BULLETIN OF YRIDEI — HISTORY OF PSYCHIATRY

# The Grammar of Diagnostic Caution

*Schneider's Konjunktiv II and the formal analysis of delusion — the German tradition from Schneider to Huber and Gross*

*Shunaidā seishinbyōrigaku no DSM ni okeru keishō to hen'yō* シュナイダー精神病理学の *DSM* における継承と変容

*Takeshi Matsuishi* 松石竹志, *M.D., Ph.D.*

Exemplar prius · editio princeps · Augustus MMXXVI — First of a pair · first edition · August 2026

*Dedicated to Dr. Hiroshi Motomura*

**ABSTRACT**

In a 2024 survey of 136 international experts, roughly half favoured restoring the special diagnostic weight of Kurt Schneider's first-rank symptoms in DSM-6, and four in five rejected the DSM-5 definition of hallucination. What exactly would be restored? This paper — the first of two — returns to the German text of Schneider's *Klinische Psychopathologie* (14th ed., 1980) and argues that the core of Schneiderian psychopathology was never a checklist but a methodological attitude inscribed in the grammar itself. Where an essentialist reading of the first-rank symptoms might take hold, Schneider's verb stands in the Konjunktiv II, the German subjunctive of the unreal (*nicht weil wir sie für "Grundstörungen" hielten*); where diagnostic practice is regulated, it stands in the indicative (the symptoms *need not be present*; the inference from symptom to diagnosis *must not be reversed*). This "subjunctive reservation" descends from a premise — the hypothetical character of a disease concept without established somatic basis — to a practical doctrine, and it governs Schneider's hierarchy of the three forms of delusion: delusional mood set aside, delusional intuition second-rank, delusional perception alone first-rank, alone sustaining the indicative *immer*, because the judgment of intelligibility (*ohne verständlichen Anlaß*) is folded into its very identification. The paper then shows, from the untranslated editions of Huber and Gross's *Psychiatrie* (1976; 7th ed., 2005), that the German orthodoxy preserved this entire structure — hierarchy, definition, and exemption — into the twenty-first century. An appendix records a Japanese translators' controversy, with soundings taken directly from Blankenburg and Huber, that is documented in no other language. The companion paper follows the first-rank symptoms into the DSM and asks what three decades of operationalization made of them.

CONTENTS

Nota in limine — Prefatory note This is Paper I of the two-paper English edition of the author's study of Schneider and the DSM, based on the Japanese original, v55 (2026). This first paper reconstructs the German tradition — the subjunctive reservation, the hierarchy of the three forms of delusion, and the orthodox succession of Huber and Gross; the transformations in DSM-III to DSM-5 are analysed in the companion paper, The Reliability Bargain. The complete argument remains the Japanese original.

**How to cite**
Matsuishi, T. (2026). The grammar of diagnostic caution: Schneider's Konjunktiv II and the formal analysis of delusion. *Bulletin of YRIDEI*, 1, Article 15-I, pp. 1–11. http://matsuishi-lab.org/bulletin/en/schneider-grammar-en.html
Japanese original: Matsuishi, T. *Shunaidā seishinbyōrigaku no DSM ni okeru keishō to hen'yō* シュナイダー精神病理学の DSM における継承と変容——接続法第 II 式・妄想知覚・幻覚定義をめぐって [The reception and transformation of Schneiderian psychopathology in the DSM: Konjunktiv II, delusional perception, and the DSM-5 definition of hallucination]. *Bulletin of YRIDEI*, 1 (2026) (in Japanese). http://matsuishi-lab.org/bulletin/schneider-konjunktiv.html

## 1. Introduction

In 2024 the international research community delivered a remarkable piece of evidence about its own diagnostic instrument. Steffen Moritz, Lisa Borgmann, Andreas Heinz, Thomas Fuchs and Jürgen Gallinat — a group spanning three German university clinics in the Humboldt tradition (Hamburg-Eppendorf, Heidelberg, the Berlin Charité) — surveyed 136 international experts, drawn from the editorial boards of *Schizophrenia Bulletin* and *Schizophrenia Research* and the International Consortium for Hallucination Research, on the future shape of the DSM-6[1]. Two results stand out. About half of the respondents (49.3%, against 34.6% opposed) endorsed the proposal that DSM-6 should once again give special weight to Schneider's first-rank symptoms, as DSM-IV had done and DSM-5 had ceased to do. And roughly four in five rejected the DSM-5 definition of hallucination — its requirement that the experience be "vivid and clear, with the full force and impact of normal perceptions" — with two out of three saying the current definition should not be maintained.

A diagnostic manual abolishes a criterion as insufficiently specific; a decade later, half the field's experts ask for it back. Something more than nostalgia is at work. Nancy Andreasen, in a much-cited retrospective confession, called the larger process "the death of phenomenology in America"[2]. This study takes the survey as its point of departure and asks what, precisely, the experts are asking to have restored — by going back to the German original.

The inquiry is published in two parts. The present paper reconstructs what Schneider's doctrine actually was. Its thesis is that the core of Schneiderian psychopathology is not a list of diagnostic contents but something like a grammar of the diagnostic act — in a sense that is almost literal. Section 2 shows that Schneider inscribed his methodological reservation in grammatical mood itself: essentialist readings of the first-rank symptoms are held off in the Konjunktiv II, the German subjunctive of the unreal, while the working rules of diagnosis — the exemption, the prohibition — are stated as doctrine in the indicative. The reservation operates one level above diagnostic practice, at the standing of the disease concept itself, whose delimitation, so long as its somatic basis is unestablished, remains a hypothetical convention. Section 3 places this "form before content" attitude in its century-long lineage, from Richarz (1848) and Falret (1864) to Jaspers (1913). Section 4 turns to the three forms of delusion — *Wahnstimmung*, *Wahneinfall*, *Wahnwahrnehmung* — and to the diagnostic hierarchy Schneider erected among them: only delusional perception is first-rank, and only there did Schneider permit himself the indicative *immer*, "always." Section 5 demonstrates, from the untranslated editions of Huber and Gross's *Psychiatrie*, that the German orthodoxy carried this entire structure — hierarchy, definition and exemption — intact from 1976 to the final edition of 2005. Section 6 draws the results together. An appendix records an episode in the Japanese reception of Schneider, preserved in no other language, which bears directly on the interpretation of one first-rank symptom.

The companion paper, *The Reliability Bargain*, follows the first-rank symptoms into the DSM: the three transformations they underwent from DSM-III to DSM-5, the false dichotomy of the reliability-first paradigm that drove those transformations, and what the Moritz survey suggests DSM-6 should restore.

Two remarks on method. All quotations from Schneider and from Huber and Gross are newly translated from the German for this paper; the existing English translation of Schneider (Hoenig & Hamilton, 1959) renders an earlier edition, lacks the Huber apparatus of the 1992 Thieme edition, and — as will become an argument, not merely an inconvenience — systematically weakens the very grammatical distinctions at issue[3]. The German original of every passage quoted in translation is given in the Texts section at the end; readers who wish to verify the moods can do so there. And since the argument turns on a feature of German that English does not share, a self-contained note on the German moods follows the opening of Section 2; readers who have German may pass over it.

