

## **Gerd Huber and Gisela Gross: The Development of the Psychopathology in Germany in the Last Decades [20<sup>th</sup> century] with an Introduction by Carlos R. Hojaij**

In 1995 the *Psiquiatria Biológica*, official Journal of the Brazilian Association of Biological Psychiatry, published an article in the “Psychopathology” section specially prepared by Gerd Huber and Gisela Gross. Considering the importance of this “witness-paper” and being founder of the journal and editor at that time, as well as President of the Association, I feel authorized to offer INHN its republication below.

From the “summary” of this paper the authors’ intention is clear: facing psychopathology’s neglect in current psychiatry, with implications in semiology, diagnosis and therapeutics, they review the contributions of several German psychiatrists “responsible” for the origin and development of this basic discipline, describing and emphasizing their own rich contributions and the avenues created for further study, until reaching more recent times with emphasis on their own rich tribute to psychiatry. The paper is another call to save psychopathology from the - maybe intentional - disregard of the complex task of approaching and apprehending the person in totality, prevailing the simplistic symptomatic diagnostic easily linked to concrete, objective pharmacological or behavioral therapies.

Following Jaspers and Schneider, Huber comes across like another *Magister Dixit*. Huber and Gross offer a huge source of knowledge for reflection and new constructions.

Their exceptional paper offer some points that might promote discussion inside INHN:

Different uses of the term “psychopathology”: phenomenological psychopathology, descriptive psychopathology, phenomenological-descriptive psychopathology and phenomenological anthropological psychopathology.

From the Heidelberg’s school: Mayer-Gross, Gruhle, Weitbrecht, Huber, Janzarick, Gross, Schüttler, Klosterkötter, Binswanger, Rümke, Storch, Zutt, Baeyer, Blankenburg and Häfner.

Kurt Schneider’s 1946 observation: “Doubtless, the task of psychopathology has not yet come to an end; on the contrary, it has a great field of work before it.”

The idea that the phenomenological psychopathological approach does not evolve to a system; it is an open process of continuous knowledge. It does not evolve to a rigid diagnostic structure, but to an arena with references and no boundaries.

Karl Jaspers' works introducing the Dilthey's method of understanding (or comprehension); the biographic perspective with genetic understanding; distinction between causal and genetic understanding (not exactly eliminating the influence of one over the other); the notions of personality development and process; the vital importance of individual inner experiences.

Kurt Schneider's monumental little book, *Clinical Psychopathology*; the nosological tripartite edifice (based on Jaspers); the specification of psychosis as expression of a somatose (disease); the identification of schizophrenia and cyclothymia just a functional psychoses (lack of an identifiable cause, organicity); the idea of metagenesis for schizophrenia.

Huber's claim that "...only a differential *typology* is possible, and not a differential *diagnosis* within the field of endogenous psychoses."

Huber's remarks: "Using the patient's introspection and the static empathy and genetic understanding of the investigator, the aim of PP [phenomenological psychopathology] is to elicit the movement, connection, and continuity of the psychic life, not only in neurotic-psychopathic developments, but also, as far as possible, in psychoses. Due to the close connection of phenomenology with genetic understanding, the psychiatrist is at the same time a participating physician and one who places himself at distance, between a personality-centered and a diagnosis-centered attitude, is an essential criterion."

Huber, Gross and Klosterkötter's idea that research "of delusional and related psychotic phenomena... can be proved using the phenomenological-psychopathological method, a psychogenic component, an understandable connection of the content of the delusional experience with a premorbid biography and personality."

Huber and Gross's continuance of the topic stating: "This indicates that there is a possibility of correcting this psychogenic biographical component of delusion, but not the component which is of somatic origin and corresponds to a substrate-close basic phenomenon, in this case to cognitive perception disorders."

Huber and Gross's concept of basic symptoms ("deficiencies subjectively experienced as deficiencies and impairments, missed before the onset of the disorder in intra-individual comparison"); the basic symptoms; the pre-psychotic syndromes, the outpost syndromes, the post-psychotic reversible and irreversible basic stages, determined by basic symptoms; the cenesthetic schizophrenia.

Huber and Gross' observations concerning basic symptoms as prodromal symptoms of schizophrenia: "The deficits of social competence and emotional stability preceding the first psychotic episodes are very frequently not premorbid personality traits, but already the consequence of the disease, which becomes manifest in prodromal and outpost syndromes many years before the loss of the patient's ability to perceive the basic deficiencies as deficiencies, before the change into the first psychotic phase with its dissolution of ego boundaries. Not the first psychotic schizophrenic episode, but the long time preceding BS and pre-psychotic based stages represent the true onset of schizophrenia and schizoaffective disorders."

