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The Reliability Bargain

Three transformations of Schneiderian psychopathology in DSM-III to DSM-5 — and what DSM-6 should restore

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

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Dedicated to Dr. Hiroshi Motomura

ABSTRACT

Between November 2023 and January 2024, 136 international experts were surveyed on the future of the DSM: about half favoured restoring the special weight of Schneider's first-rank symptoms; four in five rejected the DSM-5 requirement that hallucinations carry "the full force and impact of normal perceptions." This paper explains those numbers historically. Using the instrument derived in the companion paper — Schneider's subjunctive reservation, his hierarchy of the three forms of delusion, and the orthodox German succession of Huber and Gross — it reconstructs what the DSM made of Schneiderian psychopathology as three transformations. First, DSM-III stripped the methodological reservation that Schneider had inscribed in the Konjunktiv II, converting first-rank symptoms from clues requiring a judgment of intelligibility into absolute indicators. Second, from DSM-III to DSM-5 the eight first-rank symptoms were re-edited in three layers — explicit inheritance, compressive inheritance, complete omission — and the two symptoms omitted without residue are precisely *Gedankenlautwerden* and *Wahnwahrnehmung*, the delusional perception to which Schneider had granted his only indicative *immer*. Third, DSM-5 added a perceptual-intensity requirement to the definition of hallucination that the German original expressly holds off: Schneider had written that the sense-deceptions are "often not comparable to normal perception" (*nicht vergleichbar*), and the Huber orthodoxy's paradigm case hears voices that are "very soft." The paper then reexamines the reliability-first paradigm behind all three transformations and argues, from the empirical work of the Copenhagen school and the German basic-symptom tradition, that Spitzer's dichotomy — phenomenological judgment or reliability — was false: trained phenomenological interviewing achieves both. A closing synthesis reads the survey's own design limits: it could ask only about the most technical of the three losses, and even there four in five experts dissented. Restoration in DSM-6, it is argued, must mean more than reinstating a list.

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Nota in limine — Prefatory note This is Paper II of the two-paper English edition of the author's study of Schneider and the DSM, based on the Japanese original, v55 (2026). The instrument of the analysis — the subjunctive reservation, the hierarchy of the three forms of delusion, and the orthodox succession of Huber and Gross — is derived in full in the companion paper, The Grammar of Diagnostic Caution; Section 1 below gives only the summary needed to read the argument. The complete argument remains the Japanese original.

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1. Introduction: The 2024 Survey

Between November 2023 and January 2024, Steffen Moritz, Lisa Borgmann, Andreas Heinz, Thomas Fuchs and Jürgen Gallinat put a set of questions about the future shape of the DSM to 136 international experts — members of the editorial boards of *Schizophrenia Bulletin* and *Schizophrenia Research* and of the International Consortium for Hallucination Research[1]. The results, published under the title "Towards the DSM-6," reduce to two findings. First, 49.3% of respondents — against 34.6% opposed — endorsed the proposal that DSM-6 should once again give Schneider's first-rank symptoms the special weight they carried in DSM-IV and lost in DSM-5. Second, the DSM-5 definition of hallucination fared far worse: 79.7% answered that the requirement of experiences "vivid and clear, with the full force and impact of normal perceptions" does not necessarily hold of hallucinations; 83.9% would include in the definition inner events lacking full perceptual force, provided the subject is convinced of their reality; 66.1% said the current definition should not be maintained.

These are remarkable numbers. A criterion abolished in 2013 as insufficiently specific is, a decade later, wanted back by half the field's experts; a definition installed in the current manual is rejected by two-thirds of them. The present paper explains the numbers historically: it reconstructs, as three distinct transformations, what the DSM made of Schneiderian psychopathology between 1980 and 2013.

