lying in a somatic weakness of the brain on the one hand and in a psychic vulnerability on the other. The precedence of an organic neurological basis, as formulated by Friedreich[15] in 1836, explains the continued classification of psychoses as neuroses up to the end of the 19th century. Through the introduction of the concept of psychosis, however, psychic pathology became increasingly viewed as a discrete entity.

In the second half of the 19th century, the term psychosis was widely used, although it continued to be applied as a synonym for terms such as *mental disorder*, *mental illness*, and *insanity*. In 1859, Flemming[16] took up the term and used it to refer to both mental disorders with identifiable organic findings and disorders of the soul which were assumed to have an organic cause. In 1877, Flemming[17] increased his accentuation of psychic pathology rooted in the organic. To begin with, the nosological focus remained upon that which Möbius in 1875 referred to as endogenous psychoses and covered the spectrum of hysteria, melancholy, mania, and paranoia.[18] It was exclusively in light of etiological aspects that Möbius[19] distinguished between exogenous and endogenous psychoses in 1892. Möbius, Kraepelin, and Jaspers in his early years used the term *exogenous* to characterize the causation of mental disease through any extraneous influence, whether somatic or psychic in nature. Between 1908 and 1918, with his concept of the *exogenous reaction types*, Bonhoeffer[20,21] took the decisive step in defining the exogenous. In his principle of unspecificity, Bonhoeffer ascertained that a psychic syndrome is not specific to a particular physical illness, but rather that a multitude of different physical diseases lead to highly similar psychic syndromes. With Bumke's[22] equation of exogenous and somatogenic in 1924, the term officially received the meaning which has remained valid up to the present day.[23]

While Möbius ascribed endogenous psychoses to a hereditary-degenerative cause, Griesinger had already described mental illnesses as diseases of the brain back in 1845. At the same time, Griesinger pointed out that it was not yet possible to name specific anatomical causes or to reduce the experience of the affected individual to somatic causes.[24] Since the work of Schneider, endogenous has been understood as meaning that while the somatic cause of a psychosis is not identifiable, it is strongly assumed to exist on the basis of the psychopathology on display.[25] Kraepelin and Bleuler subdivided endogenous psychoses into manic-depressive and schizophrenic disorders based on the course of the disease.[26,27] The term *schizoaffective psychosis*, introduced by Kasanin[28] in 1933, reflects the acceptance of intermediary schizoaffective disorders, in which the symptoms of schizophrenia and affective disorders mingle. Selecting a narrow interpretation of schizophrenia which centers on negative symptoms, as in the case of Kraepelin and dementia praecox, results in an expansion of the schizoaffective spectrum, whereas a broad conception of schizophrenia, as adopted by Bleuler and Schneider, results in a narrowing of the schizoaffective spectrum.[29] This touches upon the notion of a unitary psychosis, a concept which can be traced back to the German psychiatrist Zeller and the modified versions of which continue to be of clinical and conceptual relevance up to the present day.[30] Unitary psychosis connotes an absence of psychopathologically ascertainable nosological entities and points rather to a wide variety of disease variations which merge in all directions. The idea of a unitary psychosis thus opposes the concept of natural nosological entities or multiple and distinguishable psychoses which show individual symptomatology, etiology, and course.[31,32]

In conclusion, it can be maintained that somatogenesis is of primary interest in the case of the exogenous psychoses. Psychic pathology remains for the most part unspecific in the etiology of the psychosis and is therefore of little significance. In the case of endogenous psychoses, a somatic pathogenic process is not verifiable but increasingly focused upon beginning with Kraepelin and continuing through the successive Heidelberg school including Jaspers and Schneider.[26,33] While Canstatt, Feuchtersleben, and Flemming's concept of psychosis emphasized the psychic manifestation of an organically based neurosis, psychic pathology now becomes a manifestation of somatic etiology. The concept of psychosis thus converges with the original meaning of the term neurosis.[34]