## 2. The Konjunktiv II as Method

The claim of this paper is that Schneider put a piece of grammar to methodological work: at the precise points of his *Klinische Psychopathologie* where an essentialist reading of the first-rank symptoms might take hold, the verb stands in the subjunctive — and at the precise points where diagnostic practice is regulated, it stands in the indicative. The distribution is not

stylistic accident. It is the doctrine. Readers without German will find the necessary grammar in the note below.

A Note on the German Moods

(for readers without German; readers who have it may pass on)

German verbs inflect not only for tense but for mood: the speaker's stance toward what is said is inscribed in the form of the verb itself. Besides the indicative (assertion of fact) and the imperative, German possesses a subjunctive — and it possesses it **twice over**, in two distinct forms with two distinct offices. The **Konjunktiv II**, built on the preterite stem (*wäre*, *hätte*, *könnte*), is the mood of the unreal: counterfactual supposition, guarded assertion, diplomatic reserve. The **Konjunktiv I**, built on the present stem (*sei*, *habe*, *müsse*), is the mood of report: it marks what is said as another's statement, for whose truth the speaker does not vouch. (It survives also in the hortative — *Man hüte sich* ..., "let one beware" — which will concern us in Section 4.)

The two moods measure two different distances. The Konjunktiv I measures the distance of **attribution**: whose statement is this? *Er sagte, er sei krank* — he said he was ill; the *sei* marks the illness as his claim, about which the speaker is silent; he may well be ill. The Konjunktiv II measures the distance of **reality**: is this real? *Wenn er krank wäre* — if he were ill, which he is not. German thus distinguishes, in the morphology itself, "*I do not vouch for this*" from "*this is not real*."

English once had all of this; inflectional erosion has removed nearly everything. What remains is the mandative subjunctive (*I insist that he come*), a handful of fossil phrases (*God save the King*), and the single form *were*. Everywhere else the unreal is expressed by borrowed past forms — *if I had time* — indistinguishable in shape from statements of past fact. And for the mood of report English has **no morphology at all**: in *he said he was ill*, the *was* is tense backshift, not mood, and marks nothing about the speaker's stance; the reservation must be supplied lexically (*reportedly*, *allegedly*, *is said to*). A German newspaper can run an entire paragraph in the Konjunktiv I, marking "this is the source's claim, not ours" on every verb, without a single quotation mark. English cannot.

| Tier of depth | German | English |
|---|---|---|
| Assertion of fact | indicative — *er ist* | indicative — *he is* |
| Another's statement | Konjunktiv I — *er sei* | **no form**; lexical substitutes (*reportedly*) |
| The unreal | Konjunktiv II — *er wäre* | *were* alone; elsewhere borrowed past (*had*), unmarked |

This asymmetry is not a linguistic curiosity; it is a premise of this paper's argument. German marks three tiers of epistemic depth in the verb — assertion, report, the unreal. English marks the first, and a faint trace of the third. When Schneider's *Klinische Psychopathologie* was put into English (Hoenig & Hamilton, 1959), his subjunctive reservations had, structurally, nowhere to go: the grammar that carried them does not exist in the target language. What this paper describes as the blunting of the subjunctive reservation in translation — and, in the companion paper, its final loss in operationalization — begins here, in the morphology of English itself.

Why should caution be needed at all? The phenomena enumerated as first-rank — thought insertion, thought withdrawal, voices in dialogue, delusional perception (*Wahnwahrnehmung*) — are typically observed in schizophrenia, but they are not absolute indicators proper to it alone: the same phenomena occur in what Schneider called abnormal experiential reactions (roughly, the stress-related disorders of today's ICD-11), and in organic and drug-induced psychoses. "First-rank symptoms present, therefore schizophrenia" is a clinically impermissible inference — and yet the symptoms remain indispensable instruments of diagnosis. Schneider's subjunctive, however, is not aimed directly at this practical relation of symptom to diagnosis. It is aimed one level higher, at the hypothetical character of the disease concept itself so long as its somatic basis remains unestablished; the practical consequence is derived from there.

Here is the passage of Chapter VI in which Schneider introduces the first-rank symptoms and presents the list. Nearly the whole economy of grammatical mood that concerns us is contained in it.[T1]

> Among the numerous abnormal modes of experience occurring in schizophrenia there are some that we call symptoms of the first rank — not because we held them (*hielten*: subjunctive II) to be "basic disturbances" (*Grundstörungen*), but because they carry (*haben*: indicative) a quite special weight for the diagnosis, as against non-psychotic mental abnormality and as against cyclothymia alike. This valuation, then, bears solely upon the diagnosis. Nothing is thereby said about the theory of schizophrenia, in the way that Bleuler's "fundamental" and "accessory" symptoms intend. ... The symptoms of the first rank are, in the order of our examination: audible thoughts; voices heard in the form of speech and counter-speech; voices heard commenting on one's own actions; bodily experiences of influence; thought withdrawal and other interferences with thought; thought broadcasting; delusional perception; and everything in the domain of feeling, striving and willing that is experienced as made or influenced by others. Where such modes of experience are unexceptionably present and no somatic underlying diseases are to be found, we speak clinically — *in all modesty* (*in aller Bescheidenheit*) — of schizophrenia. For one must know that probably all of them can also occur in psychotic states on the ground of an ascertainable underlying disease: in the alcoholic psychoses, in the epileptic twilight state, in symptomatic psychoses, in the most diverse cerebral processes. One might perhaps (*könnte vielleicht*: subjunctive II) recognize still other first-rank symptoms; we confine ourselves to those which can be grasped without excessive difficulty. ... The first-rank symptoms *need not be present* (*müssen ... nicht da sein*: indicative) for the diagnosis of schizophrenia; at the least, they are not always visible. We are often compelled to found the diagnosis on symptoms of the second rank — perhaps, exceptionally, even on mere expressive

> symptoms, where these are dense and distinct enough. (14th ed., p. 65)

Read the opening sentence again. Within it an asymmetry is inscribed in the inflection of the two verbs. The reading that is being set aside — first-rank symptoms as *Grundstörungen*, as the essence of the disease — is held back from assertion by the subjunctive *hielten*: "not because we *held* them to be," with the mood marking the supposition as unreal. The diagnostic weighting that is being affirmed is stated outright in the indicative *haben*. (A grammatical remark: *hielten* is identical in form with the preterite, but since the main clauses stand in the present, the past reading is unavailable; only the irrealis remains.)

