THE HISTORY OF THE BASIC SYMPTOM CONCEPT

Gisela Gross and Gerd Huber

The basic symptom concept (BSC) has been developed since the 50s by clinical psychiatrists [66-70] and, independently of this group, in the 70s by clinical psychologists [144, 146]. A comprehensive synopsis of the concept of basic symptoms (BS) and basic stages has been given a.o. in the book of Süllwold and Huber [147], in the seven editions of Huber's textbook of psychiatry since 1974 [99] and in my papers »Pure defect syndromes and basic stages of endogenous psychoses« [72] and »The concept of substrate-close basic symptoms and its meaning for theory and therapy of schizophrenic disorders« [80], furtheron in the reports on the sixteen Weißenauer Schizophrenia Symposia 1971-2006 [a.o. 56, 57, 73, 74, 78, 79, 82, 83, 88, 92, 97]. The individual BS were described in the manual of the Bonn Scale for the Assessment of BS (BSABS – [49, 58]; Italian edition 1992, Danish edition 1994, Spanish edition 1995, Japanese edition 1996).

The BSC originated with two observations which I made in the early 50s as a pupil of Kurt Schneider in his University Hospital in Heidelberg. The one concerned the so-called *pure defect syndromes* [70, 72], the other the *cenesthetic type of schizophrenia* [69, 91] with its long lasting prodromes, preceding the first psychotic episode.

(1) Pure defect syndrome of schizophrenia. We observed patients whose psychopathological cross-sectional syndrome appeared at first sight psychopathic-asthenic or organic-pseudoneurasthenic. The syndrome was determined by disturbances which were reported by the patients e.g. as diminished resistance to certain stressors, diminished resilience, energy, endurance, drive and activity, as increased exhaustibility and fatigability, as decreased emotional reagibility and as vegetative and sleep disorders. Only when the careful inquiry of case history had elicited psychotic episodes, as a rule occurring many years ago, the tentative diagnosis of a pure, nonpsychotic residual state of schizophrenia was possible. In the actual psychopathological picture none of the typical symptoms of schizophrenia could be recognized, as also K. Schneider at his own painstaking psychopathological exploration of those patients stated. It ensued that in these patients the psycho-pathologically uncharacteristic residues could not be diagnosed in their schizophrenic provenance without comprehensive inquiry and knowledge of the anamnesis [20, 21, 70, 72, 140].

In the following years, as I (G. Huber) was the chairman of the outpatient department of the Psychiatric University Hospital in Heidelberg, we followed-up patients in their domestic environment, who had shown as inpatients (1949-1953) a florid schizophrenic psychosis, but who were neither readmitted in the further course in a psychiatric hospital nor had a medical treatment as outpatients. The results of these follow-up studies were published in several papers since the late 50s [68, 69, 70, 71, 72]. We described the psychosyndromes found by our follow-ups as nonpsychotic residual types, termed as asthenic or »pure defect« [68, 70].

Already these findings led to a revision of the doctrine that residues of schizophrenia are psychopathologically always quite different from organic psychosyndromes of well known brain diseases. Based on these studies the Heidelberg checklist of BS (1962) has been developed which comprised nearly all BS that later were presented in detail in the 178 items of the Bonn Schedule for the Assessment of BS ([49, 58] – s. table 1).

It is meaningful that the essential results of the BS research were already obtained in drug-free schizophrenic patients investigated before the psychopharmacological era. I quote briefly some of these results.

Gerd Huber, Auf dem Rosenberg 18 ,D-53343 Wachtberg, Germany

E-mail: gerd.huber@ukb.uni-bonn.de

The pure defect syndrome is determined by dynamic and cognitive BS. The patients perceive and report the BS as deficiencies and disturbances and suffer from them; they are able to describe their basic deficiencies as deficiencies and to develop self-help strategies and coping behaviour, attempts of defending, avoiding and compensating [19, 58, 145].

The pure dynamic-cognitive deficiency syndromes (pure defect syndromes) that are probably more a persisting basic stage with low or lacking process activity [94, 112] than a residual state, developed independently of treatment measures, of the age of the patient and of psychosocial influences. We found that only the patients with irreversible pure defect syndromes – and not all schizophrenias – are associated with neuroradiologically provable slight, mainly internal cerebral atrophy [48, 66, 67, 68, 70, 71].