The Influence of the Concept of Neurosis

The change in meaning of the term psychosis further resulted from the changing concept of neurosis, the meaning of which was inverted through developments in the fields of neuropathology and psychoanalysis. It was initially progress in the field of neuropathology and the discovery of new somatic pathological causes of disease which in the second half of the 19th century led to an increasing constriction of the concept of neurosis to purely psychogenic disorders. It was the period in

which, for example, *Binswanger's dementia*, *Pick's* and *Alzheimer's disease*, *multiple sclerosis*, *neurosyphilis*, and *diseases of the thyroid gland* were discovered and described. Expressions such as *vasomotoric*, *trophic*, *traumatic*, *epileptic*, or *tetanic neurosis* visibly disappeared from neurological and internal specialist terminology. In Strümpell's Manual of Internal Medicine from 1887, the neuroses finally reverted to the definition of *a disease of the nervous system with no known anatomical basis*.[35]

It was, however, discoveries made within psychoanalysis that were of decisive importance for the change in meaning of the term "neurosis." Clinical investigations of hysteria carried out by the French neuropathologist Charcot from the 70s of the 19th century onward led, in the face of a manifold of hitherto inadequately differentiated symptoms, to the establishment of a distinct nosological entity. Although diagnoses were made on the basis of psychic symptoms, Charcot assumed a degenerative etiology in the form of a mental weakness. In contrast, Freud's psychoanalysis resulted from changing social and intellectual conditions which focused on the individual with his/her social involvement and biographical development as well as on the disorders ensuing from these factors.[36] While he was inspired by Charcot's work in embarking upon his investigations of hysteria, Freud[37] (1895) went on to delineate the significance of the individual biography and sexuality in the etiology of the hysterical neurosis. The change in meaning of the term neurosis was completed when, after the year 1924, Freud[38] ceased using the term *narcissistic neurosis* to refer to psychotic illnesses such as dementia praecox, paranoia, and melancholia. Since then, the term neurosis has focused upon psychic pathology and psychogenesis. An unresolved childhood conflict is restimulated by a specific trigger situation. The emerging symptoms are considered to be a symbolic expression of the unconscious intrapsychic conflict and a compromise between desire and defense.[39]

The Dichotomy of Neurosis and Psychosis

Jaspers[40] summarized the above-described development in the first edition of his *General Psychopathology* in 1913. The dichotomy of psychosis and nonpsychosis or neurosis went on to form the foundation of psychiatric nosology. While psychoses are always the result of somatic illnesses and are therefore a *process*, neuroses have psychological biographical causes and are therefore a *development* on a continuum with health. The dichotomy of process and development was followed by a dichotomization of methods, natural scientific *causal explanation* of psychoses on the one hand and *psychological comprehension* of neuroses on the other. Psychoses are not comprehensible but only explainable. The strict separation of methods facilitated clear differential diagnosis. Within each of the 2 groups, only a differential typology was possible. Schneider[41] later went on to extend this nosological dichotomy into a triadic system by more strongly distinguishing between an exogenous and an endogenous type.

With his conception, Jaspers enforced clear diagnostic distinction and demanded accountability with respect to the methods applied for the very first time in the history of psychiatry.[42] This concept of differential diagnosis, which allowed a clear prescription of therapeutic measures, formed the basis of Jaspers' now almost obsolete hierarchical principle. This principle was described by Jaspers in the first edition of his *General Psychopathology* in a chapter on the *Classification of Psychoses*: "Pathological symptoms are layered like an onion, with degenerative symptoms (primarily the psychopathies, but also Kraepelin's manic-depressive insanity) forming the outmost layer, moving inwards to the process symptoms (schizophrenias) and finally the innermost layers comprising organically based symptoms. The deepest layer reached in the course of examining an individual case is decisive. What initially appears to be a case of hysteria turns out to be multiple sclerosis, suspected neurasthenia is actually paralysis, melancholic depression a process."[40(p267)] Jaspers' approach profited in precision from the continued exchange of ideas with Schneider and was later extended beyond psychoses to incorporate the entire spectrum of psychiatric nosology in a chapter on *Diagnostic Scheme*.[43(p512)] For Schneider,[41] just as for Huber[44] in the present day, it was the layer with the deepest biological roots in the successive layers, *psychopathic-neurotic*, *depressive-manic*, *schizophrenic*, and *psycho-organic*, that was of crucial importance for diagnosis and therapy. Current versions of the *DSM* and *ICD* classification systems continue to be modeled—both in their structure and their diagnostic exclusion criteria—on the nosological hierarchy proposed by Jaspers and Schneider, although they no longer propagate a hierarchization of diagnoses. An abstention from clinical weighting of individual diagnoses in the conception of comorbidity only appears to be possible; its significance is regained, at the latest, in the selection and weighing up of therapeutic approaches.