The instrument of the analysis was derived in the companion paper and is here only recalled. Schneider's doctrine, on the reading argued there, is a structure in two joined levels, inscribed in grammatical mood: at the level of the concept, the reading of first-rank symptoms as the essence of the disease is held off in the Konjunktiv II — the German subjunctive of the unreal — 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 for the diagnosis*) and the prohibition (*the inference from symptom to diagnosis must not be reversed*) are declared in the indicative. Within the three forms of delusion, Schneider ranked delusional mood outside the diagnostic hierarchy, delusional intuition second, and delusional perception (*Wahnwahrnehmung*) alone first — the one symptom for which he permitted himself the indicative *immer*, "always," because the judgment of intelligibility (*ohne verständlichen Anlaß*) is folded into its very identification. And the German orthodoxy — Huber and Gross's *Psychiatrie*, 1976 to 2005 — preserved the whole structure, hierarchy, definition and exemption, into the twenty-first century.

Against that baseline, the present paper argues three theses. The first is the loss of the subjunctive reservation: DSM-III stripped the methodological reservation and converted the first-rank symptoms into absolute indicators (Section 2). The second is the omission of delusional perception: from DSM-III to DSM-5, *Wahnwahrnehmung* — the most important first-rank symptom, the only one Schneider trusted with the indicative — never once appeared as an item in any edition's diagnostic criteria for schizophrenia; not the dropping of an item, but the wholesale exclusion of the German analysis of delusional form (Section 2). The third is the addition of a perceptual-intensity requirement to the definition of hallucination in DSM-5, the point at which the operational tradition departs most flagrantly from the German original (Section 2). These three theses do not, strictly, lie on one dimension: the first concerns Schneider's methodological attitude toward the list as a whole; the second, the fate of a single symptom that most purely embodies "form before content"; the third, a technical revision of one definition. They are retained as the organizing structure because they illuminate three different faces of a single question — what became of Schneider's first-rank symptoms in the DSM.

Section 3 then turns from history to methodology and asks whether the reliability-first paradigm that drove all three transformations was ever forced: whether Spitzer's dichotomy — phenomenological judgment *or* inter-rater reliability — was a real alternative or a false one. Section 4 synthesizes the argument with the prior literature — Parnas, Sass, Nordgaard, Andreasen — and reads the Moritz survey's own limits by its light. Section 5 concludes with what restoration in DSM-6 would have to mean.

As in the companion paper, all quotations from Schneider and from Huber and Gross are newly translated from the German; the originals of the passages quoted are given in the Texts section at the end.

2. Three Transformations: DSM-III to DSM-5

2.1 The design and the first loss

That DSM-III could not inherit Schneider's formalism is a matter of its design. The Cooper et al. US–UK comparison of 1972[2] and the Rosenhan experiment of 1973[3] had cast international doubt on the reliability of American psychiatric diagnosis; Spitzer accepted the raising of the kappa coefficient as a supreme imperative[4]. The resulting design principle — admit only items that are "observable and checkable" — structurally excludes whatever requires Jaspersian understanding. Spitzer adopted the items that demand comparatively little judgment of intelligibility — thought interference, passivity experiences, voices in dialogue, commenting voices — and excluded the item that essentially requires it: *Wahnwahrnehmung*. This is the first face of the exclusion of the analysis of delusional form. And for the symptoms that *were* adopted, the operationalization re-ordered them as observable descriptions detached from form: the loss of the subjunctive reservation, too, has its origin at the design stage of DSM-III.

A way-station on this path is C. S. Mellor's 1970 paper "First rank symptoms of schizophrenia"[5]. Mellor redescribed the first-rank symptoms as operational indicators; for delusional perception he preserved Schneider's two-step structure, after a fashion, as "a normal perception to which a delusional interpretation is given." But the reservation of the Konjunktiv II has already fallen out of Mellor's descriptions, and the logical position of the symptom relative to the diagnosis is left indeterminate. (That the blunting had begun still earlier, in the Hoenig–Hamilton translation of 1959, was argued in the companion paper: English possesses no grammatical mood in which Schneider's reservation could have been carried.)