"Some essential results of the Bonn and Heidelberg long term studies of schizophrenia" through phenomenological psychopathology:"

"40% with non [natural organic matter] characteristic types of remission and outcome, and mainly slight pure dynamic-cognitive deficiency syndromes; after more than two decades from the onset, more than half of the 502 patients had slight pure residues or full remission; "

"...results of the Bonn Study lead to a revision of classical opinions" (schizophrenia's incurability and affective psychoses with a favorable outcome): a continuum-hypothesis of idiopathic psychosyndromes;"

“the subjective experiences of cognitive and dynamic BS occur also in prodromes and outpost syndromes before the first -and after the later- psychotic episodes.”

“Prodromes pass over continuously into psychotic first manifestation after an average course of 3.3 years, with a range of two months up to 35 years.

The completely remitting outpost syndromes, lasting an average of 5 months (range: some days up to 4 years), reveal a temporal interval until the onset of the prodrome or the first psychotic episode of 10.2 years on average (range: one to 37 years)”;

“a possibility to distinguish among patients presenting a preliminary diagnostic of anxiety, dysthymia or personality disorder a sub-group with high risk for a later development of schizophrenic first rank psychosis, “by means of distance cognitive BS [basic symptoms] that can be regarded as psychopathological predictors of (florid) schizophrenic psychoses.”

The first decades of the 21<sup>st</sup> century can be identified by a generalized impoverishment of culture and history via the predominance of superficial novelties and the consequential movement of broken pieces without a propose. This is an era of a "day without tomorrow," i.e., inconsequential. Psychiatry does not have the privilege of being excluded from this avalanche of ignorance.

By the end of the article, Gruhle’s observations are noted: "...psychiatrists on the whole did not learn enough phenomenological psychopathology” for not understanding that Jaspers developed a method and not a theory or a scheme. Further, that to practice this kind of method one is required to incorporate an attitude (a “radical attitude” according to Husserl) to be empathically connected without being dominated by prejudices. Doctors need to listen to the patient, which demands time and patience; to register the descriptions of the patient’s inner experiences; to dive into the magistral Jaspers’ works (psychology, psychopathology, philosophy); and will realize the need to search for the patient’s originality, the principle of freedom in medicine.

There was a time when psychiatry was written as a romance novel because passion moved the authors to the point of creating famous pathographies. There was a time when reading Dostoevsky’s novels one would also learn psychiatry because all beauty and madness of humans were there vividly described. There is always time to go back and read the classical psychiatric books, which are no longer produced.

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Psicopatologia

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## The Development of the Psychopathology in Germany in the Last Decades

### Key Words

Clinical psychopathology  
Phenomenology  
Basica symptoms  
Basic symptom concept  
Bon Scale (BSABS)  
Schizophrenia longterm study  
Early diagnosis of schizophrenia  
Pre and post psychotic basic stages

### Summary

The review tries to demonstrate the meaning and importance of clinical psychopathology in the line of Jasper and Schneider. Trends in contemporary psychiatry to underestimate or even neglect the psychopathological approach, result in a threatening loss of psychopathological an clinical-psychiatric competence with bad consequences for the practical and scientific psychiatry. For, only phenomenological psychopathology can meet the demand of clinical psychiatry to provide a reasonably reliable description of signs and symptoms in psychiatric disorders, upon which rational diagnosis and adequate prevention and therapy may be based. The overly objectifying psychiatry of Kraepelin has been overcome by phenomenological psychopathology as an approach that aims more at the elucidation of the patients own inner experiences than of the observation of his or her behavior and expression. Some recent results, obtained with clinical psychopathology which has to take the lead previous to all other sciences relevant to psychiatry, are outlined, regarding their importance for current and future research.

In this review of the advances of the clinical psychopathology in the last decades we can present the subject only very cursorily, confining ourselves on a few points. There are, as is well-known, different kinds and acceptations of the term "psychopathology" (PP). As in psychology experimental, behavioral, and phenomenological methods of PP are differentiated, the latter termed also introspective, descriptive, analytic-descriptive, phenomenological-descriptive or understanding PP. For the practical and scientific clinical psychiatry has relevance in the first place the clinical PP which is nearly identical with the general and special phenomenological-descriptive PP, advanced first by K. JASPERS and continued in

the German speaking psychiatric tradition, a.o. by psychiatrists as MAYER-GROSS, GRUHLE, K. SCHNEIDER, WEITBRECHT, G. HUBER, JANZARIK, G. GROSS, SCHÜTTLER or KLOSTERKÖTTER. The phenomenological approach in the line of JASPERS and SCHNEIDER has to be differentiated from the phenomenological-anthropological approach taken by HUSSELER, BINSWANGER, STORCH, ZUTT, v. BAEYER or BLANKENBURG. As well the phenomenological-descriptive approach as the phenomenological-anthropological concepts were claimed to be the fundamental approach to PP. We have shown that the phenomenological-descriptive PP which we use synonymously with

clinical PP seems to be the fundamental method relevant to clinical psychiatry (HUBER 1979, 1987; GROSS & HUBER 1993).