According to Baeyer,[45] Schneider's successor as head of the Heidelberg University Psychiatric Clinic, the concept of the fundamental incomprehensibility of psychoses resulted in the very Jaspers' theorem which steered research onto a biological track and which led to the segregation of psychotherapy from German psychiatry. While in 1913 Jaspers still acknowledged the significance of psychoanalysis in comprehending and treating neuroses, he later increasingly criticized the over expansion of the concept of comprehension in the case of psychoses, as well as the speculative and ideological character of psychoanalytic theory development.[46] Following the Second World War, independent psychosomatic clinics were thus

established outside of psychiatry.[47] According to the Heidelberg school and later Schneider, psychotic symptoms were a diagnostic indication of biological etiology.[41,48,49]

More Recent Developments

The dichotomy between neurosis and psychosis prevailed in nosological classification up to *Diagnostic and Statistical Manual of Mental Disorders, Second Edition* (*DSM-II*)[50] and *International Statistical Classification of Diseases, ninth Revision*.[51] This was, however, due less to the influence of Jaspers and Schneider than to the impact of psychodynamic influences on American psychiatry after the Second World War.[47] Indeed, the diagnostic hiatus between neurosis and psychosis which had been established by Jaspers and Schneider disappeared in the face of the somewhat simply stated belief that psychoses represented a particularly grave form of neuroses and were to be seen as reactions.[52,53] The concept of psychosis was broadly defined and targeted in *DSM-II* above all the severity of functional impairment, for example, at work, in interpersonal relationships, or in caring for oneself. In the transition from *Diagnostic and Statistical Manual of Mental Disorders, First Edition*[54] to *DSM-II*, the concept of neurosis was employed in a more inflationary and what can be consequently seen as a more arbitrary manner. The formerly independent conversion and dissociative reactions were in *DSM-II*, for instance, subsumed under the heading of hysterical neurosis.

Diagnostic and Statistical Manual of Mental Disorders, Third Edition (*DSM-III*)[55] emerged in 1980 as a result of attempts to validate various diagnoses on the basis of substantive research evidence and above all to increase reliability by replacing previous etiological premises with descriptively developed, standardized research criteria.[56–58] The concepts of psychosis and neurosis were almost completely discarded. In working on the *International Statistical Classification of Diseases, 10th Revision* (*ICD-10*) classification, Cooper[59(p22)] remarked in 1989 that "the differentiation between psychosis and neurosis as a fundamental organizing principle has been abandoned."

From this point onward, the noun *psychosis* was limited to its adjectival form *psychotic*. In 1994, in *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*),[60] the chapter *Schizophrenia and Other Psychotic Disorders* subsumed a number of disorders in which psychotic symptoms dominate. In addition, other disorders, such as delirium, dementia, and major depression, can be accompanied by psychotic symptoms. Psychotic refers primarily to symptoms such as delusion and hallucinations. In the case of *schizophrenia*, the *schizophreniform disorder*, the *schizoaffective disorder*, and the *brief psychotic disorder*, additional symptoms including disorganized thinking or catatonic behavior can occur. The diagnosis of schizophrenia is primarily made on the basis of disturbances of expression and observable behavior. A-criterion such as delusion (A1), hallucinations (A2), disorganized thinking (A3), disorganized/catatonic behavior (A4), and negative symptoms (A5) are not viewed as significant unless accompanied by occupational or social dysfunction. The B-criterion thus stipulates clear functional impairment. The focus on observable indications and limitations certainly increases agreement among investigators.[61,62] Nonetheless, it remains unclear how the subjective experiences, including the psychotic experience, of the patient are to be explored and assessed by the investigator. It is the view of the author that a loss of validity is to be expected when the method used to assess subjective experience is not reflected upon, the diversity of experience is reduced to the criteria found in classification systems and the search for that which is common and specific to the symptoms is abandoned.[1,2]