2.2 The three-layer re-editing of the eight symptoms

DSM-III (1980) admitted a subset of the first-rank symptoms into its A criterion: thought interference (insertion, withdrawal, broadcasting), experiences of influence and passivity, voices in dialogue, commenting voices. But the manner of admission deserves close reading. In item (1), "bizarre delusions" is defined by absurdity of content — "content is patently absurd and has no possible basis in fact" — a DSM invention, not a Schneiderian concept; the Schneiderian symptoms enter only as a "such as" list of examples under that independent definition. Schneider himself never called these symptoms "bizarre"[6]; DSM-III made them the paradigm cases of bizarreness. *Wahnwahrnehmung*, meanwhile, is nowhere. As Nielsen, Nordgaard and Henriksen put the matter in 2022: delusional perception is one of the first-rank symptoms deleted from ICD-11 — and a symptom "never included in the DSM"[7]. The exclusion persisted unbroken through DSM-III-R, DSM-IV and DSM-5; and the parallel withdrawal of privilege occurred in ICD-11, whose commentary literature records that the first-rank symptoms have lost their precedence (*Vorrang*), the enumerated symptoms now counting as equal in weight[8].

The re-editing of Schneider's eight items (Table 1) forms three layers. The first layer, explicit inheritance: the symptoms the patient can report in words — thought interference, thought broadcasting, voices in dialogue, commenting voices. The second layer, compressive inheritance: the bodily experiences of influence and the made experiences of feeling, drive and will are collapsed into a single "delusions of being controlled," losing the phenomenological distinctions. The third layer, complete omission: *Gedankenlautwerden* (audible thoughts) and *Wahnwahrnehmung*. The asymmetry mirrors the design principle exactly — what can be checklisted was inherited; what requires the judgment of understanding was excluded.

Table 1. The eight first-rank symptoms (14th ed., p. 65) in three generations of the DSM

Schneider's first-rank symptom	DSM-III (1980)	DSM-IV (1994)	DSM-5 (2013)
(i) Audible thoughts — *Gedankenlautwerden*	**omitted**	**omitted**	**omitted**
(ii) Voices in speech and counter-speech — *Stimmen in Form von Rede und Gegenrede*	explicit, item (4): "two or more voices converse with each other"	preserved under item (2); single-symptom sufficiency via the Note	merged into item (2); Note privilege abolished
(iii) Commenting voices	explicit, item (4): "a voice keeps up a running commentary"	preserved under item (2); Note sufficiency	merged into item (2); Note privilege abolished
(iv) Bodily experiences of influence — *leibliche Beeinflussungserlebnisse*	compressed under item (1): "delusions of being controlled" (merged with the affective-conative domain)	under item (1), as "loss of control over mind or body," an example of the bizarre	merged into item (1); Note and bizarre privileges both abolished
(v) Thought withdrawal and interference	explicit, item (1) (example of the bizarre)	under item (1); Note sufficiency	merged into item (1); privileges abolished
(vi) Thought broadcasting	explicit, item (1) (example of the bizarre)	under item (1); Note sufficiency	merged into item (1); privileges abolished

Schneider's first-rank symptom	DSM-III (1980)	DSM-IV (1994)	DSM-5 (2013)
(vii) Delusional perception — *Wahnwahrnehmung*	**omitted**	**omitted**	**omitted**
(viii) Made feelings, strivings, will — *gemachte Gefühle, Strebungen, Wille*	compressed under item (1): "delusions of being controlled"	under item (1), "loss of control over mind or body"	merged into item (1); privileges abolished

Note. "Bizarre delusion" is independently defined in DSM-III (absurdity of content) and DSM-IV ("clearly implausible, not understandable, not derived from ordinary life experiences"); the Schneiderian symptoms figure only as its typical examples. "The Note" is DSM-IV's exception clause: one A-criterion symptom suffices if the delusion is bizarre, or the hallucination consists of a commenting voice or voices conversing. DSM-5 abolished both the Note and the bizarre/nonbizarre distinction within the A criterion. The structural fact the table displays: the two items omitted across all three generations are *Wahnwahrnehmung* — the symptom to which Schneider granted his only indicative *immer* — and *Gedankenlautwerden*, where the permeability of the ego-boundary appears at its most inward.

