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First Rank Symptoms of Schizophrenia: Questions Concerning Clinical Boundaries

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SUMMARY The phenomenological criteria of prominent Anglo-American researchers on certain so-called passivity experiences, sense deceptions and delusional phenomena, reflecting their interpretations of Kurt Schneider's first rank symptoms of schizophrenia, are examined. In this way the frequent discrepancies and difficulties in delimiting the clinical boundaries of these phenomena more clearly come to light.

Introduction

In the present paper the main purpose will be to examine comparatively four detailed sets of first rank symptoms (FRS) definitions as found in the writings of selected modern Anglo-American researchers (Fish, 1962, 1967, 1969; Mellor, 1970; Taylor and Heiser, 1971; Wing, Cooper and Sartorius, 1974). These authors have been chosen for closer scrutiny because their criteria have generated the most important operationally oriented FRS research of recent years (Koehler, 1977). Their sets of definitions are all ultimately based on Schneider's (1959) *Clinical Psychopathology*, and therefore must necessarily share many essential similarities. And yet, it is often enough phenomenologically irksome trying to reconcile their positions on whether a particular phenomenon is or is not to be regarded as of first rank quality. However, the same holds true when reading FRS views held by various German writers, including some of Schneider's pupils (Koehler and Witter, 1976).

The primary contention of this paper is that the phenomenological difficulties encountered when comparing the FRS views of the above mentioned English-speaking researchers can be traced to clearly demonstrable FRS descriptive discrepancies. It must be emphasized that the point at issue cannot be: Who has the right views on first rank symptoms? Such a question is meaningless. Rather, the point at issue must be: Can divergent views on individual FRSs be documented or not? Thus, Tables I and II highlight the important areas of Anglo-American phenomenological disagreement; however, Schneider's (1971) views or those of other prominent German authors have not been formally interpreted and incorporated into the Tables. Hopefully what follows will redirect some attention to a systematic reappraisal of certain familiar phenomenological criteria.

A Provisional First Rank Continuum

For Kurt Schneider (1959, 1971) the primacy of first rank symptoms was not a theoretical matter but rather FRSs were regarded as primary only in the practical diagnostic decision-making sense. In fact, he stressed that he had no desire to speculate on a 'common structure' for all such phenomena. However, Schneider at one point did mention that those first rank symptoms usually subsumed under the term passivity or made experiences might be viewed as due to a kind of 'permeability of the ego-world boundary', whereas first rank phonemes and delusional perception could not be understood in the same light.

In contrast to Schneider, some important German clinicians, apparently impatient with the Jasperian (1912a, 1968) static-descriptive approach to phenomenology, have attempted to understand some first rank phenomena in a more dynamic way (Matussek, 1952, 1953;

TABLE I

Passivity experiences: their interpretations as first rank symptoms of schizophrenia by various Anglo-American authors

Passivity phenomena	Fish (1962, 1967, 1968)	Mellor (1970)	Taylor & Heiser (1971)	Wing *et al* (1974)
Influenced thought	+	−	+	−
Alienated thought (thought insertion)	+	+	+	+[1]
Influenced impulses	+	−[2]	+	○
Alienated impulses	+	+	+	○
Influenced volit. acts	+	+	+	−[2]
Alienated volit. acts	+	−	+	○
Influenced will	+	○	+	−
Alienated will	+	○	+	+[1]
Influenced feelings	+	−	+	−
Alienated feelings	+	+	+	+
Non-shared thought broadcast	−	+	+	−
Shared thought broadcast	+	+	−	+[1]
Pure thought block	−[3]	−	○	+
Alienated thought (thought withdrawal)	+	+	○	+[1, 4]
Influenced bodily sensations	+	+	+	−[2]
Alienated bodily sensations	+	+	+	−[2]

Plus indicates that the phenomenon actually seems to be or is assumed to be of the first rank. Minus indicates that it is not of the first rank. Circle indicates no easy interpretation possible (various reasons).

[1] Part of their schizophrenic nuclear syndrome.

[2] Where a passivity phenomenon actually seems to be or is assumed to be the result of secondary elaboration of another experience, it is not given first rank status in this paper (see 4).

[3] Thought block was for Fish, in contrast to Wing *et al*, an objective sign and not an experience.

[4] Apparently given first rank status although described as secondary, in the sense of an explanatory delusion, to 'pure thought block'.

TABLE II

Sense deceptions and delusional phenomena: their interpretations as first rank symptoms of schizophrenia by various Anglo-American authors

Sense deceptions + Delusional phenomena	Fish (1962, 1967, 1968)	Mellor (1970)	Taylor & Heiser (1971)	Wing *et al* (1974)
Pseudo-hallucinatory audible thoughts	+	−	−	+[1]
Hallucinatory audible thoughts	+	+	+	−
Pseudo-hallucinatory voices (arguing, discussing, commenting)	+	−	−	+[1]
Hallucinatory voices (arguing, discussing, commenting)	+	+	+	+[1]
Delusional notion linked to a perception	−	○	○	○
Delusional perception	+	+	+	+[1]

Plus, minus, and circle as in Table I.