The Phenomenological Method

Philosophy and Psychopathology

Phenomenology is the exploration and doctrine of the essence of that which manifests itself (Greek: *phainomenon*). The etymological derivation of the term indicates that a focus on that which is immediately given is the foundation of philosophization and common to all phenomenological approaches.[63] Philosophically systematic preoccupation with the term began with Hegel's[64] *Phenomenology of Spirit* in 1807. According to Hegel, the spirit takes shape through history and attains self-consciousness through the self-reflexivity of mankind. Disillusionment with respect to the scope of knowledge to be gained through speculative idealism and romantic metaphysics lead to a clear orientation of philosophy toward the research subjects of the successful empirical sciences. It was against this backdrop that Husserl[65] founded phenomenology in 1901 claiming it to be a fundamental science. Heidegger[66(p27)] later referred to this development in the history of philosophy as a return "to the things themselves."

In line with Brentano's concept of intentionality, world for Husserl[67(p154)] was always consciousness of world. In attempting to trace terms back to "the direct experience of things," Husserl was not interested in investigating external things, but rather the appearance of things in the intentionally directed stream of consciousness. The investigation of immediate experience was performed using the *descriptive method* which was developed by Husserl. The precedence of this method was articulated by Husserl in a personal conversation with Jaspers: "you do not need to know what it is, if you do it right."[68(p327)]

Husserl's descriptive method was applied in the area of psychopathology in 1912 by Jaspers[69] and introduced into psychiatry as a *phenomenological field of*

research.[70–72] While Jaspers also drew upon the philosophical concepts of Kant, Dilthey, Droysen, Spranger, and Weber, from which the dichotomies of form and content, explanation and understanding, and development and process originate,[73,74] and although the historical roots of describing psychopathological phenomena can be traced far back into the 19th century,[75] it was the phenomenological method that represented the primary instrument for investigating and describing the subjective experience of the patient. In light of a psychopathology which was previously dominated by Kraepelin's behavioral observations, the innovative strength of such an approach cannot be highly enough esteemed.[76] Later developments in phenomenology, such as Husserl's insight into essences or constitutive phenomenology, received just as little acknowledgment from Jaspers as the introduction of life-world or existential-analytical approaches in psychopathology.[77,78] In the time that followed, these approaches continued to be of secondary importance in both clinical practice and research.

Fundamental Principles From Jaspers' General Psychopathology

Jaspers[40] initially equated phenomenology with a *static understanding* according to which the investigator focuses on the cross-section of contents of consciousness. This understanding aims to capture current subjective experience as descriptively as possible, to distinguish experiences as clearly as possible, and to express these experiences in unambiguous terms which are primarily extracted from the self-descriptions of the patient. First, phenomenological investigation targets immediate experience because increasing distance between the investigator and the object of consciousness results in decreasing validity of psychopathological insight. Psychiatric diagnoses are thus not based on the course of illness but—as later also applied to Schneider[41]—on cross-sectional psychopathological features, eg, the presence of first-rank symptoms in the case of schizophrenia. Second, phenomenological investigation focuses on the form of experience, ie, the way in which a content is experienced, while the content itself is of secondary importance. This weighting carries clear consequences, for example, in the investigation of psychotic experience. While, for example, *DSM-IV* checks for bizarre contents of consciousness in the case of the phenomenon of delusion, content for Jaspers and later for Gruhle[79] and Schneider[41] is nothing more than a vehicle for the phenomenological investigation and extremely difficult to assess in terms of validity. In examining delusion, it is therefore the "how" of experience which is of primary importance, ie, whether a content of consciousness, a notion (delusional idea), or perception (delusional perception) has become highly invested with significance for no apparent rational or emotional reason and whether the affected individual is unshakably convicted of its truth (even if only temporarily, as in the case of the delusional idea).