The first observation, the BSC proceeded from, the pure defect syndromes, included the psychopathological and clinical awareness that the most schizophrenics the most time in their long courses look no longer schizophrenic, but develop to non-psychotic pure defect syndromes, determined by BS. There were already at that time single observations, demonstrating that distinct, rather characteristic cognitive BS (level-2 BS) are the basis for the development of distinct first rank symptoms [68: pp 194f, 208f].

(2) The cenesthetic schizophrenia with its precursors. Our second observation the BSC originated with was the first description of the cenesthetic type of schizophrenia with its long-lasting prodromes, preceding the first psychotic exacerbation. We saw in the early 50s many for the moment diagnostically unclear cases, patients who complained in a more or less peculiar manner on manifold bodily sensations. By following-up these patients for years became evident that in the further course a schizophrenic psychosis occurred, even if as a rule only in short, quickly remitting acute episodes. The prodromes of this type of schizophrenia, first represented based on a sample of 50 cases [69, 91, 102], continued 7 years on average.

The next question was to what extent such prodromes occurred also in the whole group of schizophrenia. This issue was answered by the first systematic study on *precursor stages of schizophrenia* by means of a sample of 290 patients [18]. In this sample the *prodromes* which pass over continuously into the first psychotic episode, were lasting 3.5 years on average with a great range from two months until 18 years. The *outpost syndromes*, completely remitting phases without a transition into a psychotic episode, were lasting in average 6 months with a range from 4 days until 4 years. The interval between outpost syndrome and onset of the psychotic episode amounted many years until – at the most – 35 years. We proceeded already at that time from a nosological congruity of the typical psychotic episodes on the one side and of the pre- and postpsychotic basic stages, i.e. the prodromes and the pure defect syndromes of schizophrenia on the other side.

The findings of this study [18] were all in all replicated and still more specified by the Bonn Schizophrenia Study [104]. By means of retrospective inquiry and personal exploration of 502 patients were in 52% precursor stages - i.e. prodromes and/or outpost syndromes - reliably provable. In many courses the development went from prodromes through acute schizophrenic psychotic episodes again to uncharacteristic psychosyndromes, i.e. to pure deficiency syndromes [45, 55, 95].

Regarding *cenesthetic schizophrenia* it ensued that prodromes regularly occurred; further, that also pure defect syndromes were here with 65% still more frequent than in the whole schizophrenia group with 40%. The cenesthetic type has become in view of its dominating non-psychotic pre- and postpsychotic basic stages a model for the development of the BSC. Because of the phenomenological analogies of the cenesthesias with thalamic spontaneous sensations of known brain diseases and of the neuroradiological changes of pure residues of the cenesthetic schizophrenia, we assumed that this type belongs to the organic pole of the schizophrenia group and that the cenesthesias can be considered as »substrate-close BS«. Also the other main categories of BS which are sections of the BSABS (s. table 1) were first set off on account of observations of the cenesthetic courses, i.e. as well central-vegetative and dynamic BS as cognitive perception and thought basic deficiencies, described first in our monograph of 1957 [68].

Later on the thought, perception and action (movement) basic phenomena assigned to the main categories C.1, C.2 and C.3 of the Bonn Schedule, were in detail defined and illustrated by means of typ-

ical statements of the patients [13, 29, 38, 49, 58, 72, 84, 147].

To summarize: The BSC, not behavioural but experiential in kind, has been delineated in the 50s and gradually evolved in the following decades. It has led to a new doctrine of hitherto neglected symptoms in schizophrenia, which, e.g., are not criteria of DSM and ICD, the dynamic and cognitive BS, as complaints and deficiencies which are experienced by the patients as deficiencies and are missed before the onset of the disorder in intraindividual comparison.