What must be noticed is the level at which the reservation operates. For disease units without an established somatic basis — schizophrenia and cyclothymia alike — the delimitation of the concept is not the description of an entity but a hypothetical convention resting on the present consensus of psychiatrists. Schneider states the position as doctrine in Chapter I: "One is not in fact asking, 'Is this schizophrenia?' One is asking merely: 'Does this correspond to what I am accustomed to call schizophrenia?'" (p. 7)[T2]. The diagnostic name is not a statement about the essence of a thing; it is the verification of a correspondence with a clinical appellation. And so long as the concept is delimited only hypothetically, a symptom that would embody its "essence" — a sign whose presence would of itself settle the diagnosis — cannot in principle exist. The subjunctive of *hielten* anticipates this consequence and dismisses the essentialist reading at the level of grammar.

For the argument of this paper the most important lines are the two sentences immediately after the list. At the very point where first-rank experiences are "unexceptionably" present and an organic cause has for the time being been excluded — at that point, and only *in all modesty*, may the name of schizophrenia be put forward. The ascertainment of first-rank symptoms does not, of itself, license the diagnosis. As the companion paper argues, it is precisely this structure that the DSM's operationalization lost.

From the reservation at the level of the concept, a consequence follows for practice — and it is stated as doctrine in the indicative. "The first-rank symptoms *need not be present* for the diagnosis": not subjunctive but indicative present, a modal negation, the express statement of an exemption. And the final sentence ("We are often compelled...") shows the exemption to be a concrete policy: where first-rank symptoms are absent, the diagnosis is to be founded on second-rank or even expressive symptoms. The same principle returns from the side of cyclothymia: "neither do we make the diagnosis of schizophrenia depend on the presence of the first-rank symptoms" (p. 66)[T3]. And immediately after the definition of delusional perception stands a further indicative — a prohibition: "But this must not be reversed" (*Das darf man aber nicht umkehren*; quoted in Section 4 below) — the express interdiction of the mechanical inference from symptom to diagnosis.

Let us take stock. Schneider's economy of mood forms a single structure in which two levels are joined as premise and consequence. At the upper level, the reading of first-rank symptoms as the essence of the disease is dismissed by the subjunctive (*hielten*), against the background of a disease concept that is itself only hypothetically delimited. At the lower level, the consequences for practice — the exemption (*need not be present*) and the prohibition (*must not be reversed*) — are stated as doctrine in the indicative. What this paper calls **the subjunctive reservation** is the whole of this descending structure; its sharpest marker is the Konjunktiv II. What the DSM's operationalization lost — the argument of the companion paper — is not the lower doctrine alone: the upper reservation was set aside as though it had never existed, and the first-rank symptoms were converted into definitive indicators.

The asymmetry of mood is the grammatical expression of the methodology of understanding psychology in Jaspers's sense. Diagnosis, on this methodology, is not the inference of a disease entity from observed symptoms; it is the operation in which the clinician re-lives the patient's world of experience from within (*Verstehen*) and judges whether its connections are intelligible. The Konjunktiv II marks, in the grammar itself, the place where the clinician's act of judgment intervenes. A language that places essentialist claims under subjunctive reservation, and states only exemptions and prohibitions in the indicative, is that methodological attitude — symptoms treated not as substantive signs to be checked off, but as clues for a judgment of understanding.

How that judgment works, Schneider shows with textbook clarity in a case from Chapter III, set in the discussion of anxiety[T4]. A robust young Lower Bavarian, of blameless record, from a village, never before in a city, arrives in Cologne to visit his fiancée. Within hours he believes himself watched; by evening, threatened by his fellow lodgers in the homeless shelter; in extreme anxiety he flees through the city into the garden of a villa, is arrested as a burglar, fights furiously with the police — in whom he sees the men from the shelter in disguise — and in his cell hears voices: his parents have been killed, and he too must die — in Schneider's German, the content of the voices stands in the Konjunktiv I (*seine Eltern **seien** umgebracht und auch er **müsse** sterben*): reported, not vouched for; even inside a case history, the patient's experience and the clinician's assertion are kept apart at the level of grammar. After two days he is calm, with full insight, explaining everything to himself out of his own anxiety; at follow-up two years later, nothing further. Conviction of being watched, persecutory interpretation, hallucinated voices — a set of phenomena that an operationalized item-rating would be liable to book as delusions and auditory hallucinations — and Schneider's verdict is: no schizophrenia, but a pure abnormal experiential reaction, a "primitive reaction of reference." His ground is not the presence or absence of symptom items. It is emergence and course (acute onset, rapid subsidence, full

insight, good outcome), and above all the intelligibility of the genetic connection: the false interpretations have their *occasion* (*Anlaß*) — the anxiety-filled expectation — and are therefore not true delusional perception, which arises "without occasion" (*ohne Anlaß*). "Between such paranoid reactions, intelligible on the basis of affects, and real delusional psychoses there are never transitions" (pp. 27–28). The verdict turns not on the ascertainment of items, but on the understanding of the connection in which the phenomena arose[4].

Surveying the whole: that first-rank phenomena can occur outside schizophrenia was for Schneider not a concession but a stated premise of his doctrine — for the organic psychoses, the sentence at p. 65; for the psychogenic reactions, this case. The non-specificity demonstrated empirically by Carpenter, Strauss & Muleh (1973)[5] was therefore, for Schneider, not a discovery but a point of departure. What he claimed was never an essentialist pathognomonicity, but a diagnostic precedence in the differential — after the exclusion of somatic disease, and after the judgment of intelligibility. When Carpenter and colleagues "found" first-rank symptoms in affective patients, they were rating the symptoms as observation items outside the convention that gave those symptoms their sense. The argument that took non-specificity as refuting the symptoms' diagnostic value — the argument by which DSM-5 abolished their special weight — is, so far as one returns to the original text, the rebuttal of a claim Schneider never made. The point is argued in the companion paper.

One confirmation, briefly. In his 1956 essay on Kraepelin, Schneider erected the distinction between the *how* (*Wie*) and the *what* (*Was*) of experience as the core of his methodology [6] — the same primacy of form, expressed at the level of concept, that the Konjunktiv II expresses at the level of grammar. The first-rank symptoms are not absolute indicators; they are powerful clues that demand diagnostic consideration — this is the first thesis of the present paper. The next section asks where this primacy of form came from.

## 3. From Content to Form: A Century Against Content

Schneider's formalism was not an isolated position. It was the terminus of a tradition — "form before content" — running through German-language psychopathology from the middle of the nineteenth century, a tradition that Edward Shorter has reconstructed as the standing antithesis to the content-orientation of nineteenth-century French psychiatry[7].

The point of departure is the French classification of delusion descending from Pinel and Esquirol. In 1819 Esquirol put forward his list of "monomanias" — erotomania, nymphomania and the rest — partial insanities classified by the *object* of the delusion: love, sex, religion, persecution. The question of the formal structure that makes a delusion a delusion receded into the background. In Shorter's words, Esquirol's procedure described the delusional objects "as though they were separate diseases, rather than aspects of some larger form of fixed false belief of all kinds"[8]. This content-oriented tradition remained the mainstream of French psychiatry through the century.