Static understanding is followed by *genetic understanding*, which centers on the longitudinal section of subjective experience. According to Jaspers, genetic understanding is no longer phenomenology, but rather an *understanding psychology*. Understanding psychology attempts to trace the inner development of personality and to show how one mental state clearly emerges from another. Of primary significance are therefore the contents of experience, which are empathetically woven together to form the inner biography. Despite being of little diagnostic validity, genetic understanding aims to capture the biographic development which in itself presents a coherent whole; a development which in the case of psychoses, for example, can be interrupted by a *break in the patient's lifeline*.

For Jaspers, *rational understanding*—which, for example, attempts to delineate the logical coherency of a delusional system from an external position—and *hermeneutic understanding*—which attempts to forge structures of meaning by, for example, applying philosophy or historical experience in an interpretational manner to the case under study—continually decrease in diagnostic value. In 1959, in the final edition of *General Psychopathology* edited by Jaspers,[43] the complexity of phenomenological understanding was accounted for by drawing upon the *hermeneutic circle*. Phenomenological understanding begins with the placing of oneself in the mindset of the mentally ill patient in an as nonjudgmental and impartial a manner as possible and comprises communication and a joint grappling with psychopathological concepts. It circulates from individual contents of consciousness to the whole and from the whole back to the individual in order to continually include new behavioral observations. It is only through these complex circular motions that understanding gains its precision. Only then is it possible to individually weight the individual symptoms and their involvement in the entirety of experience and in the biographical development of the patient.

In the modest manner which was characteristic of Jaspers, he continued to reject the reference to his book as a "major work in the area of phenomenology"(p42) up to the very end and ascertained that "A satisfactory organization and classification of phenomenological entities is not yet possible. Phenomenology is one of the foundations of the entire field of psychopathology and is still in its early stages."(p51)

Problems With the Reception of Jaspers

In the very first review of *General Psychopathology* back in 1914, Bumke[80] had already recognized the significance of the book for the establishment of a scientific psychopathology and nosology. Schneider[81] and Gruhle,[82]

however, soon pointed out the necessity of repeatedly reading the book in order to acquire a gradual understanding of the methods and concepts involved. The reception barrier in Germany grew from edition to edition, mainly due to the increasing influence of philosophy.[72]

In the 1930s, Great Britain became a place of refuge for a series of continental European psychiatrists.[83] Mayer-Gross, who emigrated from Heidelberg to London, was familiar with Jaspers' phenomenology and demanded of his staff and students that they precisely describe mental phenomena.[84] It is therefore even more surprising that, despite Mayer-Gross' teaching activities, no trace of an influence of Jaspers is to be found. Berrios[52,85] and Mullen[86] suspect that, in addition to the German language barrier, the complexity of the concepts influenced by continental philosophy posed a central stumbling block. The initially psychoanalytical and increasingly empirical-biological direction taken in Anglo-Saxon psychiatry is almost certainly a further reason why *General Psychopathology* first emerged in the English language as late as 1963[87]—exactly 50 years after the first German edition.

In 1967, in the United States, Fish[88] published his book *Clinical Psychopathology*, which was strongly modeled on Jaspers' phenomenological approach. While Fish thus helped to counteract what can be seen as a lack of meticulous symptom description in American literature, excessive philosophy continued to hinder the reception of *General Psychopathology* even after translation.[89] In 2004, Hoenig,[90(p235)] who together with Hamilton carried out the English translation of Jaspers' work, reported on his personal experiences with the reception of the book in *The History of the English Translation*: ''Once I visited one of the medical schools in Philadelphia, and when the chairman took me to his office I noticed the book on his shelf. I asked him whether he liked it. He said, half jokingly, 'Nobody reads it, but it is obligatory to have it seen on your shelf.' End of discussion. In the UK, too, not everyone welcomed the book. Once Professor Stengel, a leading psychoanalyst, took me aside and said: 'Why do you waste your time with this 'Imperial Psychiatry'?'''