[1] A part of their schizophrenic nuclear syndrome.

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Conrad, 1957; Janzarik, 1959, 1968; Kisker, 1960). Conrad (1957), in his monograph on acute schizophrenia, tried to demonstrate, on the basis of Gestalt psychological ideas, that dynamic phenomenological transitions between FRSs frequently occurred. Fish (1960) later reviewed Conrad's views in this area and also pointed out their possible heuristic value (Fish, 1961).

Indeed, as the writings of these last mentioned German authors imply, first rank and similar symptoms may interchange with one another in the dynamic manner they suggest. Obviously such so-called dynamic approaches represent theoretically biased continuum views whereby FRSs are seen as more or less easily recognizable. *Prägnanztypen* on any such continuum. A study of their work, however, reveals a lack of operational sharpness in the definition of the individual FRS phenomena.

Although the various psychological theories proposed offer solutions to the problems of FRS phenomenology they are not very practical in a clinical sense. For such a purpose a simplified continuum with the main stress placed on the static-descriptive aspects of certain phenomena considered as arbitrary points seems more appropriate. Table III presents a possible scheme for use in clinical practice. It is important to note that the definitions provided in this Table are meant only to serve as provisional phenomenological hints and make no claim to represent exhaustive criteria of such symptoms.

The first rank continuum in Table III is non-theoretical in the sense that no overriding, non-clinical, psychological principle governs the arrangement of the phenomena from F1 to F12. Furthermore, the order of the arrangement does not imply any corresponding degree of severity nor does the arrangement mean that these phenomena actually interchange with one another on a sort of dynamic sliding scale. Rather, the continuum suggested is best seen as a clinical common-sense device for arranging first rank and FRS-like symptoms according to phenomenological principles.

In this sense Table III can offer a provisional operational understanding of how the phenomena might be linked to one another. Moreover the broken lines of Table III arbitrarily divide the first rank continuum into three major phenomenological areas, which can conveniently be labelled the delusional, the passivity and the sense deception continua respectively. Although such a phenomenological tripartite breakdown is meant to be theoretically and nosologically neutral, representatives of the dynamic school, such as Conrad (1957) and Janzarik (1968), view the progression of an acute schizophrenic illness in terms of severity from the delusional perception through passivity experiences to phonemes.

As Strauss (1969) has aptly pointed out: 'It is one thing, of course, to stress the need for describing, rating, and conceptualizing symptoms on continua and yet another to describe in a simple and operational way the major factors that determine the position of an experience on these continua'. In other words, the components of any suggested operational definition for individual FRSs and similar symptoms representing arbitrary points on a FRS continuum, in turn actually consist of many complex continua of their own. Theoretically, such phenomena are probably best viewed on the basis of a multidimensional model of psychopathological disorder.

However, the criteria of any continuum meant to be actually used in routine clinical work must necessarily be more primitive by comparison. That this is so can be seen by the fact that in practice the arbitrary separation of the various FRSs is often made by means of rather simplified forced dichotomizations in the various areas of continua function considered phenomenologically relevant.

At first glance the arrangement of Table III might seem a sort of phenomenological procrustean bed. Of course it would be possible to tease our further distinct phenomena as arbitrary points located on such an operational clinical continuum (e.g. *alienated depersonalization*, *positive-passive experiences of alienation*). However, the arbitrary selection of the items in Table III represents the present author's own bias as to what he considers to be relevant. Other writers might favour the use of a greater or lesser number of such phenomena, a different arrangement of them or another terminology. Neverthe-

TABLE III

A provisional, phenomenologically oriented, non-theoretical, clinical continuum of first rank and associated symptoms

Delusional Continuum

F1. *Delusional mood* (Wahnstimmung): The subject perceives something in the outside world and feels that something is 'going on' in the sense that he is more or less aware that something is happening to or in his familiar surroundings, that these may have specially or significantly changed in an odd, strange or puzzling way, but he is as yet not certain if or what or how this may be occurring.

F2. *Delusional notion linked to or provoked by a perception* (Wahrnehmungsgebundener Wahneinfall): The subject perceives something in the outside world and this triggers a special, significant relatively non-understandable meaning of which he is certain and which is more or less loosely linked to the triggering perception; that is, the meaning is not contained within this particular perception itself.

F3. *Delusional perception* (Wahnwahrnehmung): The experience is like F2 except for the fact that the special, significant relatively non-understandable meaning is contained within, not merely linked to, the perception itself.