The first clear dissent came in 1848 from Franz Richarz, the psychiatrist who founded the private asylum at Endenich near Bonn. The main source of the confusion of diagnostic opinion in psychiatry, Richarz argued, lay in the field's inveterate tendency to fasten on the *content* of pathological mental phenomena; what the study and teaching of the subject required was concentration on the basic *forms* of mental illness, particularly in so far as these correspond to pathological states of the brain. Shorter credits the passage as an early and unambiguous declaration of the primacy of form.

The more direct dissent came from within France itself. Jean-Pierre Falret, senior psychiatrist of the women's division at the Salpêtrière, dismissed the whole Esquirolean apparatus of partial insanities in 1864 as "anti-scientific, and often based on accidental and secondary phenomena"; only by penetrating to the core of the disease, he held, could a proper classification be produced. The catalogue he enumerated in order to reject it — intellectual monomania, affective monomania, instinctive monomania, ambitious, erotic, mystical monomania, delusions of persecution, homicidal, suicidal, incendiary, kleptomaniac monomania — is a catalogue of delusions classified by content, innocent of any question of form. Falret's critique was a fundamental self-correction of the French content tradition, issued from inside it.

The principle of the primacy of form reached one of its summits in Jaspers's *Allgemeine Psychopathologie* (1913): for the psychopathologist, Jaspers wrote, the greater interest lies for the most part with the form; the content often appears accidental, wholly personal. Schneider inherited this Jaspersian formalism and sharpened it into an instrument of diagnosis; that he himself erected the distinction of *Wie* and *Was* as the key concept of his methodology has already been noted in Section 2. Schneider's formal doctrine thus stands at the end of a line — Richarz 1848, Falret 1864, Jaspers 1913 — more than a century of German-language psychopathology built against the classification of madness by its objects.

Only against this genealogical background does it become clear what the operationalization of the DSM after Spitzer stood to lose. Not merely the methodological legacy of one man — but, as the companion paper argues, the core tradition of German psychopathology built up over more than a century, abandoned in a regression to the French classification by content.

## 4. The Three Forms of Delusion and Their Diagnostic Hierarchy

In Chapter VI, Section II of the *Klinische Psychopathologie* Schneider distinguishes three forms of delusion (*Wahn*): delusional mood (*Wahnstimmung*), delusional intuition (*Wahneinfall*), and delusional perception (*Wahn-*

*wahrnehmung*). All three belong to formalism in the broad sense — each grasps delusion by its form, not its content. But Schneider gave diagnostic weight to only one of the three. This act of selection displays the methodological core of Schneiderian diagnostics more sharply than anything else in the book.

In Jaspers's *Allgemeine Psychopathologie*, *Wahnstimmung* had held a central place as the point of origin of delusion formation: the world vaguely and uncannily transformed, some sinister meaning pressing in, nothing yet specific — the pre-delusional atmosphere is one of the celebrated descriptions of Jaspersian phenomenology. Schneider expressly excludes it from the first-rank list. The reason is that it lacks decisive differential power: delusional mood is not proper to schizophrenia, but occurs in depressive and anxious states and in the abnormal experiential reactions. Its value as formal description is not denied; its specificity as a diagnostic indicator is. The exclusion marks the decisive turn from Jaspersian phenomenology to Schneiderian diagnostics: heir to the formal tradition, Schneider refused to convert Jaspers's forms into diagnostic indicators wholesale, and selected instead, *within* form, the forms of highest differential power.

Delusional intuition, *Wahneinfall*, Schneider placed in the second rank. It shares with delusional perception the formal mark of arising "*ohne Anlaß*" — without intelligible occasion — but differs decisively in lacking the external anchor of a perception: the conviction springs from thought alone. Schneider's ground for denying it first-rank power is given at the end of Chapter VI, Section II in the case of the prince[T5]: in hereditary-health proceedings (*Erbgesundheitsverfahren*), a young woman was diagnosed as paranoid schizophrenic because she had stated that a prince was concerned about her and was watching over her. In fact she had grown up with the prince, had borne his child at eighteen, and the prince was indeed taking a continuing interest in her life and inquiring repeatedly after her and the child. Schneider closes the case with a subjunctive of his own: were the son one day to speak of his princely descent, he too "might easily fall under the suspicion" of delusion of ancestry (*so käme er auch wohl leicht in den Verdacht* — Konjunktiv II). And there follows immediately the admonition to the clinician, in the hortative Konjunktiv I[T6]:

> Let one beware (*Man hüte sich*) of taking every intuition that strikes one as odd and strange straightaway for delusion. So far as possible, let one go into the matter (*gehe man der Sache nach*). (p. 53)

An intuition strange in content may have a real background; therefore *Wahneinfall* cannot be a member of the first-rank list.

Delusional perception, by contrast, stands at the core of the first rank. Schneider's definition[T7]:

> Following Jaspers and Gruhle, one speaks of delusional perception when an abnormal meaning, mostly in the direction of self-reference, is attached to real perceptions without any occasion intelligible rationally or emotionally (*ohne verstandesmäßig (rational) oder gefühlsmäßig (emotional) verständlichen Anlaß*). (p. 51)

The definition has two centres. First, "*ohne Anlaß*" — the absence of occasion — stands as the formal criterion. Second, the Jaspersian keyword itself, *verständlich* — intelligible — is built into the definition. The two are inseparable: to determine that the occasion is *not* intelligible, the clinician must relive the patient's experience from within and judge whether its motivational connections can be understood; the act of judgment is a constituent of the definition.

Then comes the sentence in which Schneider declares an absolute boundary — for the argument of this paper, the decisive text[T8]:

> Here lies one of the absolute boundaries between schizophrenic psychosis and abnormal experiential reaction. Where delusional perceptions are, it is *always* (*immer*) a schizophrenic psychosis, never an experiential reaction. But this must not be reversed (*Das darf man aber nicht umkehren*). (p. 52)

The final sentence is the indicative prohibition already cited in Section 2. What is decisive is the grammatical asymmetry: the same Schneider who placed every principled claim about the standing and specificity of the first-rank symptoms under the reservation of the Konjunktiv II permitted himself, for delusional perception and for it alone, the strong indicative assertion *immer*. The asymmetry can be verified within the original as a minimal pair. On the side of cyclothymia, Schneider had asked whether any symptom deserves first rank there, and answered[T9]:

> In the domain of cyclothymia we would know (*wüßten*: subjunctive II) of no symptom that we could call one of the first rank. We would know of none of which one could say: where it is, there is cyclothymia. (p. 66)

*Wüßten* is the Konjunktiv II of *wissen* (the preterite would be *wußten*) — here the morphology itself is unambiguous. Inside a doubled subjunctive frame (*wüßten … sagen könnte*) sits, verbatim, the formula of the pathognomonic claim: *where it is, there is cyclothymia*. Schneider knew the formula that runs straight from symptom to diagnosis — and, for cyclothymia, denied in the subjunctive that any symptom satisfies it. The same formula appears on the schizophrenia side — "Where delusional perceptions are…" — affirmed, in the indicative, with *immer*. Delusional perception is the one member of the three forms of delusion to which Schneider granted diagnostic power sufficient to sustain an indicative assertion.