In the last decades, and already in the fifties and after the retirement of K. SCHNEIDER (1955), the opinion has come into fashion and has been widespread that the period of phenomenological-descriptive clinical PP has drawn to an end, and that in PP new findings scarcely were to be expected. But, a critical review shows that the epoch of PP is far from over. The clinical phenomenological-descriptive PP in our opinion leads all other sciences in psychiatry. What K. SCHNEIDER wrote in 1946 is still valid today and will be valid in the future: "Doubtless, the task of psychopathology has not yet come to an end; on the contrary, it has a great field of work before it" (s. HUBER 1979, 1987). When we speak of PP in the following, we mean this clinical, phenomenological-descriptive PP in the sense of JASPERS and SCHNEIDER.

The system of clinical PP delineated by K. SCHNEIDER in the first chapter of his "Clinical Psychopathology" (K. SCHNEIDER, p.1) is according to him at the same time the system of the clinical psychiatry. Recent advances of the clinical PP in the last decades proceed from the protagonists of phenomenological PP, who created a basic psychopathological framework for psychiatry which even today seems practically useful and heuristically fruitful. This psychopathological approach does not mean strict codification but leaves room enough for new developments that may, as we have shown in earlier papers (HUBER 1979, 1987), complete, correct and change many aspects of traditional and contemporary psychiatric views.

The well-known classics of phenomenological-descriptive PP are "General Psychopathology" by JASPERS which first appeared in 1913 and has remained unchanged since the 4th edition in 1946 (JASPERS 1973), SCHNEIDER's monograph (9th edition 1950) "The Psychopathic Personalities", his "Abnormal Psychological Reaction" (1927) and many papers, published since the twenties until the sixties which were partly incorporated in "Clinical Psychopathology", a book which, according to SCHNEIDER, would include all that he had to say about psychiatry, based on his own results which were still valid for him. It was republished with a commentary in the 14th edition in 1992. In each new edition until the 8th edition which he had finished a few days before his death (1967) one finds discussions and corrections of SCHNEIDER's own position, determined by the clinical-psychopathological experience

that led him to revise his provisional triadic system of clinical psychiatry. A close look shows this type of PP to be undogmatic and much more elastic and adaptable than some critics believed. This applies as well to the work of SCHNEIDER's pupils and followers, e.g. of WEITBRECHT, JANZARIK and our own group (s. HUBER 1994; JANZARIK 1988; KLOSTERKÖTTER 1988; L. SÜLLWOLD & HUBER 1986).

For JASPERS, SCHNEIDER and the representatives of the old Heidelberg School, thus the authors of the textbook "Schizophrenia" (1932), above all for MAYER-GROSS, GRUHLE, BERINGER, and HOMBURGER, PP was fundamental to clinical psychiatry (GRUHLE 1932; MAYER-GROSS 1932). Clinical psychiatry in Germany originated with KRAEPELIN, but its pronounced psychopathological orientation was established by JASPERS and continued by the protagonists of the Heidelberg and Bonn School (s. HUBER 1984; JANZARIK 1984) and, with a more behavioral emphasis, by the WERNICKE-KLEIST-LEONHARD line (LEONHARD 1966). The over-objectifying psychiatry of KRAEPELIN has been completed by phenomenological PP, which aims at the elucidation of the patient's own inner experiences, comprehensible primarily through the self-reports of the patients and, secondarily, through the observation of behaviour and expression.

With JASPERS and his followers began a scientifically satisfying PP, particularly concerning the methods of descriptive phenomenology and genetic understanding, the fundamental differentiation between understandable and causal connections, between developments of a personality and cerebral-organic processes, by that the medical-scientific notion of disease and the provisional, didactic-classifying triadic system of psychiatric disorders. Since that time the PP has been the "via regia" of psychiatric diagnostics and psychiatry is seen to be founded on two pillars, on PP and on somatology. The triadic system differentiates somatically definable and endogenous psychoses as consequences of true illnesses (in the medical-scientific notion of illness) and variations of psychic life, especially the psychological-reactive, neurotic and psychopathic personality developments. With K. SCHNEIDER the phenomenological PP doesn't attempt to cope with this immense field of variations of psychic life by creating notions, comparable to the medical model of diseases and by labeling the individual patient with terms that look like diagnoses (s. K. SCHNEIDER, 1992, p. 17, 92). The psychic-reactive, including neurotic as well as personality disorders, are in

essence not strictly separable from normal psychic reactions and personalities. In this point clinical PP in the direction of JASPERS and SCHNEIDER agrees completely with KRETSCHMER's view that "the psychology of neuroses is the very psychology of the human mind" (quoted in HUBER 1994).

