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COMMENTARY (INVITED)

What Kurt Schneider Also Said: The Primacy of Subjective Experience in the Concept of First Rank Symptoms

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The diagnostic relevance of Kurt Schneider's First Rank Symptoms (FRS) substantially declined following their de-emphasis in DSM-5 and ICD-11. Against this trend, Moritz and colleagues have reopened the debate about the conceptual value behind them. In a first piece,[1] after tracing the history of FRS in the DSM, the authors revisited Schneider's concept of hallucination as found in the *Klinische Psychopathologie,*[2] which, complemented with recent empirical evidence, led them to propose an updated definition of hallucination, incorporating the role of insight. In a second study,[3] they surveyed expert clinicians and researchers, finding 80% approval for their proposed redefinition of hallucinations and 49% agreement that FRS should once again carry special diagnostic value in the DSM-6.

While Moritz et al. highlight a renewed interest in Schneider's conceptual work, their contribution—mainly focused on the definition of hallucinations—does not explicitly address the most critical dimension of this framework for the clinical diagnosis of schizophrenia, namely, the person's subjective experience, when it is clearly described and unambiguously captured. In this context, subjective experience refers to the specific way in which the experience of the self, others, and the world is given, exclusively, to each person. This first-person perspective cannot be adequately captured by behavioral observation or clinical inference. Its diagnostic value lies in the patient's vivid accounts—whether spontaneous or elicited—which offer the closest approximation to the lived experience itself, allowing the clinician to assess its structure and distinguish between different kinds of experiences.

This primacy of subjective experience for clinical diagnosis is grounded in Schneider's phenomenological approach and the derived understanding of what schizophrenia fundamentally does: it tears apart (*zerreißen*) the coherence and continuity of a person's life, transforming the totality of a person's experience. From a clinical perspective, this may be approached through symptoms arising from 2 complementary yet distinct sources.[2] On the one hand, "expressions" (*Ausdrücke*) are observable—from a third-person perspective—in the patient's attitudes, thoughts, and affects; on the other, there are direct first-person perspective reports of experiences (*Erleben*). Although Schneider acknowledges the value of analyzing expressions, he holds that as data, their value is limited by the heavy reliance on the clinician's observational skills and interpretative ability. In addition, the appraisal and naming of expressions might vary considerably across observers due to cultural, personal, idiosyncratic, or other differences.

The distinction between expressions and experiences is the conceptual cornerstone of Schneider's clinical hierarchy for the diagnosis of schizophrenia, where FRS occupy the highest diagnostic rank. In Schneider's words, "for diagnostic purposes, modes of experience that have been captured unambiguously have priority over abnormalities of expression, which, for the observer, become an impression with all the subjective sources of error."[2] After listing the FRS, he concludes "where such modes of experience are unambiguously present and no underlying somatic illness can be found, we speak clinically, with all modesty, of schizophrenia."[2] For Schneider, subjective experience thus becomes the primary route to access schizophrenia's fundamental rupture.

When it comes to the concept of hallucination in schizophrenia, Schneider proposed 2 criteria to clarify the *form* (*Form*/*Seinsweise*)[2] of the experience reported by the

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patient, without establishing a hierarchy between them. First, "sensory deception" (*Sinnestäuschungen*) and, second, "the attitude" (*Stellung*) toward the experience, for which Moritz et al. use the modern term *insight*.[1] In Schneider's words: "it must be said again and again: what is at issue here [in the case of hallucinations] are sensory deceptions. That is, something is experienced in a sensory way, as a sensation, and not merely as a thought, even though it is actually not there."[2] Schneider clarifies that: "the 'not there' is established objectively by the observer, not by the person undergoing the experience".[2] Schneider also. stresses the clinical difficulty of determining whether a target experience is – or is not – a hallucination because such experiences "vary considerably in their sensory content (sinnlichem Gehalt) and are often not comparable to normal perception.".[2] While Moritz et al. recover the role of insight, their proposal underemphasizes Schneider's equal weighting of sensory deceptions and the attitude toward the experience.

Beyond the above criteria about the form—or structure—of the experience, Schneider proposed a third criterion, which might aptly be considered *methodological*, as it accounts for the intersubjective nature of clinical dialogue. The idea is that only unambiguous statements (*eindeutige Angaben*) in which vivid descriptions of repeated sensory deceptions (*anschauliche Schilderungen wiederholter Sinnestäuschungen*) are offered—and which the clinician grasps in an unimpeachable manner (*einwandfreie Erfassung*)—may be regarded as genuine hallucinations.[2] In other words, within this framework, we can only speak about a hallucination when the patient clearly describes, without a trace of doubt, a perceptual experience that has happened on several occasions, even though, for an observer, what was perceived was objectively not there.

The problem here is that such accounts rarely emerge in response to the direct question "do you hear voices?". Rather, the examination of such experiences demands an iterative dialogue that allows the person to describe events from their daily life, during which these experiences may gradually unfold. For example, during conversation, a patient who denied the presence of hallucinations when asked directly, expressed distress because her children no longer wished to have dinner at home with her. As the conversation progressed, she explained that she was unable to finish cooking because she heard her neighbors crudely criticizing the way she cooked, often to the point that she would throw away whatever she had begun preparing. She reported having this experience on several occasions, and there was no trace of doubt that she heard her neighbors commenting on each step of the process. She did not question the fact—evident to the observer—that her neighbors could neither see what she was doing, nor that their voices could carry through the wall.

Reappraising FRS—for research or classification—must consider this framework that gave them diagnostic meaning, where subjective experience is the primary source of information and the phenomenological approach, the way to assess them. This method, while distinct, is complementary to the observational framework on which current diagnostic systems are built. Neither is reducible to the other and, as argued by Karl Jaspers, they are both necessary to give a comprehensive account of what happens to the totality of the person.[4]

Beyond the concept of hallucinations, Schneider's *Klinische Psychopathologie* contains conceptually rich material that remains to be re-explored by contemporary psychiatry. The discussion reopened by Moritz and colleagues suggests that we may be just beginning to rediscover what Schneider actually said—and what it still has to offer for the clinical and nosological challenges ahead.

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