Passivity Continuum

F4. *Passivity mood* (Beeinflussungsstimmung): The subject experiences that something is 'going on' in his inner world in the sense that he is more or less aware that something may be impinging upon the integrity of his self or aspects of the self, but he is not as yet certain if or what or how this may be occurring.

F5. *General experience of influence* (Allgemeines Beeinflussungserlebnis): The experience is like F4 but now the subject is quite certain that there is some general control or influence being exerted on him from without.

F6. *Specific experience of influence* (Spezifisches Beeinflussungserlebnis): The experience is like F5 but now the subject is quite certain about which specific ego areas, for example HIS OWN thoughts, feelings and so on, are being controlled or influenced by an outside force.

F7. *Experience of influenced depersonalization* (Beeinflussungs-Depersonalization): This represents a combination of the more usual experience of depersonalization of the self or aspects of the self, such as thoughts, feelings and so on, with the above-mentioned specific experience of influence (F6).

F8. *Positive experience of alienation* (Beeinflussungerserlebnis mit Ersatz-Qualität): The experience is like F6 but now the subject is quite certain of 'positively' experiencing completely alien or foreign thoughts, feelings and so on; that is, those that are definitely NOT HIS OWN have been imposed upon him from outside (e.g. thought insertion).

F9. *Negative-active experience of alienation* (Beeinflussungserlebnis mit aktiver Verlust-Qualität): The experience is like F6 but now the subject is quite certain of 'negatively' being aware that he has lost HIS OWN thoughts, feelings and so on because they have been actively taken away from without (e.g. thought withdrawal).

F10. *Negative-passive experience of alienation* (Beeinflussungserlebnis mit passiver Verlust-Qualität): The experience is like F6 but now the subject is quite certain of 'negatively' being aware that he has lost HIS OWN thoughts, feelings and so on because in some way they passively diffuse into or are lost to the outside world against his will (e.g. thought broadcasting).

Sense Deception Continuum

F11. *Pseudo-hallucinatory voices* (Pseudohalluzinatorische Stimmen):
- (a) The integrity of the ego areas is no longer experienced by the subject as being influenced or alienated from without, but rather he hears a voice or voices commenting on his actions, or voices arguing or discussing among themselves, and this experience takes place in his head, that is, in his inner world and not in external space.
- (b) Like F11a but now the voice or voices speak his own thoughts (*Pseudo-hallucinatory audible thoughts* or *Gedankenlautwerden*).

F12. *Hallucinatory voices* (Halluzinatorische Stimmen):
- (a) Like F11a but now the experience takes place not in his head but rather in external space, although there is no actual source for these voices in the outside world.
- (b) Like 12a but now the voice or voices speak his own thoughts. (*Hallucinatory audible thoughts* or *Gedankenlautwerden*).

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less the phenomenological distinctions proposed in Table III and their corresponding terms appear useful not only in clinical work, but also for the provisional framework that they offer in order to conceptualize and compare various sets of FRS criteria. In the FRS discussions of the following three sections, the major subheadings make use of Mellor's more familiar terminology for eleven Schneiderian FRSs; the corresponding analyses of the four sets of FRS criteria, however, are carried out in the light of the terminology and definitions suggested in Table III.

The Delusional Continuum

Jaspers' (1962, 1965) three basic criteria for delusional phenomena as well as his dichotomy of understandable, secondary delusion-like ideas or notions (*wahnhafte Ideen*) and the non-understandable, primary delusion itself (*echter Wahn*), are well known. His breakdown of this latter phenomenon into delusional perception (*Wahnwahrnehmung*), delusional ideas (*Wahnvorstellungen*) and delusional awareness (*Wahnbewusstheiten*) was later abbreviated by Kurt Schneider into the delusional notion (*Wahneinfall*) and the delusional perception (Berner and Naske, 1973). However, Schneider (1971) had also described another largely neglected intermediate phenomenon called the delusional notion linked to a perception (*wahrnehmungsgebundener Wahneinfall*); furthermore, another experience, obviously secondary, called the delusion-like notion linked to a perception (*wahrnehmungsgebundener wahnhafter Wahneinfall*) can also be conceptually separated from this latter phenomenon (Koehler, 1976).

The present writer, in agreement with Fish (1962; p. 121), regards the differentiation of the delusional notion provoked by a perception from a delusional perception itself as the crucial issue. Assuming that one does not subscribe to an extremely wide concept of schizophrenia, the clinical impression is that the former phenomenon often appears in both affective and schizophrenic disorder, whereas the latter symptom, when narrowly defined as in this paper, occurs much less frequently and then almost only in schizophrenia. In an attempt to clarify the distinction, Schneider (1971) offered the following suggestion: in the case of the delusional notion linked to a perception the abnormal new meaning was only linked to (*angeknüpft*) the perception but in the true delusional perception the abnormal meaning was contained in (*beigelegt*) the perception itself. Schneider's German text and examples clearly demonstrate that the precise relationship of abnormal meaning to perception was a decisive criterion in such instances (Koehler, 1976).