Essential older findings and views of clinical PP were confirmed and/or modified by studies of the last decades. We give a few examples of the range of experience and knowledge, obtained by means of clinical PP which is valid both for the traditional and for the present contemporary psychiatry.

There is a lack of specificity of psychopathological phenomena, symptoms and syndromes. Hence, the fundamental rule of psychiatric diagnostics is that diagnosis in psychiatry is not possible without complete somatic, neurological, and other, e.g. neuroradiological, investigations. The "form" and "theme" of psychotic experiences have to be differentiated: The diagnosis considers the form, the "how", and not the theme, the contents. The notions of schizophrenia and cyclothymia (affective psychoses) are defined as only psychopathological state-course-units. A diagnosis in the strict sense, as in somatically definable psychoses, is not possible, as long as characteristic, pathognomonic somatic findings are lacking: Schizophrenia, cyclothymia and other types of endogenous (idiopathic) psychoses, often mistaken for nosological entities, are only provisional diagnostic conventions (GROSS & HUBER 1978; HUBER 1990; SCHNEIDER 1992).

Real disease entities cannot be found by the KRAEPELIN-KAHLBAUM method, even with comprehensive observation of the whole syndrome and course. The efforts to single out distinct forms of endogenous psychoses as independent nosological units remind one of "chasing after a phantom" (HUBER 1990b, 1992a,b). Proceeding from this view, only a differential *typology* is possible, and not a differential *diagnosis* within the field of endogenous psychoses.

PP attends to the "psychopathologically abnormal" with regard to clinical units; thus, it becomes a doctrine of symptoms and diagnostics and loses its nosological neutrality. The triadic system of clinical psychiatry distinguishes between psychic abnormalities as consequences of illnesses (in the medical-scientific sense) and variations of psychic being ("Spielarten Reelischen Wesen" according to K. SCHNEIDER), e.g. the psychopathic personality disorders and the abnormal psychic reactions and developments including neuroses. To the results of

illnesses belong the somatically definable psychoses on the basis of known brain disorders and the endogenous psychoses, the somatically not yet definable schizophrenic and affective psychoses. Only with the somatically definable psychoses the diagnostic is two-tracked: The notions and terms are partly somatological, partly psychopathological. Distinct from the notion "psychosis", the terms "ab-normal", "abnormality", and "psychopathological" are nosologically neutral and are used both for the variations and the psychoses (HUBER 1979, 1994).

Using the patient's introspection and the static empathy and genetic understanding of the investigator, the aim of PP is to elicit the movement, connection, and continuity of the psychic life, not only in neurotic-psychopathic developments, but also, as far as possible, in psychoses. Due to the close connection of phenomenology with genetic understanding, the psychiatrist is at the same time a participating physician and one who places himself at a distance, observing and stating signs and symptoms. The ability to alternate between communication and distance, between a personality-centered and a diagnosis-centered attitude, is an essential criterion (HUBER 1984).

The attitude of the psychiatrist should be influenced in our opinion more by PP than by psycho-analysis. In the epoch after KRAEPELIN his or her interest increasingly turned to the development of personality, to the whole life situation and to the subjective experiences of the patient. The restriction of genetic understanding to the scope of conscious experiences, does not impede exploration of the patient's biography and the communication with him or her. The psychopathologist tries to grasp first the subjective experience of the patient, the process of experiencing itself, and not only its result, and moreover, the biographical development of personality. Thus, the phenomenological PP has taken since JASPERS and SCHNEIDER the step from the actual or apparent objective, i.e. the expression and behavior, to the subjective, i.e. the individual inner experiences of the patient. Phenomenological PP in a stricter sense, i.e., the realization and description of the modes of experience, of psychic states and qualities, first by means of self-reports and then also by means of expression and behavior of the patient ("Ausdruckssymptome" according to SCHNEIDER) works hand in hand with genetic understanding, feeling into "how experiences develop from other experiences with evidence" (JASPERS). At the beginning is the description of what the patient communicates, while the definition of and the assignment to



distinct notions and terms and their fixing by conventions should be, as SCHNEIDER emphasized, the second step.

Also the subjectivity of the method of genetic understanding can be criticized, because its dependence on the capability of the psychiatrist to understand, of his or her norms determined by different social and cultural factors. Notwithstanding that, genetic understanding remains as important and indispensable aspect of clinical PP that cannot be replaced by other modes of comprehending, e.g. the psychoanalytic and other hermeneutic methods of "as-if-understanding" (JASPERS; HUBER 1994). In the field of psychoses, much can be comprehended with this method. Thus, the themes of the psychoses are determined by biographical experiences and largely understandable. Every psychosis has its psychological-reactive traits (HUBER 1979; HUBER & GROSS 1977). Psychological reactions to the psychotic and other psychological experiences are much more common, freedom, insight, and responsibility are available to a much greater extent than has been conceded by classical psychiatry, but also by anthropological phenomenology, which claimed as a rule a total and specific change of personality, a principle, insurmountable heterogeneity of the schizophrenic human being (HUBER 1966; HUBER & GROSS 1977; WEITBRECHT 1973).

