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Subjective Symptoms of Schizophrenia in Research and the Clinic: The Basic Symptom Concept

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Recent focus on early detection and intervention in psychosis has renewed interest in subtle psychopathology beyond positive and negative symptoms. These are self-experienced subclinical disturbances termed basic symptoms (BS). The phenomenologies of BS and their development in the course of psychotic disorders will be described.

Key words: psychosis/prodrome/postpsychotic basic stage/anomalous self-experience/self-disturbance

Introduction

Diagnosis, treatment, and research studies of psychosis have focused mainly on its cardinal positive and negative symptoms. However, the current attention on prodromal phases of the illness has generated renewed interest in the early subtle, self-experienced changes in mentation that have been observed and described since Kraepelin's articulation of dementia praecox.[1–3] The most thorough description of these symptoms is provided within the framework of the basic symptoms (BS) concept developed by the German psychiatrist Gerd Huber.[3–5]

Basic Symptoms

BS are subtle, subjectively experienced subclinical disturbances in drive, affect, thinking, speech, (body) perception, motor action, central vegetative functions, and stress tolerance.[4,5] They can occur and have been reported in every stage of the illness, ie, in the prodrome to the first psychotic episode, in prodromes to relapse, in residual states, and even during psychotic episodes per se.[4–6]

By definition, BS are different from what is considered to be one's "normal" mental self. Being subjective, they remain predominately private and apparent only to the affected person. They are rarely observable to others, although a patient's self-initiated coping strategies (including avoidance strategies and social withdrawal) in response to his/her BS may be recognizable to others. Being self-experiences, BS differ from negative symptoms as they are currently understood, ie, as functional deficits observable to others.[1] BS are also distinct from frank psychotic symptoms that are experienced by the patient as real, normal thinking, and feeling. In contrast, BS are spontaneously and immediately recognized by the affected person as disturbances of his/her own (mental) processes. Insight that something is wrong with one's thinking is present, yet some experiences might be so new and strange that they remain nearly inexplicable. The rare, highly introspective person may be able to articulate what is happening, but any detailed description of these experiences usually requires help in the form of guided questioning.[6] The ability to experience BS with insight and to cope with them often attenuates with progressive illness and emerging psychotic symptoms but is restored upon remission.[4] Thus, an evaluation of BS is often hindered by acute and/or prominent psychotic symptoms.

In Anglo-American psychiatry, 2 researchers, James Chapman[7] and John Varsamis,[8] described self-experienced symptoms like BS in the 1960s and 1970s without exploring them in as much detail as Huber and colleagues. Recently, BS emphasizing anomalies of self-awareness have been described by Josef Parnas.[1,9]

BS in the Course of Schizophrenia

BS were regarded as the earliest subjectively experienced symptoms of psychosis and the most immediate symptomatic expression of the neurobiological correlates of the illness (figure 1)—thus the term "basic."[4,5] According to the original concept, (early) symptoms of psychosis occur in 3 developmental forms: "uncharacteristic" BS affecting mainly drive, volition, and affect, as well as concentration and memory (level 1); "characteristic", qualitatively peculiar BS, especially of thinking, speech,

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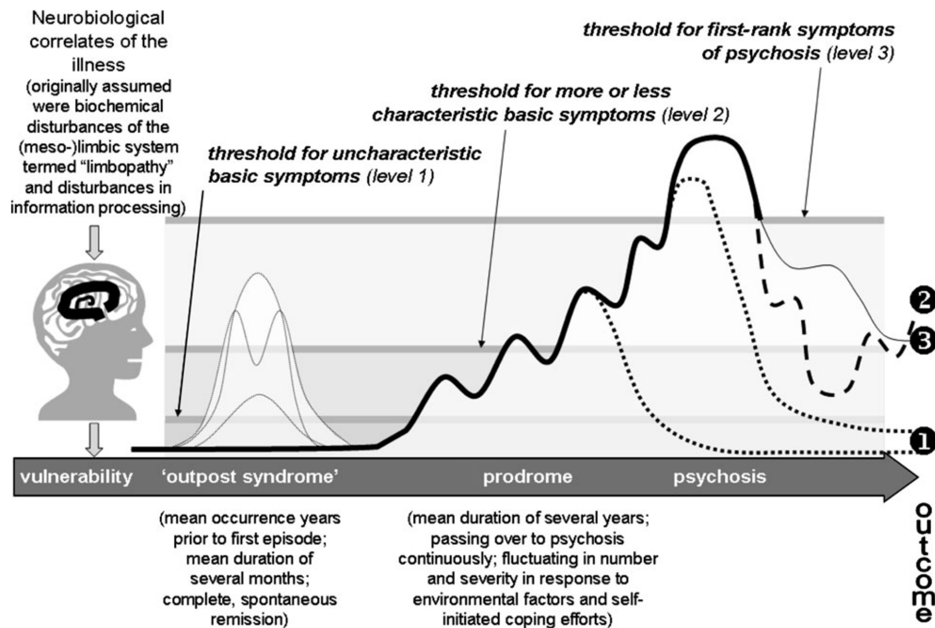