The findings of the cited studies of the BS research represented the essential presuppositions for designing and accomplishing a prospective study into the BS oriented early detection and intervention of schizophrenic disorders. Because we knew from these results of BS research obtained by clinical-psychopathological inquiry and supported by experimental-psychological [61, 62, 77, 113], neurophysiological [103, 127], neuroradiological [3, 7, 66, 67, 68, 70, 71, 99] and neurochemical [51, 99, 133, 134] methods, the knowledge of persisting pure defect syndromes after psychotic episodes and long-lasting prodromes before the first psychotic manifestation, constituted by the different types of BS, the assumption was plausible that many seemingly neurotic, psychopathic and borderline syndromes turned out to be in reality basic stages or formes frustes of schizophrenia and related idiopathic psychosyndromes [25, 50, 96, 99].

The *Bonn prospective early recognition study,* carried out since 1970 with the help of the Bonn Schedule for the Assessment of BS BSABS, confirmed this assumption [22, 31, 37, 49, 52, 53, 54, 58, 75, 79, 80, 82, 88, 92, 99, 104, 105, 108, 112, 115, 144, 147]. It was possible to differentiate out of a great number of patients, hitherto largely misdiagnosed and mistreated as neurotic, psychopathic and borderline syndromes, a group of patients with a high risk of the later development of schizophrenic psychoses.

Thus, the empirical data of the BS research were above all a great challenge to recognize the *proper initial phases of schizophrenia*, and its true onset many years before the first psychotic episode; and, thus, by realizing the possibilities for *early therapeutic intervention* and prevention of the psychosis to improve the long-term prognosis of the disorder [s. 33], chances that were unfortunately too long time not utilized.

Similar approaches for early detection of schizophrenia in the Anglophone and Swiss psychiatry. Are there points of contact of the presented approach of the German psychiatry with similar efforts in other countries? We try to outline very briefly comparable concepts of the Anglophone and Swiss psychiatry and pay special attention to the issue of early detection of schizophrenia in precursor stages before the first psychotic manifestation.

If we first look at *DSM-IV* such precursor stages within the diagnostic criteria for schizophrenia are considered under the heading C, »Duration«. It is said that continuous signs of .schizophrenia, persisting for at least six months, may include, apart from obligatory criteria, i.e. A-symptoms, also periods of prodromal (or residual) symptoms that may be manifested by only negative symptoms (or criterion-A-symptoms in an attenuated form). Otherwise in DSM-IV the topic is only mentioned in the section »associated features« with the remark, that schizotypal, schizoid or paranoid personality disorders sometimes precede the onset; whether these personality disorders are prodromal to schizophrenia or constitute a separate earlier disorder would not be clear. If they are prodromal, there would be close connections to the concept of a personality-related preceding defect in the sense of Janzarik [44, 46, 47, 89, 90, 106].

Unlike DSM-IV in *DSM-III-R* the prodromal (and residual) symptoms are defined, but, as distinct from the prodromes of Mayer-Gross and BSC, the nine listed signs are not experiential in kind, but are abnormal behaviour or negative symptoms respectively, i.e. social withdrawal, impairment in role functioning, peculiar behaviour, impairment in personal hygiene, blunted affect, poverty of speech, lack of initiative and, moreover, questionable positive symptoms as ideas of reference or recurrent illusions. It is remarkable that the prodromal (or residual) symptoms according to DSM-III-R and also DSM-IV correspond largely to the diagnostic criteria for schizotypal personality disorder of DSM-IV or schizotypal disorder (F.21) of ICD-10 respectively.

Thus, it is clear that the prodromes of DSM are not identical with the prodromes described by Mayer-Gross [122] and in our studies, determined by »the subjective psychological deficit« [147], i.e. by dynamic and cognitive BS that are not accessible by observa-

tion of behaviour and expression, but only recognizable by self-reports of the patients. The patients are aware of the basic deficiencies as deficiencies and are able to develop self-help and coping strategies, unlike to the patients with true negative and behavioural symptoms, listed as prodromal symptoms in DSM, who have no longer the ability to perceive their deficit symptoms in the same manner as patients with prodromal symptoms experiential in kind according to the BSC.