DSM-IV (1994) retained a privileged position for the Schneiderian symptoms at the core of its A criterion through the Note[9] — this is why partial return to DSM-IV could still command 49.3% support in the Moritz survey — and made the reference explicit at p. 275: delusions "expressing loss of control over mind or body" are "included in Schneider's list of first-rank symptoms" and "generally considered bizarre." But "loss of control over mind or body" is a different conceptualization from the German original's *Durchlässigkeit der Ich-Umwelt-Schranke* — the permeability of the barrier between ego and world — and *Konturverlust des Ich*, the loss of the ego's contour: the phenomenological core is compressed even where the inheritance is explicit. And *Wahnwahrnehmung* remained absent. DSM-5 (2013) then abolished the privileged position altogether — and, at the same stroke, redefined hallucination[10].

2.3 The intensity requirement against the German definition

DSM-5 defines hallucinations as "vivid and clear, with the full force and impact of normal perceptions, and not under voluntary control." The definition stands in direct contradiction to the hallucination doctrine of the German original. Schneider opens the treatment of perception in Chapter VI, Section II with a definition of the sense-deceptions (*Sinnestäuschungen*) [T1]:

> Among the manifold disturbances of perceiving ... the most important for psychiatric diagnosis are the deceptive perceptions or sense-deceptions. Let it be said again and again (*Immer wieder sei gesagt* — the hortative Konjunktiv I): what is at issue must be sense-deceptions, that is, something is experienced sensuously, sensationally (*sinnlich, empfindungsmäßig*), not merely in thought, which is not there. The "not there" (*nicht da*) is established objectively, from the side of the observer — not by the one who experiences. (p. 47)

Two elements make up the core: the sensuous, sensational character of the experience; and the objective establishment, from the observer's side, of the object's absence. Perceptual *intensity*, and comparability with normal perception, are entirely absent from the definition. What is decisive is that Schneider immediately adds an express reservation on exactly this point[T2]:

> This, incidentally, is also because the sense-deceptions are very various in sensuous content and often *not comparable* (*nicht vergleichbar*) to normal perception. (p. 47)

The DSM-5 requirement — "the full force and impact of normal perceptions" — is the kind of stipulation this sentence exists to reject. For Schneider, whether a sense-deception is *comparable* to normal perception was no essential attribute bearing on the definition, but one range within a variation he called "very various." DSM-5 elevated an attribute Schneider had declined to place in the definition into a necessary condition, and structurally excluded the range of variation his *nicht vergleichbar* had held open. The third transformation is thus a structural inversion of the German definition itself: from a definition that reserved *incomparability* as a live possibility, to a definition that requires *comparability*.

The Huber orthodoxy makes the divergence concrete. The paradigm case of first-rank voices in Huber and Gross 2005 (p. 307), quoted in the companion paper, is a patient who in the quiet of the evening hears acquaintances talking about her, "the voices of her family doctor and her pastor clearly distinguishable — *though the voices are very soft*." In the German tradition, first-rank hallucinated voices never required the vividness of normal perception; the typical case is precisely the soft, distinct, formally complete voice. What Schneider had made diagnostically decisive — the unmotivated abnormal attachment of meaning, the violation of the ego-boundary — was abandoned, and a perceptual-intensity criterion, phenomenologically peripheral, was installed at the diagnostic core.

2.4 What the abolition answered — and what it missed

The methodological justification for DSM-5's abolition of the first-rank privilege goes back to Carpenter, Strauss and Muleh's 1973 question, "Are there pathognomonic symptoms in schizophrenia?"[11] — and to weigh it, one must hold in view what Schneider himself had said at p. 65 of the original. The core of the passage, quoted in full in the companion paper, bears repeating[T3]: where such modes of experience are unexceptionably present and no somatic underlying disease is to be found, "we speak clinically — *in all modesty* (*in aller Bescheidenheit*) — of schizophrenia. For one must

know that probably all of them (*wohl alle*) can also occur in psychotic states on the ground of an ascertainable underlying disease: in the alcoholic psychoses, in the epileptic twilight state, in anaemic and other symptomatic psychoses, in the most diverse cerebral processes."