Besides the mentioned findings and results we outline some advances, obtained by clinical PP in the last decades.

As to research of delusional and related psychotic phenomena in schizophrenia has been shown that even with schizophrenic first rank symptoms, e.g. delusional perception ("Wahnwahrnehmungen"), can be proved, using the phenomenological-psychopathological method, a psychogenic component, an understandable connection of the content of the delusional experience with the premorbid biography and personality. This was possible just when the phenomenon was fully developed, i.e. after the phases of irritation, externalisation, and concretisation (HUBER & GROSS 1977; HUBER 1982; KLOSTERKÖTTER 1988). This indicates that there is a possibility of correcting this psychogenic biographical component of delusion, but not the component which is of somatic origin and corresponds to a substrate-close basic phenomenon, in this case to cognitive perception disorders (GROSS et al. 1987; HUBER & GROSS 1977) and the protopathic "regression in the subject-centrism of the ptolomaic view".

The concept of basic symptoms (BS) in schizophrenic and schizoaffective disorders has been developed

since the fifties, starting with the disclosure and the description of cenesthetic, central-vegetative and perception disorders (HUBER 1957; GROSS & HUBER 1972), then the direct and indirect dynamic BS, the cognitive thought- and action disorders and the additional category of coping strategies. It has led to a new doctrine regarding nonpsychotic and more or less uncharacteristic symptoms in schizophrenias (HUBER 1957, 1961, 1966, 1971, 1983, 1992c; GROSS & HUBER 1972; HUBER et al. 1979; GROSS et al. 1987; review: SÜLLWOLD & HUBER 1986). The BS are deficiencies, subjectively experienced as deficiencies and impairments, missed before the onset of the disorder in intraindividual comparison. The prepsychotic prodromes and outpost syndromes (GROSS 1969) and the postpsychotic reversible and irreversible basic stages are determined by BS. Because of the far-reaching overlapping of the phenomenological picture of the pre- and postpsychotic basic stages, the Bonn Scale for the Assessment of Basic Symptoms (BSABS) could be constructed for a standardized documentation of all types of pre- and postpsychotic basic stages (GROSS et al. 1987). The psychotic end-phenomena are based on an amalgamation of these substrate-close BS with the "anthropological matrix" (WEITBRECHT 1973). We spoke of *substrate-close BS*, because they are in process active stages nearer to the hypothesized cerebral substrate, i.e. disorders of information processing and - genetically determined - biochemical deviations in the limbic system (GROSS & HUBER 1978; HUBER 1973). Hints for this hypothesis are, a.o., the results of psychological, neurophysiological, electroencephalographic, neurochemical and morphological studies, and the observation that the BS occur - even if rarely - in organic brain diseases, preferentially of the limbic system (HUBER 1980, 1982; overview: SÜLLWOLD & HUBER 1986). On the other hand we spoke of *basic symptoms*, because some of these symptoms, i.e. the cognitive thought-, perception-, and action BS and the cenesthesias form the basis, the primary experiences out of which develop the different kinds of first rank symptoms (HUBER 1957, 1966, 1983; KLOSTERKÖTTER 1988).

For example, distinct cognitive thought disorders are the primary experiences of auditory hallucinations and of disorders of ego experience; certain cognitive perception disorders develop into delusional perceptions; cognitive action disorders, as motor interference, motor blockage or loss of automatic skills show transitions into imposed experiences in the spheres of drive,



volition, and action ("Willensbeeinflussung"); or qualitatively abnormal bodily sensations (cenesthesias) develop into bodily hallucinations with the "criterion of being influenced from without" ("Kriterium des Gemachten"). Thus, the concept of BS allows us to consider distinct basic phenomena actually as symptoms, i.e. as indices to somatic brain processes, of disorders of information processing, probably in the limbic system. With the phenomenological PP, BS have been found that are closer to a cerebral substratum than the typical, diagnostically relevant, usually highly complex schizophrenic end-phenomena. The BS were described and operationally defined in the BSABS, thus providing a starting point both for biological hypothesis and for the typology and classification, and here for the continuum-hypothesis, of endogenous psychoses (HUBER 1990a,b, 1992a; GROSS & HUBER 1978). Basic stages, determined by BS, precede and follow psychotic episodes of schizophrenic and schizoaffective disorders, where BS are as frequent as in schizophrenias (GROSS et al. 1986). BS also occur in affective psychoses, but here mainly dynamic BS as direct and indirect minus symptoms, rarely cognitive BS.