In connection with a critique of some Present State Examination (PSE) criteria and the phrasing of some PSE questions relating to delusional phenomena (Wing *et al*, 1974), the example in the PSE glossary (pp. 153–4) of a delusion of reference was recently used as the point of departure to analyse further such phenomena in terms of the above-mentioned clinically crucial distinction (Koehler, 1976): (1) Did the fact that someone crossed his legs set off a train of associations that made you believe that other people thought you were homosexual? and (2) Did the crossing of the legs in itself contain the meaning that people thought this? Assuming that the symptom was not obviously secondary to some basic psychic phenomenon, especially to major mood change, then the so-called delusion-like notion linked to a perception can be dropped from consideration and one would opt for a delusional perception if the answer to the second question, or perhaps to both questions, were positive. On the other hand, if only the first question were answered affirmatively then a delusional notion linked to a perception would seem more likely. A more detailed consideration of this differentiation can be found elsewhere (Koehler, 1976).

Delusional Perception (Table II). As mentioned, the essential distinction between the delusional notion linked to a perception (F2) and the delusional perception (F3) had been seen by Fish. In his book on schizophrenia (Fish, 1962; p. 121) he stressed the differential diagnosis from affective disorder and stated: 'Often it is difficult to be sure that a patient has a delusional perception . . .' and in the next sentence we read: 'Thus . . . in (some patients) an apparent delusional perception may turn

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out to be . . . a sudden delusional idea provoked by a perception'. Unfortunately, no further help is then given for making this distinction in the concrete case. Moreover, there is no mention at all of the delusional idea provoked by a perception in the long discussion of delusional symptomatology in his monograph on schizophrenia (Fish, 1962; pp. 29–35), his *Clinical Psychopathology* (Fish, 1967; pp. 39–48) or in his article on the diagnosis of acute schizophrenia (Fish, 1969).

In all these cited references, Fish pointed out the difference between the delusional perception and what he called the delusional misinterpretation (Fish, 1962; pp. 30–1; 1967; pp. 40–1; 1969; p. 42), whereby the latter was obviously defined in terms of a Jasperian secondary phenomenon; indeed, his delusional misinterpretation is identical with the concept of the delusion-like notion linked to a perception mentioned earlier (Koehler, 1976). Mellor, Taylor and Heiser and Wing and his co-workers (pp. 172, 214, 218), all appear to follow Schneider in defining delusional perception (called primary delusion by Wing *et al*); all apparently stress the presence of a real perception and the special meaning connected with this perception. Although in all three definitions it is suggested that the delusional special meaning is somehow contained within the perception itself, no explicit statement is made regarding the exact nature of the special meaning to perception relationship in the light of the distinction between the delusional notion linked to a perception and the delusional perception itself.

The Passivity Continuum

The German terms for *gelenkte, gemachte oder beeinflusste Erlebnisse* have been variously translated into English as *made, fabricated* or *passivity experiences* as well as by *experiences of influence or alienation*. In most instances, German and non-German writers use such terms interchangeably, seemingly not recognizing any phenomenological differences, or, when aware of possible distinctions, failing to assign them any particular significance. It was therefore of interest that Taylor and Heiser's (1971) list of FRSs clearly differentiated between what they arbitrarily called *experiences of influence* and *experiences of alienation. Influenced experiences* were defined as those in which the patient knew that HIS OWN thoughts, feelings, impulses, volitional acts or actual somatic sensations were controlled or imposed upon him by some external agency. In contrast, *alienated experiences* were described as the patient's awareness that thoughts, feelings and so on where NOT HIS OWN in the sense that they were coming from an outside source.

A further important phenomenon can be considered as intermediate between the *influenced* and *alienated* experiences just mentioned. Thus, the subject may be aware of HIS OWN thoughts and feelings AS IF in some way they were NOT HIS OWN, while simultaneously experiencing that all this is due to some outside influence. This phenomenon seems to be a depersonalization experience, in which the patient experiences himself or aspects of the self as not belonging to himself, in combination with the experience that this is happening because of being controlled by an external source. Despite its clumsiness, the expression *influenced depersonalization* (F7) seems suitable for this experience. Fish's (1967) term *schizophrenic depersonalization* cannot properly be used in this context since, conceptually, it actually encompassed all the passivity experiences under discussion here.