Phenomenology and Schizophrenic Psychosis

Searching for Specific Symptoms in Schizophrenia

As early as 1896, Kraepelin had attempted to identify a specific symptom connecting the various forms of dementia praecox, a symptom for which he coined the term ''Zerfahrenheit'' (English: distraction, dilapidation, incoherence).[91] Zerfahrenheit subsumes formal thought disorders for which the following descriptions can apply: getting confused, becoming blurred, losing grip, or a derailing of thought to the point of schizophasia. Kraepelin's patient descriptions are viewed as highly differentiated, although they focus more on manifest expression than subjective experience.[92] Schneider later classified Zerfahrenheit as belonging to the diagnostically less conclusive *expression symptoms*, ie, disorders of mimic, gesture, gait, voice, and speech. In contrast to Kraepelin, Bleuler[93] clearly came closer to the experience of the patient. His renowned distinction of primary symptoms as an expression of the suspected somatic illness from secondary symptoms as an expression of the biographically determined reaction to the onset of illness opened up a way for drawing near to the patient in an understanding manner. Of even greater significance was, however, Bleuler's distinction between fundamental and accessory symptoms according to diagnostic value. While accessory symptoms, which included delusion and hallucinations, were seen by Bleuler as temporary and unspecific, fundamental symptoms were viewed as representing a permanent modification of the entire personality. Common to all fundamental symptoms was a *loosening of the tension of associations*.

Subsequently, numerous attempts were undertaken to identify the specific *weakness* or *insufficiency* inductive of secondary symptoms.[94] The majority of these attempts were made by German-speaking psychiatrists, who were closely connected with the Heidelberg Clinic and its phenomenological approach. The line of tradition stretches from Berze,[95] Beringer,[96] Berze and Gruhle,[97] Gruhle,[79] Rümke,[98] Conrad,[99] Blankenburg,[100] Mundt,[101] Janzarik,[102] up to Gross and Huber,[103] and Klosterkötter.[104,105] Since the time of Kraepelin, the search for an integrative concept accounting for the diverse array of schizophrenic symptoms has been and remains one of the most central questions in psychopathological research.[106]

Positive and Negative Symptoms

Jaspers viewed the consideration of basic disorder concepts as useless because these expressed nothing more and nothing less than the *incomprehensibility* of the psychotic.[43(p486,487)] At the same time, phenomenological examination was to remain limited to the psychopathological cross-section, ie, static understanding from a methodological viewpoint. Schneider[41] expressly pointed out that his cross-sectionally assessed first-rank symptoms were not identical to the basic disorder but rather represented a differential diagnostic appraisal in discriminating from the nonpsychotic and the cyclothymias. He restricted his descriptions to *abnormal forms of experience* and *abnormal forms of expression*. For Schneider, externally observable symptoms of expression were of least diagnostic value. First- and second-rank symptoms were most significant in diagnosing schizophrenia. These were phenomenologically conceived of as abnormal experiences, which, however, did not necessarily have to be present or manifest in the course of illness.

The concept of first-rank symptoms was made internationally accessible through translation of the fifth edition of Clinical Psychopathology into English in 1959,[107] through Fish's book[88] and through the International Pilot Study of Schizophrenia carried out by the World Health Organization.[108] The concept is widely accepted[109–111] as a component of the diagnostic criteria in *DSM-III* and *ICD-10*.[112] The diagnostic significance and specificity of the first-rank symptoms is, however, a subject of constant dispute, as a result of which new impetus for the continued development of diagnostic criteria is generated.[113–115]