The adverbial phrase and the express concession say plainly that Schneiderian diagnostics treated the first-rank symptoms not as observation items but as clues for clinical judgment. And alongside the symptomatic psychoses named at p. 65 stands cyclothymia itself: if, in a severe depressive phase, phenomena resembling first-rank symptoms are observed, and they are judged intelligible from the depth of the depressive mood or the inhibition of thought, then they are *not identified as first-rank symptoms at all*. The "*ohne verständlichen Anlaß*" of the delusional-perception definition, argued in the companion paper to be folded into the symptom's identification, is only the most explicit formal expression of an understanding-psychological principle that governs the identification of every first-rank symptom.

Only against this structure does the fundamental confusion of the specificity literature come into focus — the line that runs from Carpenter 1973 through Nordgaard et al. 2008[12] to the Cochrane review of Soares-Weiser et al. 2015 [13]. Carpenter and colleagues, using IPSS data, reported first-rank symptoms in 51% of schizophrenic patients, but also in 23% of patients with affective disorder and 9% with "neuroses and personality disorders," and took this as an empirical challenge to pathognomonicity. The argument is empirical in form; its methodological premise — identify first-rank symptoms externally, as observable items, and test frequency differences across diagnostic categories — steps outside the very framework that gave the symptoms their sense. In Schneiderian diagnostics a first-rank symptom is not an observation item but a diagnostic judgment: the observed phenomenon becomes a first-rank symptom only after the clinical judgment that it is *not* intelligible from the patient's mental background, affective state, and underlying disease. When Carpenter reports that 23% of affective patients "showed" first-rank symptoms, a substantial part of that 23% consists of cases in which, within the Schneiderian framework, the phenomena would be judged intelligible from the affective state — and hence never identified as first-rank symptoms in the first place.

Carpenter later chaired the DSM-5 Psychotic Disorders work group, and placed his 1973 argument at the centre of the methodological justification for abolishing the first-rank privilege. But the argument never left the Spitzerian frame of the observation item. For Carpenter, "first-rank symptoms occur in manic-depressive illness" was a refutation of specificity; for Schneider it had been a point of departure — since the core of his diagnostics lay precisely in the clinical judgment of whether the observed phenomenon is intelligible from the patient's mental background. The de facto end of Schneiderian formalism in DSM-5 is the structural victory of a half-century of specificity critique; but it is the victory of an argument that had structurally failed to grasp what it was arguing against — a victory over Schneiderian psychopathology that was never a methodological victory *against* it.

The two theses of this section, taken together, form a single chiasmus. The symptoms Schneider had guarded with the subjunctive were converted by the DSM into absolute indicators; the symptom he had trusted with the indicative — *Wahnwahrnehmung*, and with it the *immer* — was omitted entire. Separate events, and both testimony, from opposite sides, to the same loss: the loss of form as the core of the doctrine.

3. The False Dichotomy: Reliability Reconsidered

Against the argument so far, the practising clinician will raise an obvious concern. Grant the importance of the Schneiderian phenomenological attitude — does a return to phenomenology not mean a regression to the diagnostic disarray that the US–UK comparison and the Rosenhan experiment exposed, the very disarray Spitzer's paradigm was built to overcome? Whoever criticizes the reliability-first paradigm owes an answer to the question of diagnostic agreement. This section gives the answer, on the empirical record accumulated over the past quarter-century by the Copenhagen school and the German basic-symptom tradition.