In his *Klinische Psychopathologie*, Kurt Schneider (1971; p. 121) stated: '. . . dass die eigenen Akte und Zustände nicht als solche eigene, sondern als von andern gelenkte und beeinflusste erlebt werden', and Fish (1967; p. 84) conveyed Schneider's uncharacteristically vague German text regarding such passivity phenomena into English by stressing that the patient was aware that his own thoughts, feelings and so on were being experienced as being foreign or manufactured against his will by some outside influence. By closely analyzing the exact wording used by Schneider and Fish to describe the essence of these so-called specific schizophrenic ego disturbances, one could conclude that their criterion was vague enough to allow for phenomenological interpretations covering *influenced experiences, alienated experiences* and *influenced depersonalization* as already defined.

The attempt to break down Schneider's and Fish's description of passivity into various phenomenological components may seem like unnecessary hair-splitting; however, such distinctions assume no little importance when one realizes that there are authors, as Table I shows, who separate some *influenced experiences*, as defined above, from the other ego disturbances and then proceed to deny the former first rank status.

For the most part, German writers have followed Schneider's (1971) general position on the schizophrenic ego disturbances. However, Jaspers (1965), in his discussion of thought insertion, had actually foreshadowed the Taylor-Heiser dichotomy of *influenced* versus *alienated* experiences (Koehler and Witter, 1976). Unfortunately, after breaking down the phenomenon of thought insertion into the influencing of the patient's own thoughts from without and the more specific insertion of alien thoughts by an external agency, Jaspers failed formally and systematically to transfer these phenomenological insights into other psychopathological areas.

Recently, a provisional phenomenological breakdown, based on Taylor and Heiser's *influenced* versus *alienated* differentiation, of ideally typical pathological ego disturbances into four main phenomenological areas lying on a passivity continuum has been suggested (Koehler and Witter, 1976). In the present paper, this latter clinical continuum view has been modified and extended into an arbitrary passivity continuum representing part (F4–F10) of the first rank continuum shown in Table III.

Thoughts Ascribed to Others or Thought Insertion (Table I). For Fish (1967; p. 39), the term *thought alienation* was a more general concept meant to cover *thought insertion*, *thought deprivation* (withdrawal) and *thought broadcasting*. He defined *thought alienation* as the subject's experience that 'his thoughts are under the control of an outside agency, or that others are participating in his thinking', a description obviously vague and wide enough to cover not only positive alienation of thought (F8), negative-active (F9) and negative-passive (F10) thought alienation (see later), but also the specific experience of influenced thought (F6). However, his description of thought insertion (Fish, 1967; p. 39) was clearly couched in terms of a positive experience of thought alienation (F8): '. . . he knows that thoughts are being inserted into his mind, and he recognizes them as being foreign and coming from without'. In defining thought insertion, Mellor similarly selected criteria unmistakably pointing to positive thought alienation (F8): the subject 'experiences thoughts which have not the quality of being his own' and complains that some external agency is imposing these thoughts.

Although Taylor and Heiser did not use the term thought insertion as such, they obviously distinguished between first rank experiences of specific influence of thought (F6) and first rank experiences of positive thought alienation (F8), the latter clearly equivalent to thought insertion as defined by Fish and Mellor. As for the more recent description of thought insertion given by Wing *et al* (pp. 160–1), it is no different since the criteria are also framed in terms of positive thought alienation (F8): the subject 'experiences thoughts which are not his own intruding into his mind. The symptom is not that he has been caused to have unusual thoughts, but that the thoughts themselves are not his'.

Thus, a sharp separation of thought insertion (F8) from influenced thought (F6) is obviously carried out. Interestingly, Wing and colleagues also rate positively for thought insertion in those cases where the patient, although quite certain the thoughts are not his own, does not as yet know that they originate from an external agency; this would therefore represent another of the possible intermediate experiences that could be placed on the passivity continuum.

Made Impulses (Drives) and Made Volitional Acts (Table I). Fish's (1967; p. 78) description of alienation of personal action (e.g. 'his actions are under the control of some external power' and 'knows his actions are not his own and may attribute this control to . . .') can easily be interpreted as covering not only specific experiences of influenced volitional acts (F6) but also positively alienated (F8) experiences in this area. It can be assumed that these broad views would also govern Fish's position on influenced and alienated experiences of impulses and of the

will, phenomenological areas he apparently did not explicitly treat.

The definition given by Mellor of made impulses is quite complex, appearing to combine an experience of positive impulse alienation (F8) with the secondary experience of an influenced volitional act (F6-like): 'The impulse to carry out the action is not felt to be his own, but the actual performance of the act is', and 'the impulse is made by an external agency'. In contrast, Mellor's position on made volitional acts, as it stands, clearly described a primary experience of influenced volitional acts (F6): the subject 'experiences his own actions as being completely under the control of an external influence'.