The BS as well as all symptoms of florid and full developed schizophrenic and affective psychoses are also observed in somatically definable brain diseases. There are "symptomatic schizophrenias", e.g. in temporal lobe epilepsy, encephalitis, substance-induced psychoses, brain tumors, especially of the limbic system, and in many other somatically definable brain diseases, as well as "symptomatic cyclothymias", e.g. in the early stages of degenerative brain processes (HUBER 1972, 1988, 1994; WEITBRECHT 1973).

In endogenous psychoses where the diseases is always working with "prepsychotic material", determined by biography and personality (K. SCHNEIDER), the process activity can be so low that it is not possible to differentiate psychoses from neurotic or psychopathic disorder: There exists, especially in these inactive stages, a partial overlap between neurotic-psychopathic syndromes and - endogenous or organic - psychoses in the psychopathological cross-section picture, a fact which was always stressed, following K. SCHNEIDER, by the Bonn School (HUBER 1985). The BS can pass over in the same patient from uncharacteristic level 1 to more or less characteristic level 2 into typical schizophrenic symptomatology of level 3, including first rank symptoms and vice versa; as long as no fixation takes place in level 3, this development is reversible. Follow-ups de-

monstrated psychopathological transitions between BS and psychoses or, in the usual, but misleading terminology, between negative and positive schizophrenia (HUBER 1966, 1985; GROSS et al. 1986). Because so-called negative schizophrenias can become positive ones conversely, it is not justified to maintain a classification that divides into positive and negative, or type-I and type-II-schizophrenias (HUBER & GROSS 1981). But, these terms have, according to the results of our studies, to be specified, insofar as negative symptoms are not identical with BS and the transition from so-called negative into positive symptoms really means the development of florid psychotic first rank phenomena from cognitive BS that are themselves "microproductive" phenomena, i.e. positive symptoms in "statu nascendi", and, at the same time, phenomena with a higher degree of process activity and a high risk of change into psychotic, delusional and hallucinatory symptoms (HUBER 1990a, 1992a; KLOSTERKÖTTER et al. 1988). We must distinguish between basic, positive and negative symptoms and syndromes as different stages of the same disease process which, as a rule, also develop in this chronological sequence.

The psychopathological approach of the BS concept allows us to go beyond the concepts of ANDREASSEN and CROW, who assume a dichotomy between positive and negative, type-I and type-II-schizophrenia (HUBER 1983, 1992b; HUBER & GROSS 1989). The deficits of social competence and emotional stability preceding the first psychotic episodes are very frequently not premorbid personality traits, but already the consequence of the disease, which becomes manifest in prodromal and outpost syndromes many years before the loss of the patient's ability to perceive the basic deficiencies as deficiencies, before the change into the first psychotic phase with its dissolution of ego boundaries. Not the first psychotic schizophrenic episode, but the long time preceding BS and prepsychotic basic stages represent the true onset of schizophrenia and schizoaffective disorders (GROSS & HUBER 1989; GROSS et al. 1987; HUBER 1980, 1983, 1985).

Some essential results of the *Bonn longterm study of schizophrenia* were only tenable with the phenomenological PP: Thus, that about 40% revealed noncharacteristic types of remission and outcome, and mainly slight pure dynamic-cognitive deficiency syndromes ("pure defect" HUBER 1961; 1966), that more than two decades after the onset more than half of the 502 patients had shown slight pure residues or full remission, and that the

disorder frequently shows an improvement in the sense of the "second, positive bend" ("zweiter, positiver Knick") with reduction of many years persisting typical schizophrenic psychoses to pure residues, and that, with regard to longterm and lifelong courses, most of the schizophrenics are most of the time not schizophrenic. The results of the Bonn Study lead to a revision of classical opinions about schizophrenia: The doctrines of incurability, of incessant progression and, above all, of the fundamental heterogeneity and numinous singularity. According to ZUBIN it is an essential result of the Bonn Study, together with the other European longterm studies, that the outcome is far more favourable than had been assumed previously, a result that means, as ZUBIN thought, a revolution in the knowledge on schizophrenia (ZUBIN 1987, s. in HUBER 1990a,b). The findings, e.g. the limitations of KRAEPELIN's rule - schizophrenias have not such an unfavourable, affective psychoses not such a favourable outcome (ANGST 1980), as had been assumed, furtheron the impossibility of a "prognostic diagnostics" (LEONHARD 1966) at the onset of the disorder, as well as the occurrence of endogenomorphic-depressive syndromes in schizophrenic courses (GROSS & HUBER 1980), and of pure deficiency syndromes in cyclothymic courses (HUBER 1957; HUBER et al. 1969), and the lack of clear-cut discontinuities in idiopathic psychosyndromes, the more so as psychopathological symptomatology and the course of abortive forms ("formes frustes") is considered (s. HUBER 1985), speak for the continuum-hypothesis of idiopathic psychosyndromes (HUBER 1990b, 1992a).