The first point is historical. The diagnostic disagreement of the pre-DSM-III era did not arise *because* American practice relied on a phenomenological attitude; it arose from the absence of phenomenological training and the prevalence of unstructured interviewing. The diagnostic habits of 1960s American psychiatry had drifted far from the discipline of phenomenological description that the Schneider–Jaspers tradition had achieved. What Cooper et al. (1972) exposed was an asymmetry — New York diagnosing schizophrenia at more than twice the London rate — and one reason the London side could show relatively high agreement was that British psychiatry, under the Maudsley tradition, still preserved that descriptive discipline. The comparison exposed not the failure of phenomenology but its American absence. Spitzer's dichotomy — phenomenological judgment (valid but unreliable) versus concrete observational criteria (reliable but phenomenologically blind) — could be erected only by keeping this historical fact out of view. It was a false alternative.

The second point is empirical. The Copenhagen school has demonstrated, over twenty years, that trained phenomenological interviewing achieves high inter-rater reliability. From Møller and Husby's reliability study of the phenomenological description of the prodrome (2000)[14], through the EASE scale of Parnas et al. (2005)[15], which reported good reliability between trained raters for the assessment of disturbances of the minimal self, to Nordgaard, Revsbech, Sæbye and Parnas (2012)[16] — a study of precisely this section's question — the record shows two things at once: that the reliability of structured interviews is not as high as their design was expected to guarantee, and that semi-structured phenomeno-

logical interviews by trained clinicians combine good validity with good reliability. Nordgaard, Sass and Parnas (2013)[17] drew the methodological balance: reliability is truly achieved only by the trained rater's clinical judgment, and checklist refinement produces the appearance of reliability rather than the thing itself.

The same development occurred inside the German-speaking world. The Bonn Scale for the Assessment of Basic Symptoms (BSABS, 1987), developed by Huber, Gross and Klosterkötter[18], translated Huber's concept of the basic symptoms into a clinically assessable form on the same methodological footing as the later EASE; its successors, the Schizophrenia Proneness Instruments (SPI-A, SPI-CY) of Schultze-Lutter and Klosterkötter[19], showed that basic-symptom ratings achieve good reliability between trained clinicians, and are now standard instruments of international prodrome research. The BSABS/SPI line is the terminus of Huber's own trajectory — the orthodox heir of Schneiderian psychopathology translating the phenomenological tradition into the vocabulary of empirical research. The German orthodoxy refused the alternative "checklist or phenomenology" and opened, empirically, a third way: phenomenological assessment by trained clinical judgment.

The conclusion is a diagnosis of the paradigm itself: the founding premise of the reliability-first paradigm was wrong. The alternative Spitzer posed — understanding-psychological judgment serving validity at the cost of reliability, versus concrete observational criteria securing reliability at the cost of phenomenological validity — is defeated by a third option demonstrated on both the Danish and the German record: trained phenomenological judgment achieving both. As Nordgaard and colleagues insist, reliability is a problem of rater training, not of instrument design; and a return to the phenomenological tradition is not a regression to the pre-1970s disarray but the radical treatment of its root cause — the lack of phenomenological training.

For the clinical reader the practical consequence is plain. A return to Schneiderian phenomenology means not diagnostic anarchy but investment in trained clinical judgment; the departure from checklist dependence is not a regression into arbitrariness but a reinvestment in the psychopathologist's craft of understanding the patient's experiential world from within — an investment whose feasibility the Copenhagen and Bonn data guarantee.

4. Synthesis: Parnas, Sass, Andreasen — and the Limits of the Survey

The survey results with which this paper opened can now be explained; this section aligns the explanation with the prior literature and, in doing so, reads the survey's own limits.