Taylor and Heiser distinguished between specific influenced impulses and volitional acts (F6), on the one hand, and the positive alienation of impulses and volitional acts (F8) on the other. To cover the psychopathological area under discussion here, Wing *et al* (p. 167) introduced the expression *delusions of control*. Indeed, their definition remained quite narrow, being obviously formulated only in terms of positive alienation of the will (F8): the subject 'experiences that his will is actually replaced by that of some other force or agency'. However, they also highlighted the various elaborations that this phenomenon might take on; for example, the patient may feel 'even his bodily movements being willed by some other power'. Apparently, this latter elaboration represents a combination of an experience of primary positive alienation of the will (F8) with the secondary experience of influenced volitional acts (F6-like).

Made Feelings (Table I). Fish's (1967) views on made feelings are similar to those he actually held or can be assumed to have held on made volitional acts, impulses and will. Mellor apparently defined made feelings in terms of positive alienation of feelings (F8): the subject 'experiences feelings which do not seem to be his own' and 'thus they are attributed to some external source'. Once again, Taylor and Heiser sharply differentiated between influenced feelings (F6) and positively alienated feelings (F8).

In the ninth edition of their Present State Examination, Wing and colleagues made no mention of made feelings. However, one can probably assume that their views on thought insertion and made will (delusions of control) would also be applicable to made feelings; that is, they would most likely define the latter phenomenon as a primary experience of positively alienated feelings (F8).

Diffusion or Broadcasting of Thoughts (Table I). Fish's definition of this phenomenon seemed rather narrow: the subject 'knows that as he is thinking everyone else is thinking in unison with him (Fish, 1967; p. 39),' that is, he has 'the certain knowledge that everyone else is participating in his thoughts (Fish, 1962; pp. 28–9.)' Apparently the actual sharing of thoughts remains an essential criterion in his description so that the mere diffusion of thoughts from the patient's head would not suffice to merit a positive rating. At any rate, Fish's concept of thought broadcasting represents an experience of negative-passive thought alienation (F10). Earlier, Fish (1962; p. 29) had also mentioned that thought broadcasting 'may form the basis of the delusion that his thoughts are being read'. However, in a later discussion (Fish, 1969), the primary-secondary roles of these two phenomena are apparently reversed, that is, thought broadcasting now appears to be the secondary explanation for thought reading.

In contrast to Fish, Mellor's definition of thought broadcasting was not as narrow in the sense that for him the criterion of actual sharing was not absolutely necessary: the subject experiences not only that 'thoughts escape from the confines of the self into the external world' but then 'they may be experienced by all around'. This phenomenon, obviously, is also a negative-passive experience of alienated thought (F10).

Taylor and Heiser separated thought broadcasting not only from all other general and specific experiences of influence (F5+F6), but also from all other experiences of positive alienation (F8). In their example, a description of an initiating experience of influenced thought (F6) is also given, for they spoke of 'the machines' (from outside) being used to broadcast the patient's thoughts; indeed, in this instance, thought broadcast is actually described in terms

of a secondary experience of negative-passive alienation of thought (F10-like). However, their formal definition of thought broadcast can be regarded in terms of primary negative-passive thought alienation (F10): the subject has 'the experience that as his thoughts occur they are escaping from his head into the external world'. It is also very important to note that for Taylor and Heiser the actual sharing of the diffused thoughts was not considered an essential requirement for a positive rating. Moreover, their description of thought broadcast did not seem clearly to separate it from hallucinatory audible thoughts (F12b).

On the basis of their definition of *thought broadcast* or *thought sharing*, Wing and colleagues (p. 161) evidently considered pseudo-hallucinatory *Gedankenlautwerden* or audible thoughts (F11b) as some sort of prior stage to thought broadcasting. As for their description of thought broadcast itself, this was clearly framed in terms of negative-passive thought alienation (F10). Indeed, their definition was as narrow as Fish's concept since they also insisted that only when the subject actually experiences his thoughts being shared with others, irrespective of the mechanism, could a positive rating be made. As for delusions of thoughts being read, these, for Wing and his colleagues, could at times represent a possible secondary elaboration of thought broadcast.

Thought Withdrawal (Table I). Fish (1967; p. 39) defined thought deprivation (withdrawal) as an experience of negative-active alienation of thought (F9): the subject finds that 'as he is thinking his thoughts suddenly disappear and are withdrawn from his mind by a foreign influence'. Of interest is the fact that for Fish (1967; p. 38) thought blocking was 'an objective sign', that is, an abnormality of expression or behaviour (*Ausdruckssymptom*) and not defined in terms of an experience (*Erlebnissymptom*). Thus, he suggested that thought deprivation was 'the subjective experience of thought blocking'. These views become important when compared with those of Wing and colleagues on 'pure thought block' (see below).