The fact that the BS of schizophrenia, occurring in the prodromes and after the first psychotic manifestation in the postpsychotic basic stages and pure defect syndromes, are largely disregarded in psychiatric practice and research and are not criteria of DSM-IV and ICD-10, must be seen as a serious disadvantage for the patients and the early detection and intervention of their disorder at the true onset of schizophrenia. At a APA-Symposion of 1990 »Symptoms of schizophrenia that are not criteria of DSM«, we expounded this issue and substantiated that and why we have to consider the findings under discussion, in order to enable a recognition and treatment of schizophrenia as early as possible [23, 24, 26, 30, 32, 34, 36, 41, 42, 43, 98, 101]. This means, many years before the first manifestation of the disorder, diagnosable by the current operationalized classifications, DSM-IV and ICD-10.

In ICD-10 too the prodromes in the sense of the BSC, i.e. the prepsychotic precursor stages before the first psychotic episode, are not considered. Neither in the »Clinical descriptions and diagnostic guidelines« nor in the »Diagnostic criteria for research« the prodromes, indispensable for timely detection and therapy, are listed in the index. In the annotations to selected categories (ICD-10 »Clinical descriptions and diagnostic guidelines«), i.e. to criteria of duration for schizophrenia, are given the reasons for this neglect. Yet, the arguments for the prodromes' neglect are disproved by the findings of the BS research. E.g., there are enough data to what extent similar prodromes occur in other psychiatric disorders; further, it has been shown that precursor stages constituted by BS can also occur as completely remitting phases, i.e. as outpost syndromes, 10 years in average before the first psychotic episode; finally, there is no doubt that certainly not all, but distinct BS, i.e. characteristic cognitive thought, perception and movement phenomena, can be clearly differentiated from precursor stages of neurotic and personality developments and from healthy conditions. Also the in the annotations of ICD-10 advocated opinion, that prodromes have a duration of weeks or months is no longer applicable, because the studies of our [18, 37, 62, 80, 93, 104, 110, 114, 116 , 147] and the Mannheim group [59, 60] have shown, that the prodromes are lasting three until five years on average.

The view of ICD-10 and DSM-IV, regarding the prodromes and residues, the pre- and postpsychotic basic stages of schizophrenia and related disorders, cannot be maintained. It even remains behind the knowledge of the traditional psychiatry, f.i. the classical delineation of the onset of schizophrenia by Mayer-Gross (1932 – [122]), who already differentiated between uncharacteristic and rather characteristic prodromes of schizophrenia and anticipated some aspects of the concept of basic stages and BS which - as shown - has been gradually developed since the 1950s [17, 69, 70, 75, 86, 87, 97, 100, 111].

That the modern doctrines did not come beyond such rough concepts as negative and positive schizophrenia, seems to be founded in an increasing loss of clinical-psychopathological competence [32, 81], that also entailed to the neglect of the experiential analogies of the »psychological deficit«, i.e. the BS and their transition ways, proceeding from distinct BS to distinct first rank symptoms [68, 109, 138]. Certainly, such data are only available by means of an explicit »phenomenological attitude« of the psychiatrist as urgently required by Karl Jaspers in his 4th edition of »General Psychopathology« [107].

It is scarcely to understand that the schizophrenia research did so less take notice of the prodromes, of the first incursion of the basic deficiencies in the healthy personality at the true onset of the disease. Indeed, there are until the 90s only a few notable exceptions also in the Anglosaxon and later in the Swiss psychiatry, thus, the contributions of the Chapman group [10, 11], of McGhie and Chapman [123], and, in the 80s, of Herz [64, 65] and of Böker and Brenner [8].

The findings of James Chapman's study on »The early symptoms of schizophrenia« [10] in some important aspects correspond to the results of our investigations of the late 1950s and early 60s. Also using the

phenomenological method in the sense of Jaspers and Schneider, he interviewed newly admitted patients, concentrating on changes in the patients' subjective experience, which are presented in the form of selected quotations. As the authors of the BSC, Chapman [10, 11], and McGhie and Chapman [123], found that the patients perceive the disturbances subjectively, that they report suffering from basic impairing experiences on the cognitive, psychomotor and affective level, and that they are able to learn to recognize these deficiencies as risk indicators and as danger signals of an impending psychotic exacerbation. They also see, that the described disturbances have less to do with the patients personality reactions, but are more basic to the schizophrenic process itself and that they resemble deficiencies, found in organic cerebral disease, rather than neurotic disorders. In concordance with our view of »substrate-close BS« Chapman believed in agreement with Huber and Gross that the findings support the opinion that schizophrenia is an organic illness and that there exists e.g. a close resemblance between some of the subjective experiences, described by schizophrenic patients and phenomena of temporal lobe epilepsy [10, 15, 75, 76, 77, 85, 130, 131, 149]. As to the difficulties in speech, relating to expressive and receptive aspects of communication, Chapman thinks that the patients tend to avoid other people, because of their defective capacity in communicating, correspondent with the assumption of a »secondary autism« by our group [19, 73, 74, 147] and with the basic disorders of receptive and expressive speech (BSABS C.1.6 and C.1.7 – [49, 58, 144, 147]).