The ground lies in its two-step structure. Delusional perception has an external anchor — a real perception — and the abnormality lies in the *attachment of meaning* to it. The first step, the perception, is observable by others (a dog is sitting on the steps; an acquaintance is speaking); only the second step, the abnormal attachment of meaning, is the object of the judgment of understanding. Where delusional mood lacks an object, and delusional intuition lacks a perceptual anchor, delusional perception — by virtue of this two-step structure

— holds phenomenological description and diagnostic differentiation together at the highest attainable level. Nor does the *immer* collapse into tautology: the identification of a delusional perception already contains the judgment "*ohne verständlichen Anlaß*" — the understanding-psychological determination is folded into the very recognition of the symptom[4].

Schneider's own paradigm case in Chapter VI, Section II shows the formal core with unmatched clarity — the case of the dog. A schizophrenic patient, on the steps of a Catholic convent house, sees a dog sitting upright, raise a forepaw as he approaches. He hurries after a man walking a few metres ahead and checks quickly whether the dog had "presented" before him too. The man's astonished No settles it. In the patient's own words, as Schneider records them[T10]: "His astonished No now set me in the certainty that I was dealing here with a manifest revelation" (p. 51). The perception itself — a dog sitting on steps, lifting a paw — is entirely normal, without one grain of strange content. What is abnormal is the *form*: that to this everyday perception a self-referential meaning ("a manifest revelation, meant for me") is attached without any intelligible occasion. Schneider's ground for ranking delusional perception first is not strangeness of content but abnormality of form.

This hierarchy of the three forms — delusional mood effectively excluded from the diagnostic hierarchy, delusional intuition second-rank, delusional perception alone first-rank — shows that Schneiderian diagnostics was never mere "formalism" but a *formal selection*: the discovery, within form, of a gradient of differential power. And it carries a consequence that the companion paper will draw out at length. The dog case — Schneider's own paradigm of the most important first-rank symptom — is, in its content, perfectly banal; no operationalization keyed to content, to the strangeness or implausibility of what is believed, can capture it. In fact, from DSM-III (1980) to DSM-5 (2013), *Wahnwahrnehmung* has never once appeared as an item in any edition's diagnostic criteria for schizophrenia. The symptom to which Schneider granted his only indicative *immer* is precisely the symptom that vanished, whole, from the diagnostic system that understood itself as the operational heir of his first-rank symptoms — the decisive sign, as the companion paper argues, of a mutation of form back into content.

## 5. The Orthodox Succession: Huber and Gross, 1976–2005

Gerd Huber and Gisela Gross's textbook *Psychiatrie*, first published in 1966, was the orthodox continuation of Schneiderian psychopathology in the German-speaking world, developed through successive editions. This section takes two of them as its principal sources — the second edition of 1976 and the seventh and final edition of 2005 — and presents the continuity, and the progressive refinement, of the doctrine across three decades[9]. Table 14 of the 1976 edition (p. 158), "Symptome 1. und 2. Ranges bei Schizophrenie," carries Schneider's classification forward, reorganized under the superordinate category of *abnorme Erlebnisweisen* (abnormal modes of experience); Table 22 of the 2005 edition (p. 307) is its direct descendant. Huber, moreover, was the annotator of the 14th edition of Schneider's *Klinische Psychopathologie* in its 1992 Thieme printing — the orthodox transmitter of Schneider in the German-speaking world in the most literal, editorial sense.

The structure of the tables displays the inheritance of the Schneiderian hierarchy at a glance. Under the heading *Wahn* — delusion — the first rank contains exactly one entry: *Wahnwahrnehmung*. *Wahneinfall* is placed in the second rank, together with simple self-reference (*einfache Eigenbeziehung*). The hierarchy argued in Section 4 — delusional perception alone first-rank, delusional intuition second — stands unaltered in both the 1976 table and the 2005 table. What makes a delusion first-rank is not strangeness of content but the two-step structure itself — a real perception, an unmotivated abnormal meaning attached to it; *Wahneinfall*, sharing the *ohne Anlaß* but lacking the perceptual anchor, remains second-rank across every edition.

On hallucinated voices, the 2005 edition (p. 307) classifies the first-rank forms in the Schneiderian triad: voices in dialogue (*dialogische Stimmen*), commenting voices (*kommentierende Stimmen*), audible thoughts (*Gedankenlautwerden*). The exemplary case given there — a patient who could clearly distinguish the voices of her family doctor and her pastor, "though the voices are very soft" — makes the doctrinal point exactly: what is diagnostically decisive is not the intensity of the percept but the form of the dialogue. A voice may be "very soft" and yet, if the formal structure is complete, it is first-rank. (The bearing of this on the DSM-5 requirement that hallucinations carry "the full force and impact of normal perceptions" is taken up in the companion paper.) One extension Huber makes explicitly in his own name: imperative voices (*imperative Stimmen*) are counted among the first-rank symptoms "wir (doch nicht K. SCHNEIDER)" — "we (though not K. Schneider)" — an expansion beyond the master, flagged as such, and discussed further in the Appendix[10].

On delusional perception, the 2005 edition preserves and sharpens the definition. Page 308 repeats Schneider's formula with the double qualification made explicit — an abnormal meaning attached to real perceptions "without occasion intelligible rationally *or emotionally*" (*ohne rational oder emotional verständlichen Anlaß*). Page 309 converts the criterion into a technical term — *Bezugsunwahrscheinlichkeit*, the improbability of the reference — and defines it as what cannot be grasped by the "*Methode des genetischen Verstehens*," the Jaspersian method of genetic understanding. That is: the constitutive intervention of the judgment of understanding, argued in Section 4 to be folded into Schneider's definition, is here named and placed at the centre of the symptom's diagnostic identity. And the Bonn study data reported at p. 311 quantify the doctrine's other half: first-rank symptoms were ascertainable in 78% of schizophrenic cases — the remaining

22% being diagnosed, exactly as Schneider's exemption provides, on second-rank symptoms.

The exemption itself is carried forward almost verbatim. At the head of the section on second-rank symptoms (p. 312) stands the sentence: "*Die Symptome 1. Ranges sind nicht in jedem Fall und Stadium einer Schizophrenie vorhanden; sie sind nicht obligat für die Diagnose*" — the first-rank symptoms are not present in every case and every stage of a schizophrenia; they are *not obligatory for the diagnosis*[T11]. This is Schneider's *müssen … nicht da sein* of p. 65, restated by Huber in 2005 as *nicht obligat*. The whole of the methodological caution that Schneider distributed across his grammar — the essentialist claim held in the subjunctive, the exemption declared in the indicative — is reaffirmed by his editor and successor half a century later. The German orthodoxy held the reservation to the beginning of the twenty-first century.

One further point of the 2005 text — the rendering of *Rede und Gegenrede*, speech and counter-speech, as *dialogische Stimmen* — bears on a controversy in the Japanese reception of Schneider that is documented nowhere else and is recounted in the Appendix.