The Copenhagen school has argued for two decades that DSM operationalization fails to capture the phenomenological core of schizophrenia. The EASE scale translates into clinical assessment the disturbances of the minimal self — the concept Schneider's original had formulated at p. 65 as the *Durchlässigkeit der Ich-Umwelt-Schranke*, the permeability of the ego–world barrier[20]; Sass's hyperreflexivity is a contemporary continuation of Schneiderian formalism[21]; Nordgaard's interview studies demonstrated that reliability is a training problem[16]. And Andreasen — chair of the DSM-IV schizophrenia work group — confessed in 2007 that DSM-III operationalism had cost American psychiatry its tradition of phenomenological training[22]: a consequence, this paper has argued, structurally entailed by the design of the reliability-first paradigm. What Andreasen called "the death of phenomenology in America" has, at its core, the loss of the formal reservation that Schneider had carried in the Konjunktiv II.

Against this background, the Moritz survey — the most substantial empirical sign of the community's discontent — has four limits.

First, of this paper's three theses, the survey's questionnaire contains items corresponding only to the third. The loss of the subjunctive reservation and the omission of *Wahnwahrnehmung* from every DSM edition have no direct counterpart among its questions; what the survey directly measured was the intensity requirement in the hallucination definition — the most technical of the three losses.

Second, the survey's design structurally excludes the question of restoring *Wahnwahrnehmung*: by asking whether the DSM-IV privilege should be restored, it takes as its baseline a manual in which delusional perception had already never figured.

Third, the "conviction" criterion that Moritz and colleagues propose for the new hallucination definition remains within the operational frame: a subject-side certainty item in place of a percept-side intensity item is an improvement, but it is not the recovery of the judgment of intelligibility.

Fourth, the survey inherits the methodological limits of the specificity critique itself. Moritz et al. (2023)[23] cite Carpenter 1973 and Nordgaard et al. 2008 approvingly on the non-specificity of first-rank symptoms; the argument identifies first-rank symptoms externally as observation items, and does not register that Schneiderian diagnostics treated them as diagnostic judgments (Section 2.4).

One structural fact deserves notice here: the author list of Moritz et al. (2023) includes W. T. Carpenter himself — first author of the 1973 paper and chair of the DSM-5 Psychotic Disorders work group. In that paper Carpenter joins a partial reconsideration of the DSM-5 hallucination definition (this paper's third thesis), while the specificity critique he founded — the methodological justification of the transformations treated in the first and second theses — is reaffirmed: "Carpenter and others were convincing in their challenge to the specificity or pathognomonic nature of first-rank symptoms." The position is self-consistent: distance from DSM-5's definitional innovation, fidelity to the critique that underwrote DSM-5's abolition of the privilege. And the composition of the paper displays, in its very authorship, that the Moritz group inherits the Carpenter line together with its methodo-

logical premises. A second co-author makes the display sharper still: Thomas Fuchs, holder of the Jaspers memorial professorship, has published an independent phenomenological analysis of delusional perception[24] and, in the Stanghellini–Fuchs centenary volume on Jaspers, an independent critique of the reduction of the ego-disturbances to content concepts in ICD-10 and DSM-IV[25]. In the Moritz paper on which Fuchs appears as co-author, that critique is nowhere to be found.

The limits are not incidental. They show that the questionnaire the community would need — one capable of asking about the logical structure of symptom and diagnosis, and about the fate of a symptom that embodies form as such — does not yet exist; the deepest losses are the ones the survey could not formulate.

5. Conclusion: What Restoration Would Mean

This pair of papers set out from the Moritz survey — four in five experts against the DSM-5 hallucination definition, half for the reinstatement of the first-rank symptoms — and sought its causes in the German original. The companion paper established the baseline: Schneider's formalism as the terminus of a century-long tradition (Richarz 1848, Falret 1864, Jaspers 1913); the subjunctive reservation as a two-level structure joining the hypothetical character of the disease concept to the practical exemptions and prohibitions of diagnosis; the formal selection among the three forms of delusion, with *Wahnwahrnehmung* alone first-rank in virtue of its two-step structure; and the preservation of all of it, to the letter of *nicht obligat für die Diagnose*, in the German orthodoxy of Huber and Gross through 2005.

On that baseline the present paper has established three further propositions.