Chapman supposed also that the disturbances in thinking, attention, perception, memory, motility and speech, may be subjectively experienced by the patients, long before signs of established disease appear overtly, e.g. subjectively perceived impairment in the process of empathy with other people long before blunting of affect can be noticed by the psychiatrist. Thus, the author was already aware that BS precede the true negative symptoms [37, 92, 93, 147]. The typical self-reports of the patients on the difficulties they encountered during the early stages of their psychosis, reveal experiences that largely correspond to BS, described in the main category C of the BSABS, regarding the thought, perception and action disorders [49, 58]. These cognitive BS can be explained in the pre- and transphenomenal area as a disorder of information processing, e.g. as reduced influence of regularities of passed experience on current perception, as an inability to restrict the range of attention, so that the patient is »flooded by sensory impressions from all quarters« [10], corresponding the BSABS item C.2.8 (»hypervigilance«).

In the following the Chapman group, authors as Herz [64, 65], Birchwood [4] and, with regard to experimental-psychological, neuropsychological, psychophysiological and neurochemical findings and concepts, Kornhuber [119], Nuechterlein [125], Hemsley [63], Frith [16], Venables [148] and Zubin [150] dealt with this issue and here also with the vulnerability-stress-coping-model, which has obvious relations to the BSC [1, 2, 99, 139, 150]. The BS as self-experiences of disturbances of affect and drive, of thought, perception, proprioception and motor action can be regarded as expression of the underlying vulnerability and are associated with objectively measurable neuropsychological deviations [s. 49, 58, 61, 62, 77, 85, 99, 113, 114, 147]. The BSC and the vulnerability-stress-model can be combined by placing BS in the latter instead of the prodromal symptoms of Nuechterlein or, within the vulnerability factors, hypothesized on psychometric level, as self-perceptible susceptibility to cognitive-affective disturbances [s. 115]. This makes sense because the BS of the BSABS are, what is decisive for the clinical and therapeutic utility, experiential and not behavioural in kind, and are much more precise, expended and detailed defined, compared with the rough definitions of prodromal symptoms by Nuechterlein, by DSM and also with the »early signs« of special Angloamerican instruments: The »Early Signs Questionnaire« of Herz and co-workers [65] or the »Early Signs Scale« of Birchwood and co-workers [4]. These instruments are used for predicting relapses in schizophrenia and mainly with families and other persons of reference as observers.

Similar differences in relation to the BSABS are pertinent regarding the schizotypal scales of the Chapman group (1987 – [11]); again, the BSABS offers more adequate and detailed descriptions of the experienced deficiencies than e.g. the »Physical Anhedonia or Perceptual Aberration Scale«. F.i. by the Herz group as prodromal symptoms or early symptoms of relapse respectively, reported by the patients,

are only named depression with restlessness, reduced enjoyment, loss of interest and pre-occupation with only one of two things. These symptoms lasting weeks before the psychotic relapse, are of an uncharacteristic type corresponding our level-1 BS [49, 58, 80, 141].

Moreover, there is neither by the Herz group nor by other Anglophone authors engaged in this issue an attempt to differentiate transition-relevant cognitive thought, perception and action disorders, proved by our group as psychopathological predictors of a florid psychotic episode (table 2). This can be easily understood, because there exist as far as we know no prospective BS oriented studies for early detection and intervention of schizophrenia, apart from our own, published in the last decade [s. 37, 52, 54, 92, 93, 99, 115].