## 6. Conclusion: What the Tradition Held

Three results may be recorded.

First, the subjunctive reservation. Schneider's caution was not a rhetorical humility but a structure with two joined levels, inscribed in grammatical mood: at the level of the concept, the essentialist reading of the first-rank symptoms — and with it the pathognomonic formula "where it is, there is X" — is held in the Konjunktiv II, because a disease concept without established somatic basis is itself only a hypothetical convention; at the level of practice, the exemption (*the symptoms need not be present*) and the prohibition (*the inference must not be reversed*) are declared in the indicative. The first-rank symptoms, on the original doctrine, are not definitive indicators but privileged clues, and their ascertainment licenses a diagnosis only after the exclusion of somatic disease and the judgment of intelligibility — a judgment exercised, as the Lower Bavarian case shows, on the genetic connection of the phenomena, not on their itemized presence.

Second, the formal selection. Schneider stood at the end of a century of "form before content" — Richarz, Falret, Jaspers — and radicalized it into diagnostics by a further act of discrimination *within* form: delusional mood set aside for want of differential power, delusional intuition second-rank for want of a perceptual anchor, delusional perception alone first-rank. Only there, where the judgment of unintelligibility (*ohne verständlichen Anlaß*) is folded into the very identification of the symptom, did Schneider permit himself the indicative *immer* — the one pathognomonic assertion in a book built of reservations, made possible precisely because the reservation is contained inside the symptom's definition. The minimal pair with cyclothymia (*wüßten … könnte* against *ist … immer*) shows the asymmetry to be deliberate to the letter.

Third, the orthodox succession. None of this was a private subtlety lost with its author. The hierarchy of the three forms, the understanding-based definition of delusional perception, the softness-tolerant formal analysis of voices, and the exemption *nicht obligat für die Diagnose* were carried, table by table and sentence by sentence, through Huber and Gross's editions from 1976 to 2005 — the same Huber who edited Schneider's own 14th edition. As of the early twenty-first century, the German tradition still possessed, intact, everything the Moritz survey's respondents now describe as missing.

What became of this structure when it crossed into English, and then into the operational criteria of DSM-III, DSM-IV and DSM-5 — which of its elements were preserved, which compressed, and which deleted without residue; and why the deletion of precisely *Wahnwahrnehmung*, the one symptom Schneider trusted with the indicative, is the sharpest measure of the loss — is the subject of the companion paper.

## Appendix. The Japanese Reception: A Translators' Controversy and Two Soundings

*The episode recorded here is documented in no other language. The present author had it in part directly from one of the participants.*

In the first Japanese translation of the *Klinische Psychopathologie* (by Shizuya Hirai and Toshinori Kanokogi, from the 6th German edition of 1962), Schneider's "*Stimmen in Form von Rede und Gegenrede*" was rendered as "voices in the form of address and reply" — the patient addressed by a voice, the patient answering. The rendering resonated with Japanese clinical experience: psychiatrists in Japan were long familiar with the picture of a patient answering back — often in protest — to a voice that speaks to him, and the translation and the clinical experience supported one another.

When DSM-III appeared in 1980, however, the corresponding item read "two or more voices conversing with each other": not the patient in dialogue with a voice, but third parties conversing *about* the patient. Within the Japanese Society of Psychiatry and Neurology this produced confusion, and the original rendering came to be suspected as a mistranslation. Kanokogi took the question directly to Wolfgang Blankenburg in Marburg — and received the answer that the original rendering was acceptable. The consultation is said to have been recorded; with the deaths of both men, the tape has not been possible to verify. The present author had this account from Kanokogi in person.

In the second Japanese translation (by Hirohiko Harima, from the 15th German edition; published 2007), the passage is rendered "voices disputing with one another." Harima, in the course of his work, put the question directly to Gerd Huber, and records in his translator's notes Huber's answer: the original means *dialogische Stimmen* — voices in dialogue.

The present paper's reading of the episode is as follows. Schneider himself did not count imperative voices among the

first-rank symptoms. Huber moved toward adding them in the second edition of *Psychiatrie* (1976) and added them explicitly in the seventh (2005), with the flag already quoted: "*Wir (doch nicht K. SCHNEIDER) rechnen auch akustische Halluzinationen, in denen Befehle erteilt werden: imperative Stimmen, zu den Symptomen 1. Ranges*" — we, though not K. Schneider, count auditory hallucinations that issue commands, imperative voices, among the symptoms of the first rank. Yet the exemplary case Huber gives there — "a voice commanded: hang yourself; another voice said: do not do it, think of your family" — is not, in fact, an example of command alone: it is two voices in speech and counter-speech. The example and the doctrine it is meant to illustrate do not quite fit, and why Huber chose it is not clear. Imperative voices are an everyday clinical finding; Schneider's refusal to admit them to the first rank may well reflect their wide occurrence outside schizophrenia — and Blankenburg, answering Kanokogi as he did, presumably shared that clinical estimate. It should be noted that the two authorities stood in different relations to Schneider: Huber, the direct Heidelberg successor and annotator of the 14th edition; Blankenburg, an independent phenomenological psychopathologist of the next generation in Marburg, never Schneider's pupil. Why Kanokogi carried his question to Marburg rather than to Bonn, the present author failed to ask while it could still be asked.

The episode is more than an anecdote of translation. It shows two national traditions — one reading *Rede und Gegenrede* through the clinical picture of the answering patient, the other through the DSM's "voices conversing with each other" — each stabilizing its reading through direct recourse to the German authorities; and it shows the authorities themselves dividing along the very line (form of the dialogue versus content of the command) that this paper has argued is the axis of Schneiderian diagnostics.

## Texts

*German originals of the passages quoted in translation. Schneider: Klinische Psychopathologie, 14. Aufl., Stuttgart: Thieme, 1980 (page numbers of that edition; cf. also the 1992 Thieme printing with the annotations of G. Huber). Huber/Gross: Psychiatrie, 2. Aufl. 1976; 7. Aufl. 2005, Stuttgart: Schattauer.*