Crow's[116] simplifying description of schizophrenia in terms of a positive and a negative form has, for example, led to increased interest in pathological deficits. In distinguishing between primary and secondary negative symptoms, Carpenter et al[117] have revived the long-standing question concerning primary core deficits. Andreasen[118] calls for an investigation of the negative symptoms which were described by Kraepelin and Bleuler as schizophrenic core symptoms and which have thus far been neglected on account of concerns with respect to a lack of reliability. The focus of research has thus shifted toward patients with low positive and high negative symptoms, as striven for by Blankenburg[100] in his phenomenological study back in 1971. For Andreasen and Carpenter[119] and Andreasen,[120] it is the thought disorders described by Bleuler which are of primary interest. As primary symptoms, these disorders indicate the presence of a *misconnection syndrome* involving the cortico-cerebellar-thalamic-cortical circuit and also serve to supplement a group of schizophrenias primarily defined on the basis of first-rank symptoms.

Early Schizophrenia

Within Anglo-Saxon psychiatry, the term phenomenology appears to primarily refer to the description of externally observable symptoms, so that even subjective consciousness and experience are treated as elements of the natural environment.[121] In the early diagnosis of schizophrenia, the "Anglo-Saxon school" therefore assumes a *prodromal phase* which begins with initial changes in the patient's behavior and ends with the onset of the first psychotic episode.[122] On the basis of such unspecific early symptoms, an early prediction of schizophrenia is scarcely possible.[123,124] In their review, Cannon et al[125] report a predictive value of 30%–35% in an ultrahigh-risk group within a period of 1–2 years.

The so-called "German school" draws upon *basic deficits*,[122] a concept which corresponds to the primary symptom approach. Basic symptoms are neuropsychological disturbances which are perceived by the patient him/herself and which can be explored with the aid of the phenomenological method.[126,127] Klosterkötter[128] delineated so-called transition sequences in the development from basic symptoms to manifest psychotic symptoms. In 1987, Gross et al[129] pooled the early symptoms of schizophrenia in the *Bonn Scale for the Assessment of Basic Symptoms*. In the course of an 8-year follow-up investigation of 96 identified patients, first-rank symptoms occurred in 58%, although—with 23% false-positive diagnoses—room for improvement was evident with respect to specificity.[130] The predictive value of the basic symptoms primarily rests on subjectively perceived, cognitive phenomena such as thought disorders or distortions of perception. Follow-up studies over a considerably shorter period of time which have focused more intensely on neurocognitive indicators and the distinction between early and later prodromal phase have failed to produce improvements in predictive value or sensitivity.[131,132] The search for conclusive neurocognitive indicators continues at an international level.[133,134]

A New Phenomenological Approach to Core Symptoms

For some length of time, Parnas et al[135] have been working on an interesting and promising approach to phenomenological diagnostics, which sees the core schizophrenic syndrome in a form of depersonalization. The historic roots of this approach are to be found in German-speaking psychiatry. (I have elsewhere attempted with the concept of *obsession in a stricter sense* to elucidate the core syndrome of obsessive-compulsive disorder using the phenomenological method.[136,137])

Jaspers[40] proposed the following modes in which the self is aware of itself: (1) *activity of the self*, (2) *unity of the self*, (3) *continuity of self-identity over time*, and (4) *distinction of the self from the outside world*. Disturbance of one of these modes results in typical formal disorders of self-consciousness. Jaspers attributed particular importance to the activity of the self. This activity accompanies all thoughts, images, memories, feelings, and perceptions, including perceptions of the body, and lends these the quality of being *mine*, of being *personal*. Depersonalization represents formal variation of the activity of the self. In depersonalization, contents of consciousness are no longer mine, but rather alien. Schneider[41] strengthened Jaspers' point of view by indicating that, in clinical practice, it is exclusively *consciousness of activity*—which he more precisely formulated as *sense of mineness*—that is disturbed. The *disturbance of mineness* leads to formal incomprehensibility of the contents of consciousness.