The Anglophone psychometric high risk research and the BS research are, as seen, different, the former based on the definition of »schizotypy« as an expression of the liability to schizophrenia [s. 120, 124, 126], the latter rather, but only partly, related to E. and also M. Bleulers concept of »latent schizophrenia« [6, 99], characterizing a subclinical expression of the disposition to a »manifest schizophrenia«. Such »formes frustes« occur according to E. and M. Bleuler as well in the relatives of schizophrenics as previous to the outbreak of the schizophrenic psychosis in the individual course. Nevertheless, the BSC specifying these formes frustes, the latent or larvate schizophrenia [105] and the pre-and postpsychotic basic stages [70, 72, 74, 75, 82] with reference to the experiential phenomenology can be conceptually compared with the syndromes considered in the high-risk- and the vulnerability-stress-model.

Aside from the Anglophone authors, in Europe Böker and Brenner [8] dealt with this theme; these authors were concerned especially with self-help phenomena and experiential basic disorders as risk indicators. The inquiry of the patients' coping with individual symptoms needs, according to the Swiss authors, to be based on an empirically relevant disorder model, as the concept of basic disorders or the vulnerability concept by Zubin and Spring, that both provide elements that could be operationalized as reference points for such a model. Because the patients perceive the BS subjectively and report suffering from basic impairing experiences, they are able to learn gradually to recognize the deficiencies as risk indicators and »danger signs« of an impending psychotic episode. Such learning processes are the precondition of conscious self-help efforts of the patients which could then be employed purposely and enhanced in their efficiency by the therapist [8].

Böker and Brenner carried out a study, in which they tried to test experimental psychologically an aspect of individual vulnerability at a given moment and to uncover relations between subjective experiences of basis disorders and autoprotective efforts of the patient. In agreement with the findings of Süllwold and our group the schizophrenics differed significantly from healthy as well as from neurotic subjects by the number of positive answers in the Frankfurt Questionnaire (FQ – [144]) and by their inferior performances in the psychological tests (reaction time measures; span-of-apprehension-test). As opposed to our findings in reversible basic stages and pure residues [62] Böker and Brenner found no correlation between the deviations in the psychological tests (i.e. the extent of attentional deficits) and the number of basic disorders and, also, the number of reported compensatory efforts. Yet, to divide the patients' compensatory attempts into problem-solving oriented coping reactions and non-problem-solving oriented avoiding reactions seem us not always justified. For, also the frequent avoidance behaviour (BSABS F.1 – [49, 58]) turned out to be useful in the basic stages of the disorder, f.i. in order to inhibit an increase or release of BS or of psychotic relapses [29, 79, 147]. That the Swiss authors could not show an association between BS, i.e. the number of affirmed items of the FQ and the objectifiable impairments in the psychological tests, as opposed to our data, can be explained already by different patient samples. We investigated pure residues and reversible basic stages with an average duration of the disorder of 3.4 years and found that the positive correlation of the decrease of performance in the psychological tests and the number of positive answered items of the FQ was more distinct in the basic stages than in the pure residues with a disease duration of 9.3 years. The Swiss patients with an average duration of illness of 7.7 years were not differentiated as to the psychopathological syndromes (mixed or pure residues? typical schizophrenic defect states? – [72, 104]). The explanation of the authors seems us to be

evident, i.e. that possibly in their patients with severe attentional deficits - and, as we suppose at least partly true negative symptoms - the awareness of disorders is less well developed, so that the patients would not necessarily register and indicate more basic disorders despite their marked objectifiable deficits; consequently, they would also not be able to compensate for their performance deficits. Patients with negative symptoms have more or less lost the ability to cope with their deficiencies, in contrast to the patients with BS [31, 78, 80, 88, 99, review: 147]. In any case the at present available data do not allow the statement that experimentally testable impairments would be in all stages of schizophrenia not related to subjectively experienced basic disorders.

On the other side Süllwold and we agree completely with the view of Böker and Brenner that self-help efforts of schizophrenics are much more frequent than assumed hitherto and that subjectively perceived BS are experienced and evaluated by the patients as critical conditions for emotional »danger signs«. Also if Böker and Brenner with reference to Anglophone authors [e.g. 64] notice that the majority of psychotic episodes is preceded by prodromal symptoms, this remark is so far in agreement with our findings too. But, while the Swiss and the American authors stated that prodromes last only days or weeks and that they occur exclusively before psychotic relapses, by our group were described prodromes preceding the first psychotic episode, lasting years, i.e. 3.3 years in average and, in addition, outpost syndromes occurring 10 years before the first psychotic episode [18, 104].