**[T1]** (S. 65) „Unter den zahlreichen bei der Schizophrenie vorkommenden abnormen Erlebnisweisen gibt es einige, die wir Symptome 1. Ranges heißen, nicht weil wir sie für „Grundstörungen" hielten, sondern weil sie für die Diagnose sowohl gegenüber nichtpsychotisch seelisch abnormem, wie gegenüber der Zyklothymie ein ganz besonderes Gewicht haben. Diese Wertung bezieht sich also nur auf die Diagnose. Nicht aber ist damit etwas zur Theorie der Schizophrenie gesagt, wie das Bleulers „Grundsymptome" und „akzessorische Symptome" meinen oder seine und anderer Autoren „primäre" und „sekundäre" Symptome. Wir haben die Symptome 1. Ranges alle im Laufe unserer Untersuchung hervorgehoben und auch mit Beispielen illustriert. Symptome 1. Ranges sind in der Reihenfolge unserer Untersuchung: Gedankenlautwerden, Hören von Stimmen in der Form von Rede und Gegenrede, Hören von Stimmen, die das eigene Tun mit Bemerkungen begleiten, leibliche Beeinflussungserlebnisse, Gedankenentzug und andere Gedankenbeeinflussungen, Gedankenausbreitung, Wahnwahrnehmung, sowie alles von andern Gemachte und Beeinflußte auf dem Gebiet des Fühlens, Strebens (der Triebe) und des Wollens. Wo derartige Erlebnisweisen einwandfrei vorliegen und keine körperlichen Grundkrankheiten zu finden sind, sprechen wir klinisch in aller Bescheidenheit von Schizophrenie. Man muß nämlich wissen, daß sie wohl alle auch einmal bei psychotischen Zuständen auf dem Boden einer faßbaren Grundkrankheit vorkommen können: bei den Alkoholpsychosen, im epileptischen Dämmerzustand, bei anämischen und anderen symptomatischen Psychosen, bei den verschiedensten Hirnprozessen. Man könnte vielleicht noch andere schizophrene Symptome 1. Ranges anerkennen. Wir beschränken uns aber auf solche, die begrifflich und bei der Untersuchung ohne allzu große Schwierigkeit zu fassen sind. […] Die Symptome 1. Ranges müssen für die Diagnose der Schizophrenie nicht da sein; zum mindesten sind sie nicht stets sichtbar. Wir sind oft genötigt, die Diagnose der Schizophrenie auf Symptome 2. Ranges, vielleicht ausnahmsweise sogar einmal auf bloße Ausdruckssymptome, wenn sie entsprechend dicht und deutlich sind, zu gründen."

**[T2]** (S. 7) „Sondern man fragt lediglich: ‚Entspricht das dem, was ich eine Schizophrenie oder dem, was ich eine Zyklothymie zu heißen pflege!'"

**[T3]** (S. 66) „...denn auch die Diagnose der Schizophrenie machen wir ja nicht abhängig von dem Vorhandensein der Symptome 1. Ranges."

**[T4]** (S. 27–28) „Ein 24jähriger kräftiger unbescholtener Niederbayer, der aus einem ganz kleinen Dorf stammt und noch nie in einer größeren Stadt war, kommt nach Köln, um seine Braut zu besuchen. Schon bald nach der Ankunft glaubt er sich von den Menschen angesehen und abends im Obdachlosenasyl von Schlafgenossen auch bedroht. In größter Angst rennt er durch die Stadt, um schließlich vor den vermeintlichen Verfolgern in den Garten einer Villa zu fliehen. Er wird entdeckt und vom Überfallkommando als Einbrecher verhaftet. Bald beginnt ein wütender Kampf gegen die Beamten der Wache und des Polizeigefängnisses, in denen er verkleidete Leute aus dem Asyl zu sehen glaubt. Er verwundet im ganzen sieben Beamte nicht unerheblich. Er hört in der Zelle auch reden: seine Eltern seien umgebracht und auch er müsse sterben. Nach zwei Tagen beruhigt er sich und bald ist er völlig einsichtig und erklärt sich alles selbst aus seiner Angst. Die Erinnerung an die zwei Tage ist nicht ganz lückenlos. Eine nach zwei Jahren erhobene Katamnese ergab, daß er inzwischen nicht mehr aufgefallen war. Wir bezeichneten solche Reaktionen früher als „primitiven Beziehungswahn" entsprechend Kretschmers Primitivreaktion: ein angstvolles Reagieren bevor noch das Erlebnis richtig aufgefaßt

oder gar verarbeitet ist. Einer primitiven Persönlichkeit bedarf es dazu nicht; wohl jeder kann in gegebener Lage so reagieren. Es ist also nicht wie beim „sensitiven Beziehungswahn", der eine spezifische Persönlichkeit voraussetzt. Um wirklichen Wahn als Wahnwahrnehmung „ohne Anlaß" handelt es sich aber nicht, weshalb man besser von primitiver Beziehungsreaktion spricht. Die falschen Deutungen haben eben ihren Anlaß: die angstvolle Erwartung. […] Die Differentialdiagnose zur Schizophrenie beruht bei beiden Spielarten außer auf der Art der Entstehung und des Abklingens auch auf der Symptomatik. Vor allem findet man nie eindeutig schizophrene Symptome. Zwischen solchen paranoiden Reaktionen, verständlich aufgrund von Affekten, und wirklichen Wahnpsychosen gibt es niemals Übergänge."

**[T5]** (S. 52–53) „So erlebten wir einmal, daß ein Mädchen in einem Erbgesundheitsverfahren als paranoid schizophren diagnostiziert wurde, weil es angegeben hatte, ein Fürst kümmere sich um sie, beobachte sie. Tatsächlich war es aber wirklich so, daß ein Fürst, mit dem sie zusammen aufgewachsen war und von dem sie mit 18 Jahren ein Kind empfangen hatte, sich für ihr weiteres Leben interessierte und sich nach ihr und ihrem Kinde immer wieder erkundigte. Würde dieser Sohn später von seiner fürstlichen Abkunft reden, so käme er auch wohl leicht in den Verdacht, an Abstammungswahn zu leiden."

**[T6]** (S. 53) „Man hüte sich, alle Einfälle, die einen befremden und seltsam anmuten, gleich als Wahn zu nehmen. Nach Möglichkeit gehe man der Sache nach."

**[T7]** (S. 51) „Man spricht mit Jaspers und Gruhle von Wahnwahrnehmung, wenn wirklichen Wahrnehmungen ohne verstandesmäßig (rational) oder gefühlsmäßig (emotional) verständlichen Anlaß eine abnorme Bedeutung, meist in der Richtung der Eigenbeziehung, beigelegt wird."

**[T8]** (S. 52) „Hier liegt eine der absoluten Grenzen zwischen schizophrener Psychose und abnormer Erlebnisreaktion. Wo Wahnwahrnehmungen sind, handelt es sich immer um eine schizophrene Psychose, nie um eine Erlebnisreaktion. Das darf man aber nicht umkehren."

**[T9]** (S. 66) „Auf dem Gebiet der Zyklothymie wüßten wir nun kein Symptom, das wir eines 1. Ranges heißen könnten. Wir wüßten keines, von dem man sagen könnte: wo es da ist, ist Zyklothymie."

**[T10]** (S. 51) „Ein Hund auf der Treppe eines katholischen Schwesternhauses lauerte mir in aufrechtsitzender Stellung auf, sah mich ernst an und hob eine Vorderpfote hoch, als ich in seine Nähe kam. Zufällig ging einige Meter vor mir eine andere männliche Person des Weges, die ich eiligst einholte und schnell kontrollierte, ob der Hund vor ihm auch präsentiert hätte. Ein staunendes Nein von diesem setzte mich nun in die Gewißheit, daß ich es hier mit einer deutlichen Offenbarung zu tun hatte."