In terms of diagnostic valuation, Jaspers equated depersonalization with the "Erlebnis des Gemachten,"[(p90)] ie, with the impression of being manipulated, influenced, or guided by an external source, and Schneider identified the disturbance of mineness with ipseity disturbance, which he viewed as including thought insertion and thought withdrawal. He combined ipseity disturbance

with delusion and hallucinations to form the first-rank symptoms of schizophrenia. For the benefit of diagnostic clarity, potential transitions as well as the distinction between primary and secondary symptoms were abandoned. In his phenomenological approach from 1960, Kisker[138] attributed a very different value to ipseity disturbance. He viewed thought insertion as a secondary symptom of a primary *autopsychic depersonalization*. The concept of ipseity disturbance is not established within *DSM* classification.[2] Thought insertion and withdrawal are classified under bizarre delusional phenomena, while depersonalization is not referred to as a primary symptom.[60] In contrast, Blankenburg[100] earlier listed *schizophrenic alienation* as a specific primary symptom and Bleuler[139] referred to *depersonalization* as a fundamental symptom of schizophrenia. Bleuler described depersonalization in the form of transitivism, appersonation, and deficient orientation with respect to one's own person, as a result of which the boundaries of the self are perceived as being undefined, thinking and feeling become alien, and the environment is dependent upon one's own will. Furthermore, even delusion and hallucinations can be understood as an alienation from the contents of one's own consciousness.[140]

In accordance with phenomenological tradition, Zahavi and Parnas[141] explicitly focused on the conceptualization of activity of the self as a stream of consciousness which lends the contents of consciousness their I-like character. In this way, all experience occurs as self-experience in the first-person, through an implicit prereflexive self-centering which accompanies every experience. The core syndrome of schizophrenia, which is thought to be specific for the schizophrenic spectrum as well as for prodromal schizophrenia, is described by Parnas et al[142] as a disturbance of the prereflexive formation of experience and more specifically as an impairment of the prereflexive self-awareness which is viewed as the nucleus of the vast array of patient self-portrayals. The result is alienation from one's own thoughts, experiences, and actions; from interpersonal interactions; and from one's own body as well as a loss of that which was previously self-evident, the acquirement of a third-person perspective and a hyperreflexivity.[140] Based on these conceptual considerations, Parnas et al[143] have developed the *Examination of Anomalous Self-Experience* (*EASE*), a symptom checklist for the semistructured phenomenological exploration of symptoms. The EASE focuses on anomalies of self-experience in 5 experiential areas: (1) cognition and stream of consciousness, (2) self-awareness and presence, (3) bodily experience, (4) demarcation/transitivism, and (5) existential reorientation. It is claimed that an experienced EASE investigator is able to clearly distinguish between the monozygotic and dizygotic twin of a schizophrenic patient on the basis of the phenomenological exploration of self-experience.[144]

Conclusions

The consideration of the concept of psychosis is a conflict-charged domain of dichotomies which continue to be highly relevant within psychiatric diagnostics and nosology: psychosis and neurosis, unitary psychosis and multiple psychoses, etiological and descriptive diagnostics, forms of expression and forms of experience, primary and secondary symptoms, explanation and understanding, form and content, biological and phenomenological methods, etc. Knowledge concerning historical concepts may help to increase our awareness of the wealth of experience which psychiatry has to offer above and beyond current *DSM* and *ICD* classification systems. Following a 30-year focus on the establishment of diagnostic reliability and a common language as well as on advancements in a biological psychiatry within psychiatric research, the long-standing question once again resurfaces in unmodified form: What is psychosis or schizophrenia? The path which must be traveled in order to answer this question does not so much wind its way through expression and behavior as through an investigation of subjective experience, an approach which has proven most fruitful in the past. Experience is the research subject of the phenomenological method, the application of which is anything other than self-evident. It is in direct clinical contact with the patient that the method takes shape, its value is shown, and in turn, that which is common and specific to the illness is revealed.

The core syndrome of schizophrenia can be described as a disorder of self-consciousness. In the view of the author, a revival of the phenomenological method can contribute to improving the quality of psychiatric diagnoses. Through such a revival, psychiatric diagnostics would be reconnected with an important part of their history and also rerooted in the relationship to the patient, in whose interest the psychiatrist is commissioned with the tasks of carrying out research and providing treatment.

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