First, the path from DSM-III to DSM-5 transformed the inherited structure in three places: the stripping of the Konjunktiv II reservation in DSM-III; the complete exclusion of *Wahnwahrnehmung* from the schizophrenia criteria of every edition; the addition, in DSM-5, of a perceptual-intensity requirement that the German original's *nicht vergleichbar* expressly holds off. The three transformations lie on different dimensions, but they flow from a single design principle — the reliability-first paradigm's demand for the observable and checkable.

Second, that paradigm rested on a false dichotomy. The pre-1980 disarray arose not from phenomenology but from its absence; and the Copenhagen and Bonn traditions have since demonstrated empirically that trained phenomenological interviewing achieves reliability and validity together. The practical consequence for the clinician is investment in phenomenological training, not deeper checklist refinement.

Third, the survey's correspondence to the three theses is unequal in a way that is itself diagnostic. Its first-rank questions measure clinical *usefulness* — restoration of the DSM-IV weighting, utility for diagnosis, prognosis and treatment, attitudes to the specificity debate — and contain nothing that corresponds to the logical structure probed by the first thesis or the symptom-fate probed by the second. Only the third thesis, the intensity requirement, is directly measured — and there the verdict is stark: 79.7% object to the "full force and impact" requirement (84.9% among the verified experts, n = 53); 83.9% would include inner events without full perceptual force where conviction of reality is present; 66.1% oppose retaining the current definition; and assent to the conviction-centred reformulation is strongest precisely in the verified expert group (85.7%). Even under a questionnaire that could formulate only the most technical of the three losses, four in five experts dissented from the current definition of DSM-5 and DSM-5-TR.

What, then, would restoration in DSM-6 mean? Reinstating a Note, or re-weighting a list, would restore the smallest part of what was lost. The core of Schneiderian psychopathology, these two papers have argued, must be read not as a list of diagnostic contents but as a methodology of the diagnostic act — a grammar, in the almost literal sense that the companion paper gave the word; the Konjunktiv II was its sharpest marker, and the dimension most easily lost, twice over, in translation and in operationalization. The recovery pursued by Parnas, Sass, Nordgaard and Andreasen's heirs is the reconstruction of that methodological legacy; the Moritz numbers show a community already in revolt against the definition it can vote on, while the questions it cannot yet formulate — the logical standing of symptom and diagnosis, the restoration of delusional perception — mark the work that remains. To that work, the Japanese reception of Schneider — with its own soundings of the German orthodoxy, recorded in the companion paper's appendix — may yet contribute a voice of its own.

Texts

German originals of the passages quoted in translation. Schneider: Klinische Psychopathologie, 14. Aufl., Stuttgart: Thieme, 1980. For the passages of S. 65 (the first-rank list with in aller Bescheidenheit and the exemption), S. 51–53 (the definitions and cases of the three forms of delusion), S. 66 (the cyclothymia minimal pair) and Huber/Gross 2005, S. 307–312, see the Texts section of the companion paper.

[T1] (S. 47) „Unter den mannigfachen Störungen des Wahrnehmens, der ersten unter den Arten des Erlebens, sind für die psychiatrische Diagnose die Trugwahrnehmungen oder Sinnestäuschungen die wichtigsten. Immer wieder sei gesagt: es muß sich dabei um Sinnestäuschungen handeln, d.h. es wird etwas sinnlich, empfindungsmäßig, nicht nur gedanklich erlebt, was nicht da ist. Das „nicht da" ist objektiv, vom Beobachter aus festgestellt, nicht vom Erlebenden."

[T2] (S. 47) „Das liegt übrigens auch daran, daß die Sinnestäuschungen an sinnlichem Gehalt sehr verschieden und oft nicht der normalen Wahrnehmung vergleichbar sind."

[T3] (S. 65) „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."

Notes and References

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[10] American Psychiatric Association. *DSM-5*. Washington, DC: APA, 2013. Schizophrenia Spectrum and Other Psychotic Disorders, Diagnostic Features; the hallucination definition "vivid and clear, with the full force and impact of normal perceptions, and not under voluntary control."

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