Fig. 1. A Model of Huber's Concept of Basic Symptoms (BS).[4,5] (1) Reversible postpsychotic basic stage; (2) prodrome of relapse; (3) irreversible postpsychotic basic ("pure defect syndrome").

(body) perception, and motor action (level 2); and psychotic symptoms per se (level 3; figure 1).[4,5]

Upon debut at level 1, BS will gradually increase in number and severity and, in most cases, will ultimately develop into psychotic symptoms. Temporary improvements, however, are possible (figure 1; thick line). In some cases, level 1 and/or level 2 BS will remit completely and spontaneously before reaching the threshold for psychotic symptoms (figure 1; thin dotted lines on left of the figure). These symptomatic phases without conversion to a frank psychotic episode can mimic true prodromal stages and are called "outpost syndromes" because they herald the subsequent prodrome.[5]

The emergence of level 2 or characteristic BS and their conversion to level 3 psychotic symptoms can be triggered by everyday situations and demands that overstrain an already pathologically vulnerable information processing capacity.[4,5] Given favorable environmental and personal conditions (eg, a supportive social network, good social, and problem solving skills or coping successfully with pressure such as passing difficult exams), BS can be compensated for at any state almost completely as long as their number and/or severity do not overextend personal resources and coping strategies (figure 1; first thick dotted line). Thus, in earlier phases, the developing illness will only become obvious to others when negative coping strategies are employed (eg, social withdrawal or avoidance of certain situations/activities) or when coping abilities are exhausted, and BS start to interfere with behavior as functional deficits and/or disorganizations of communication.

Following the first frank episode, BS evolve into 3 categories of outcome or "postsymptomatic basic stages" (figure 1 on right of the figure): (1) a reversible stage characterized by complete remission of BS within 3 years following treatment (figure 1; thick dotted lines); such an outcome is the hope of early intervention before the outbreak of psychotic symptoms, (2) a prodromal stage of relapse developing from a low-symptom or even an asymptomatic state into a second episode (thick dashed line), and (3) an irreversible symptomatic stage or "pure defect syndrome" with level 1 and level 2 BS, especially disturbances in drive, stress tolerance, and affect and deficits in cognition, persisting on a level interfering with functioning for more than 3 years (thin solid line).

BS Rather Specific to Psychoses

Table 1 details some cognitive and perceptual BS that are common to persons with active psychosis, residual psychosis, or risk for psychosis. Statements have been taken from the "Schizophrenia Proneness Instrument, Adult Version (SPI-A)" [6] that gives more extended descriptions of BS and instructions for their assessment.

Other BS such as disturbances in drive, stress tolerance, affect, body perception, and level 1 cognitive BS may occur in other disorders, especially nonpsychotic affective disorders.[10–12] The subset detailed in table 1, however, appear to be rather specific to psychosis[10–12] and is currently employed in 2 prodromal criteria sets.[6,12]

These BS, if present, can be assessed in most persons, including those with mild mental impairment (IQ $\geq$ 50).[13] Even in patients with fully intact cognitive capacity, however, what usually gets described spontaneously are broad, nonspecific complaints such as having trouble

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Table 1. Cognitive and Perceptual Basic Symptoms Associated With Psychosis and Prototypic Self-observations by Patients