There is also no doubt that many vulnerable individuals can remain in a prepsychotic labile state on the boundaries of manifest illness without decompensating for a long time and even for years. All the more we should aspire to detect as early as possible the prodromes before the first psychotic episode and to identify the transition-relevant cognitive BS which have proved to be psychopathological predictors of an imminent psychotic exacerbation [37, 52, 54, 115]. In our opinion already today a primary prevention of the schizophrenic psychosis in the prepsychotic precursor stages is possible and justified, if the results and experiences of the research into BS and basic stages are considered.

With regard to psychotic relapses we agree largely with the conlusions of Böker and Brenner: The more we know about the basic phenomena, partly varying from patient to patient, the better we can help the individual patient to select and intensify those coping strategies that may interrupt the vicious circle leading up to a psychotic manifestation. These are points where the development of prevention, therapy and rehabilitation programs must set in, which make use of the available knowledge about releasing stress factors and control and counter measures in the sense of a preventive training [8, 29, 146, 147]. In our view, this is most likely possible, if we have acquired the clinical-psychiatric and psychopathological competence, today largely lost [32], proceeding from the work of pioneering researchers as Jaspers (1946 – [107]), Mayer-Gross [122], and Kurt Schneider [140].

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Table 1: Five Main categories of the Bonn Schedule (BSABS – [49, 58]*)*

BSABS (Bonn Scale for the Assessment of Basic Symptoms) Five main categories, 178 items
A. Dynamic deficiencies with direct (partly indirect) minus symptoms B. Increased impressionability, excitability, reflectivity; obsessive-compulsive, phobic, depersonalization phenomena C. Cognitive thought, perception and action disorders D. Cenesthesias E. Central-vegetative disturbances *Additional category*: F. Coping strategies

Table 2: The 24 most frequent level-2-basic symptoms at index investigation in patients who developed lateron a first rank psychosis (stepwise discriminant analysis – [37; see also 54, 58])

BSABS-Items		Df	X^2	P
A.6.2	Incapacity to discriminate different emotional qualities	2	7.813	0.020
A.7.2	Disturbances to present oneself in facialexpression and gestures	2	10.426	0.005
A.8.4	Inability to split attention	2	11.249	0.004
C.1.1	Interference of thoughts	2	19.605	0.000
C.1.3	Pressure of thoughts	2	30.974	0.000
C.1.4	(Subjective) blocking of thoughts	2	7.974	0.024
C.1.6.1	Disturbances of receptive speech (reading)	2	14.450	0.001
C.1.6.2	Disturbances of receptive speech (hearing)	2	8.125	0.017
C.1.7	Disturbances of expressive speech	2	9.996	0.007
C.1.13	Disturbances of thought initiative and intentionality	2	9.275	0.010
C.1.15	Disturbances to discriminate between imaginations and perceptions	2	8.291	0.016
C.1.17	Immediately corrected tendency to self-reference(»subject centrism«)	2	24.173	0.000
C.2.1.3	Partial seeing	2	6.813	0.033
C.2.2.1	Hypersensitivity to light or optic stimuli	2	6.849	0.033
C.2.2.2	Photopsias	2	9.184	0.010
C.2.3.2	Micropsias	2	7.680	0.041
C.2.3.5	Changes in perception of face and/or body of others	2	10.370	0.001
C.2.3.6	Changes in perception of the own face (so-called mirror phenomenon)	2	6.470	0.039
C.2.4.2	Auditory hypersensitivity, acoasms	2	5.514	0.036
C.2.8	Hypervigilance	2	10.426	0.005
C.2.9	Enthralment by details of perception	2	5.657	0.017
C.2.11	Derealization	2	4.389	0.036
C.3.1	Motor interference; automaton syndrome (»Automatosesyndrom«)	2	5.657	0.017
C.3.3	Loss of automatic skills	2	7.983	0.018