Also the "sensitive delusion of reference" and the *paranoia* are, according to our longterm phenomenological studies, marginal types of schizophrenia, interindividually evolving without any sharp distinction against other paranoid types of idiopathic psychosyndromes. Among our life-long courses only 1.8% fulfill the criteria of "paranoia" or "sensitive delusion of reference". But, all these patients had besides the paranoid delusion typical disorders of affect, rapport, expression and thinking as well as conesthesias and vegetative and depressive phenomena. The sensitive delusion of reference with a persisting sensitive core was missing entirely (GROSS et al. 1977; HUBER & GROSS 1977).

As to *schizoaffective psychoses*, including also cycloid and so-called psychogenic or reactive psychoses (KASANIN 1933; PERRIS 1974, s. in GROSS et al. 1986; RETTERSTOL 1978) we had shown in a polydiagnostic approach that these psychoses of the schizoaffective

intermediate field (JANZARIK 1968, 1988) have, compared with the whole group of 502 SCHNEIDER schizophrenias, a significantly better longterm prognosis. This is surprising, because the diagnostic criteria of the different types of schizoaffective psychoses are identical with the prognostically favourable factors of the Bonn schizophrenia study, e.g., normal, syntonic primary personality, provocation by life events, peracute and acute onset of the first psychotic episode, or endogenomorphic-depressive syndromes (GROSS et al. 1986; HUBER et al. 1980).

The *prospective study on BS oriented early diagnosis of schizophrenia* (Gross et al. 1990, 1992) proceeded from the Heidelberg and Bonn longterm studies of schizophrenia and the observation that the subjective experiences of cognitive and dynamic BS occur also in prodromes and out-post syndromes (GROSS 1969) before the first - and the later - psychotic episodes. *Prodromes* pass over continuously into psychotic first manifestation after an average course of 3.3 years, with a range of two months up to 35 years. The completely remitting *outpost syndromes*, lasting an average of 5 months (range: Some days up to 4 years), reveal a temporal interval until the onset of the prodrome or the first psychotic episode of 10.2 years on average (range: one to 37 years - HUBER et al. 1979).

In the study on BS oriented early diagnosis we investigated patients, diagnosed at the index examination as neurotic or psychopathic disorders, but, according to the criteria of the Bonn schedule (BSABS), with the suspicion of a prepsychotic precursor stage (prodrome or outpost syndrome) of schizophrenia. The follow-up, on average of 7 years later, revealed that a subgroup of 31% had developed a schizophrenic first rank psychosis. This subgroup had shown at index examination a significantly higher score of cognitive thought, - perception - and action BS than the sample without any psychotic features at the catamnesis (GROSS et al. 1991, 1992). Thus, distinct, with the BSABS operationally defined cognitive BS are suitable for an early diagnosis and treatment in the prepsychotic precursor stages that precede by many years the first psychotic episode. By means of phenomenological PP and the BSABS, it is possible to single out from a group of patients, who would be diagnosed according to DSM-III-R or ICD-10 as anxiety, so metaform and personality disorders or dysthymia, a subgroup with an increased risk for later development of schizophrenic first rank psychosis, by means of distinct cognitive BS

that can be regarded as psychopathological predictors of (florid) schizophrenic psychoses.

In view of the partial psychopathological overlap between psychoses and neuroses in inactive basic stages, we have dealt with the question of a border area between endogenous psychoses and psychoreactive-psychopathic disorders, a problem that has been discussed ever since KRETSCHMER's constitutional theory (KRETSCHMER 1967) until to modern continuity models which suppose a manifest psychological-psychopathological dimension of schizothymia-schizophrenia (HUBER 1985, 1992a, b). There exists, as we have substantiated elsewhere, no true etiological continuum between neurotic-psychotic and psychotic disorders, but there is a spectrum of schizophrenic and affective psychosyndromes from a nuclear group to marginal groups and formes frustes (HUBER 1985, 1994). In analogy to other mainly genetic disorders also in endogenous psychoses we must take into account an essential portion of many years or even lifelong persistent abortive courses which have been described in schizophrenia by BLEULER, HOCH and POLATIN and other older authors as latent, pseudo-neurotic or pseudopsychopathic schizophrenia, and, with the phenomenological-psychopathological approach by the Bonn group, as cenesthetic (HUBER 1957, 1992c) and larvate schizophrenia (HUBER et al. 1982), as juvenile-asthenic failure syndromes (GLATZEL and HUBER 1968) or as endogenous obsessive-compulsive disease (GROSS et al. 1988).