Mellor also defined thought withdrawal in the sense of an experience of negative-active thought alienation (F9): the subject simultaneously experiences a cessation of his own thoughts and their being withdrawn by some external force. Surprisingly, neither Taylor and Heiser's description of influenced thought (F6) nor of alienated thought (covering only F8 and F10) made any allowance for the phenomenological possibility of thought withdrawal viewed as an experience of negative-active alienation of thought (F9). Indeed, they made no separate mention of thought withdrawal as had been the case with the separate listing of thought broadcast.

Wing and colleagues (p. 162) used the expression thought block or thought withdrawal as if both components were merely different terms for the same phenomenon. In their descriptions, pure thought block, the experience of a sudden stopping of the subject's own thoughts quite unexpectedly, was clearly separated from what they called the 'explanatory delusion of thought withdrawal', that is, the experience that 'his thoughts have been removed from his head so that he has no thoughts'. This latter elaboration actually represents a secondary negative-active experience of alienated thought (F9-like); however, despite the obvious secondary nature of their description, the impression is still given that thought withdrawal is considered to have primary first rank status (F9).

Influences Playing on the Body or Somatic Passivity (Table I). In his discussion of bodily or somatic hallucination, Fish (1969) stressed that 'one must make sure that the patient actually experiences bodily sensations as being produced by an external agency'. Unfortunately, he did not precisely distinguish between influenced (F6) and alienated (e.g. F8) somatic sensations; however, it will be assumed that for Fish both forms of experience would be acceptable as being of the first rank.

In describing this phenomenon, Mellor also did not make it clear if the resulting bodily sensations, despite the external influence, were still being experienced by the subject as his own, or were now experienced as being not his own, that is, as completely foreign sensations. Thus, Mellor's definition of the phenomenon stated that the subject is 'a passive . . . and reluctant recipient of bodily sensations imposed upon him by some external agency', and it is stressed that

the perception is simultaneously experienced as being both a bodily change and externally controlled. Since he went on to concede that such bodily sensations might be due either to actually present abnormal physical sensations or to haptic, thermic or kinaesthetic hallucinations, Mellor appeared to be quite open to the experiential possibilities of influenced (F6) as well as positively alienated somatic sensations (F8).

Although they included experiences of influence of actual somatic sensations (F6) among their FRSs, Taylor and Heiser failed explicitly to mention that positive alienation in this area (F8) could also occur; however, on the basis of their *influenced* versus *alienated* dichotomy for related phenomena, it can be assumed that they would affirm this possibility for somatic sensations. In defining other hallucinations and delusional elaboration, Wing and colleagues (pp. 166 and 212) apparently differentiated between haptic hallucinations, (something seems to touch him but when he looks nobody is there), and the possibility of delusional elaboration of this hallucinatory experience. For example, such secondary elaboration could take either the form of an experience of influenced (F6-like) or of positively alienated bodily sensations (F8-like), a fact not specifically stated in the glossary definition.

The Sense Deception Continuum

In his classical papers on sense deceptions (*Trugwahrnehmungen*), Jaspers (1911, 1912b) stressed the distinction between true hallucinations and pseudo-hallucinations; his essential criteria were that the latter lacked concrete reality or substantiality (*Leibhaftigkeit*) and occurred within the patient's head or mind, whereas the former were perceptions without an object being experienced substantially in objective space. Schneider (1971) continued to conceptualize his first rank sense deceptions, formally at least, as Jasperian true hallucinations; however, his concrete examples of audible thoughts appeared to be more like Jasperian pseudo-hallucinations. At any rate, the Jasperian position at the present time is not followed by most German-speaking psychiatrists (e.g. Bleuler, 1972), the tendency now being to make the presence of insight (pseudo-hallucination) or its lack (true hallucination), the main criterion of differentiation. Recently, there has also been some non-German criticism of Jaspers' point of view (e.g. Fish, 1962, 1967; Hare, 1973) as well as some more positive renewed interest (e.g. Sedman, 1966a, 1966b).

Audible Thoughts or Gedankenlautwerden (Table II). In his description of phonemes, Fish (1962; pp. 35–6) apparently favoured a continuum view that ranged from the clarity of ordinary voices to the voices heard in the mind, the latter being called pseudo-hallucinatory. Indeed, Fish (1967; pp. 19–20), although clearly aware of the Jasperian distinction on sense deceptions, maintained (Fish, 1962; pp. 35–6) that 'the pseudo-hallucination is purely of academic interest and has no prognostic or diagnostic value in schizophrenia". One wonders why Fish (1969) felt it necessary to point out that for the diagnosis of acute schizophrenia 'one should always get the patient to give examples of his hallucinatory experiences and to explain the origin of his voices. It is particularly important to be sure that the patient is not merely describing very vivid auditory imagery'. Moreover, in describing *Gedankenlautwerden* in acute schizophrenia, Fish (1962; p. 24) said: the subjects can hear 'their thoughts being spoken aloud as they think, and the voice which speaks their thoughts may come from inside (F11b) or outside (F12b) the head'. In contrast to Fish, Mellor clearly defined this phenomenon in the Jasperian sense of true hallucinations (F12b), that is, audible thoughts were sharply separated from inner voices, the latter 'usually (being) forms of imagery, including pseudo-hallucinations'.