**[T11]** (Huber/Gross 2005, S. 312) „Die Symptome 1. Ranges sind nicht in jedem Fall und Stadium einer Schizophrenie vorhanden; sie sind nicht obligat für die Diagnose." — Vgl. auch S. 307 (Tab. 22; „Wir (doch nicht K. SCHNEIDER) rechnen auch akustische Halluzinationen, in denen Befehle erteilt werden: imperative Stimmen, zu den Symptomen 1. Ranges"), S. 308 (Definition der Wahnwahrnehmung), S. 309 (Bezugsunwahrscheinlichkeit; Methode des genetischen Verstehens), S. 311 (Bonn-Studie, 78%).

## Notes and References


[1] Moritz, S., Borgmann, L., Heinz, A., Fuchs, T., & Gallinat, J. "Towards the DSM-6: Results of a Survey of Experts on the Reintroduction of First-Rank Symptoms as Core Criteria of Schizophrenia and on Redefining Hallucinations." *Schizophrenia Bulletin*, 50(5), 2024, pp. 1050–1054. doi:10.1093/schbul/sbae061.

[2] Andreasen, N. C. "DSM and the death of phenomenology in America: an example of unintended consequences." *Schizophrenia Bulletin*, 33(1), 2007, pp. 108–112.

[3] Schneider, K. *Klinische Psychopathologie*, 14. Auflage. Stuttgart: Thieme, 1980; cited here by the pagination of that edition. See also the 1992 Thieme printing of the 14th edition with the annotations of G. Huber. English translation of an earlier edition: *Clinical Psychopathology*, trans. M. W. Hamilton. New York: Grune & Stratton, 1959. Two Japanese translations exist — the first by S. Hirai and T. Kanokogi (from the 6th edition), the second by H. Harima (*Shinpan Rinshō Seishinbyōrigaku*, Tokyo: Bunkodo, 2007, from the 15th edition); their history is the subject of the Appendix. All translations from the German in the present paper are the author's own, made in consultation with both Japanese versions.

[4] That the condition "*ohne verständlichen Anlaß*" is folded into the very identification of a delusional perception is displayed in an example long used in Japanese clinical teaching: a man walking through a building hears footsteps behind him and is convinced they are the footsteps of a detective pursuing him. If the man has in fact committed a crime and is being sought by the police, the conviction is intelligible — and no delusional perception is diagnosed. The example is formally identical with Schneider's dog case (S. 51), but by adding the counterfactual clause — *if he were being pursued* — it lays bare the understanding-psychological judgment that intervenes in the identification. (Its original source the author has been unable to trace, though it appears in several Japanese textbooks.) The same structure of judgment governs the differential in the abnormal experiential reactions; and Schneider's own battlefield observations (S. 27) show how far he was prepared to carry it: among the types he "found in the field" he lists anxious excitement and perplexity, pathetic-solemn tension, apathetic stupor, and pseudodementia with grossly wide answers, for which "a purposive reaction (*Zweckreaktion*) may usually be assumed" — malingering-adjacent reactions included in the differential. "In the field," he writes, "the differential diagnosis between psychogenic twilight state and schizophrenia was often difficult"; "I once saw three such disputed cases at the same time"; and, in the sentence that weighs most, "In the individual case the decision can sometimes be, at first (*zunächst*), impossible even for the most practised" (S. 68–69, S. 27). The same Schneider who declared for the cross-sectional principle — "he who (as we do) takes the former course" — conceded that in true intermediate cases "precisely the course, too, will be assessed," and that a diagnosis may be undecidable "here and now, or for a long time." Chapter I supplies the numbers and the norm: in the Munich-Schwabing statistics of 1932–36, only 28 cases were in dispute between 1,647 abnormal personalities and experiential reactions and 941 schizophrenias ("this is very few"), whence the "sharp differential diagnostics" (*schroffe Differentialdiagnostik*) between the two domains; and where the diagnosis nevertheless cannot be cleared up, "it is better to say 'unresolved case,' or 'suspected schizo-

phrenia,' 'suspected cyclothymia.' In the concrete case one must attempt the decision to the limit — and almost always the decision can be made without forcing (*ohne Zwang*)" (S. 6–7). To attempt to the limit, but not to force; to give the undecidable its own name — this is the diagnostic horizon in which the Lower Bavarian case stands, and its contrast with an operational system that obliges a decision from a cross-sectional item count could not be sharper.

[5] Carpenter, W. T., Strauss, J. S., & Muleh, S. "Are there pathognomonic symptoms in schizophrenia? An empiric investigation of Schneider's first-rank symptoms." *Archives of General Psychiatry*, 28(6), 1973, pp. 847–852. On the basis of IPSS data, first-rank symptoms were observed not only in schizophrenia (51%) but in affective disorder (23%) and in "neuroses and personality disorders" (9%). The methodological standing of this line of research — first-rank symptoms identified externally as observation items and tested for frequency differences across categories — is examined in the companion paper, where Carpenter's later role as chair of the DSM-5 Psychotic Disorders work group is also discussed.

[6] Schneider, K. "Kraepelin und die gegenwärtige Psychiatrie." *Fortschritte der Neurologie und Psychiatrie*, 24, 1956, pp. 1–7; the *Wie/Was* distinction at p. 4. The author owes his knowledge of this essay to Shorter (2015), n. 24.

[7] Shorter, E. *What Psychiatry Left Out of the DSM-5: Historical Mental Disorders Today*. New York: Routledge, 2015. Chapter 2, "Disease Designing," esp. pp. 17–18 ("Form rather than content"). At the close of that section Shorter places Schneider at the end of the formalist line Richarz 1848 – Falret 1864 – Jaspers 1913, and declares that "the shift in emphasis from form to content is today being reversed by the novel content diagnoses of DSM-5."

[8] Shorter (2015), ch. 2, p. 17 ff. The primary sources Shorter cites: Richarz, F., "Ueber die Grundformen der chronischen Seelenstörungen," *Allgemeine Zeitschrift für Psychiatrie*, 5 (1848), 318–326, esp. 318–319; Falret, J.-P., *Des maladies mentales* (Paris: Baillière, 1864), xxxviii–xxxix; Jaspers, K., *Allgemeine Psychopathologie* (Berlin: Springer, 1913), 19. These are cited here at second hand, from Shorter.

[9] Huber, G., & Gross, G. *Psychiatrie: Systematischer Lehrtext für Studenten und Ärzte*, 2. Auflage. Stuttgart: Schattauer, 1976 (Tab. 14, S. 158). Huber, G., & Gross, G. *Psychiatrie: Lehrbuch für Studium und Weiterbildung*, 7. Auflage (final edition). Stuttgart: Schattauer, 2005 (Tab. 22, S. 307; imperative voices as Huber's own addition, S. 307; the doubled qualification of the *Wahnwahrnehmung* definition, S. 308; *Bezugsunwahrscheinlichkeit* and the *Methode des genetischen Verstehens*, S. 309; Bonn study, S. 311; "nicht obligat für die Diagnose," S. 312).

[10] See the Appendix for the full passage, Huber's exemplary case, and the difficulty it raises.

* * *