Seemingly neurotic or psychopathic disorder are frequently, as our prospective study on early diagnosis of schizophrenia (GROSS et al. 1992) proved and the studies of the Mannheim group (HÄFNER 1994) confirmed, prepsychotic basic stages, preceding the positive symptoms and the first psychotic episode many years. It emerged to from these studies and from a systematic investigation by KLOSTERKÖTTER on "BS and end-phenomena of schizophrenia", that distinct cognitive BS are connected by distinct psychopathological transition rows with distinct first rank phenomena (KLOSTERKÖTTER et al. 1988). On the other hand the Heidelberg, Wiesloh and Bonn longterm studies and also the follow-up study of cenesthetic idiopathic psychosyndromes (HUBER et al. 1979; HUBER 1957, 1971, 1992c) revealed that these transition relevant BS of level 2 derive from completely uncharacteristic level 1 BS, which are only retrospectively and by the observation of the longterm courses recognizable as such.

## Final Remarks

The results, obtained with clinical PP may lead to a revised view of crucial psychiatric problems, e.g. regarding symptomatology, course and outcome, diagnostic and therapeutic concepts of idiopathic psychosyndromes, and provide preconditions for the earling recognition, treatment, and prevention of schizophrenic and schizoaffective disorders. In our opinion we must object to trends in contemporary psychiatry to underestimate the phenomenological approach resulting in a threatening loss of psychopathological and clinical-psychiatric competence. This would have grave consequences for our discipline and our patients. For, competence in these areas is a prerequisite for rational diagnostics and therapy as well as for efficient psychiatric research including studies of association between clinical syndromes and somatic, e.g. neuroradiological, neurochemical, or electroencephalographic parameters as also those of our group have shown (HUBER 1957, 1980, 1994; HUBER & GROSS 1992; SÜLLWOLD & HUBER 1986). It is also a consequence of the decrease of psychopathological competence in psychiatry that the findings and data, meaningful for theory and practice, are largely neglected in modern diagnosis systems. The criteria used in these systems, such as DSM-III-R or ICD-10, are often not sufficiently defined or are of different validity. This applied to the criteria of DSM-III for major depression with the consequence that the results, based on such diagnostic systems, according to STRÖMGREN (s. in HUBER 1990a) must be useless. Generally, the operationalized diagnostic systems are not able consider all sources of information, used by the experienced clinical psychopathologist (s. also HUBER & GROSS 1991).

Because phenomenological PP is not a self-contained theory but an open approach, based on methodological reflection (JASPERS), showing ways for research, it has to take the lead previous to all other sciences, relevant to psychiatry. PP does not dispense with understanding too early; rather many psychiatrists too quickly come to an end with PP, or, still worse, do not commence with it at all. But, a careful description of the phenomenon is, as RÜMKE said (s. in WEITBRECHT 1973), the beginning of all scientific work; it cannot be replaced, but only completed by scales and operationalized diagnostic systems. If SCHNEIDER's maxim "Phenomenology is prior to genesis and interpretation" is ignored, or, if phenomenological PP is confused with and mistaken for philosophical phenomenology, the results of such a procedure are doubtful. As the poet tells us:

"Who misses the first buttonhole doesn't manage to button up".

Already nearly 50 years ago GRUHLE (s. in HUBER 1984) stated that psychiatrists on the whole did not learn enough PP and named the reasons: E. g., it is only a method and not a self-contained theory; it must be thoroughly and exhaustively studied and the required "phenomenological attitude" ("Phänomenologische Einstellung" - JASPERS) is by no means a matter of course but can be acquired only after troublesome effort to overcome prejudices; adoption of the tradition, clear methodological thinking and pains with terms and concepts are not in any case the matter of psychiatrists, who also work too much with unverifiable interpretations and go too far with hermeneutic understanding. And, the psychiatrist is not always capable of changing between communication and distance, a personality - and patient - centered and, at the same time, a phenomenon and diagnosis centered attitude which are complementary to one another. Finally, in practicing PP, it is important not to make l'art pour l'art, not to occupy oneself with methodology as an end in itself, but also to show what is the use of the method. This we have tried to do with regard to some examples of the last decades.

The results, obtained with PP in so-called major psychoses, show that the patients themselves are the best witnesses of their experiences. E.g. the concept of BS, using the psychopathological method, represents a new doctrine of symptoms and a new view of what schizophrenia and related psychoses may really be, and how they arise. The studies, prompted by this approach, revealed that KRAEPELIN'S, ANDREANSEN'S and CROW'S models of the course of schizophrenia must be revised (s.a.). Last but not we have to consider the substantial influence of the psychopathological-phenomenological attitude of the physician on the psychology and sociology of clinical practice, on the atmosphere of a psychiatric hospital and on the style and kind of psychiatric research. These effects are conditioned above all by the fact that psychopathologists can do practical and scientific work only with the patient, and in very close relation to the patient; all research must be guided and coordinated by clinical psychiatry (HUBER 1982, 1992a). Thus, 80 years after the first edition of JASPERS' "General Psychopathology" and in the years of 14th edition of SCHNEIDER'S "Clinical Psychopathology", the psychiatry does still need PP and mainly phenomenological-descriptive PP, according to the axiom: "First things first".

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