Taylor and Heiser agreed on this point for in their terminology audible thoughts are considered to be so-called 'complete auditory hallucinations', that is, 'clearly audible voices coming from outside (F12b) the patient's head'; thus, the latter are distinct from what they called non-schizophrenic auditory hallucinations, which are experienced 'as coming from inside the head (inner voices)'. On the other hand, Wing and colleagues (p. 161) subsumed *Gedankenlautwerden* under *thought broadcasting* or *thought sharing*, as if audible thoughts were a primitive stage of thought broadcast. Their

formal definition clearly stated that the subject's 'own thoughts seem to sound aloud in his head almost as though someone standing nearby could hear them'. Obviously, such a description implies a Jasperian pseudo-hallucination (F11b). In addition, for these workers (Wing *et al;* p. 162) *thought echo* (experiences his own thoughts as repeated or echoed, not just spoken aloud in his head) and *thought commentary* (experiences alien thoughts in his head that are in association with his own, or comment on his own) were apparently regarded as variants of *Gedankenlautwerden.*

Voices Arguing and Voices Commenting (Table II). Fish's (1967; p. 23) continuum position on phonemes (covering F11ab and F12ab), including voices arguing or discussing and commenting, has already been considered under audible thoughts. For Mellor, voices arguing or commenting were 'hallucinatory voices', his examples amply demonstrating that concrete voices with no actual source of origin in objective space in the Jasperian sense (F12a) were meant to be sharply distinguished from inner voices.

Taylor and Heiser also used their concept of complete auditory hallucinations, as defined above, for these voices (F12a), clearly separating them from their non-schizophrenic auditory hallucinations. Taking a broad stand on the matter, Wing and associates (p. 164) gave instructions that not only true hallucinations (F12a) but also pseudo-hallucinations (F11a) should be included when rating positively for such phenomena.

Comment

On examining the writings of important Anglo-American investigators of FRSs (Fish, 1962, 1967, 1969; Mellor, 1970; Taylor and Heiser, 1971; Wing *et al,* 1974), it can be said that the boundaries of these phenomena are often viewed quite differently, sometimes being defined in wider and sometimes in narrower terms. At the risk of oversimplification, it seems that the clinician's main options in judging the presence or absence of FRSs boil down to the following dichotomies of narrow (= a) versus wide (= b) concepts of such symptoms:

1. (a) Are only experiences of positive alienation (F8) of thought (thought insertion), of impulses, of volitional acts, of feelings and of somatic sensations to be considered of the first rank? (b) Or should experiences of influence (F6) in these areas also be rated positively?
2. (a) Is thought broadcasting as a negative-passive alienated experience of thought (F10) only first rank when the thoughts leaving the patient's head are actually also shared with others? (b) Or does it suffice for a first rank rating that the thoughts must only diffuse out, sharing being immaterial?
3. (a) Should the experience of thoughts ceasing in the patient's head because of an external agency in the sense of a negative-active experience of alienated thought (F9) be considered as constituting thought withdrawal of the first rank? (b) Or should so-called pure thought block, when clearly present as an experience, and not just as an objective sign, also be acceptable?
4. (a) Are voices arguing or discussing, voices commenting and audible thoughts only first rank when they are Jasperian true hallucinations (F12ab)? (b) Or should pseudo-hallucinatory experiences (F11ab) also be rated as having first rank quality?
5. (a) Should one define the first rank symptom of delusional perception (F3) very strictly? (b) Or should the frequently occurring delusional notion linked to a perception (F2) also be acceptable as being a first rank phenomenon?

Whether wider or narrower views are considered acceptable remains purely an arbitrary matter. However, the simple realization that such different interpretations are possible and actually do exist, is of no little importance. Thus, until a more generally binding agreement can be hopefully attained, two things seem essential and should be demanded of all clinicians: 1. an unmistakably clear statement of their own personal first rank boundary criteria, and 2. a similar statement of the nosological bias they personally attach to these phenomena.

This second point is particularly relevant

when one recalls that, for example, Kraepelin (1913), Leonhard (1968) and Berner (1977) in Europe, as well as some modern American researchers (e.g. Winokur *et al*, 1969; Taylor and Abrams, 1973; Luria and McHugh, 1974), do not automatically give a schizophrenic weighting to first rank or first rank-like phenomena appearing in functional psychosis, especially in the presence of strong affective clinical features. This seems, then, to be in contrast to the usual bias influencing the clinical practice of German Schneiderians (Koehler *et al*, 1977).

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