Thought interference, ie, an intrusion of completely insignificant thoughts hindering concentration/thinking ("I can't help thinking about other things, which is very distracting.")
Thought perseveration, ie, an obsessive like repetition of insignificant thoughts or mental images ("I always have to mull over what I just said. I can't stop thinking about what I might have said wrong or what I could have added although I really don't think that anything was wrong with what I said.")
Thought pressure, ie, a self-reported "chaos" of unrelated thoughts ("If I am stressed out my mind gets chaotic and I have great problems thinking straight. Too many thoughts come up at once.")
Thought blockages either with or without intrusion of a new thought also includes a sudden loss of the thread or train of thoughts ("Sometimes my thoughts just stop, are suddenly gone, like being cut off.")
Disturbance of receptive language, ie, paralysis in the immediate comprehension of simple words/sentences, either read or heard, that can result in giving up reading or avoiding conversations ("I often can't get the meaning of common words when I am reading.")
Disturbance of expressive speech, ie, problems in producing appropriate words, sometimes also experienced as a reduction in active vocabulary ("Sometimes I think it must appear as if English were really my second language, like I don't know English very well because I have difficulties expressing myself. I forget the words.")
Disturbances of abstract thinking, ie, an unusual basic symptom seen when asking the patient to explain sayings or idioms ("Sometimes I get puzzled if a certain object or event only stands as a metaphor for some more general, abstract or philosophical meaning.")
Inability to divide attention between simultaneous nondemanding tasks that each draw primarily upon a different sense that would not usually require a switching of attention ("Doing two things at once has become impossible even with the simplest things. I always have to concentrate on one thing at a time, like if I prepare a sandwich, I cannot do anything else, like watch a film.")
Captivation of attention by details of the visual field that catches and holds the look ("Sometimes an object really seems to stand out from the rest of what I see. My eyes then fix on it. It's like being spellbound, even though I don't want to look at it at all.")
Decreased ability to discriminate between perception and ideas, true memories and fantasies ("I thought about my grandparents. Then a weird thing happened: I couldn't remember if knew my grandparents properly, if they were real or if they were just in my imagination. Did I know them, or had I made them up?")
Unstable ideas of reference with insight ("When I was listening to the radio the idea that the lyrics had some special meaning for me suddenly popped up into my head. Of course I knew straight away that it was just my imagination, a kind of weird thing. I did not have to think twice about it to know that.")
Derealization, ie, a decreased emotional and gestalt connection with the environment ("Sometimes, I feel disconnected from the world around me, like I'm under a glass cover.")
Visual or acoustic perceptual disturbances with insight. Unlike hallucinations or schizotypal perceptual distortions, basic symptom perceptual observations are not regarded as real but are immediately recognized as a sensory or subjective problem. The knowledge that the misperception, eg, a wrong coloring, distorted shape or changed sound quality/intensity, has no counterpart in the real world is immediate and unquestioned ("People suddenly seemed changed and had different hair colors.")

concentrating or thinking. Yet, starting from these, specific cognitive BS can be queried about and teased forth. Furthermore, because these phenomena, especially perceptual disturbances, are recognized by the person as not normal, they are often appraised as something extraordinary or "crazy" and beyond understanding. As such, the presence of BS can be kept hidden and might not be volunteered at all unless they are asked for explicitly. When this happens, however, patients often feel empathically understood for the first time and relax.

Discussion

BS are an integral part of the psychoses and can appear throughout various stages of the disorder. Currently, BS are mainly employed in the early detection and preventive intervention of psychosis.[3,6,11,12] In clinical practice, the most important feature of BS is that they are experienced and reported as abnormal and burdensome by the patients themselves. As such, they are appropriate to describe in awareness and information campaigns of psychosis to promote early detection and indicated prevention. They should also be described to patients in remission from psychosis as representing early signals of a risk for relapse. BS are also important signals of the need for rehabilitation in residual, postpsychotic states.[5] They support a more complete description of the degree of remission beyond positive and negative symptoms. In this, BS can be used for titrating adequate combinations of pharmacological, psychological, and rehabilitative interventions.[5]

Finally, a patient's encounters with and motivations for treatment may be improved by relating therapeutic strategies to phenomena that are clearly recognized as subjectively burdensome symptoms. The BS concept can also educate patients and their families about the expressions of psychosis and support them in acquiring a deeper understanding of the expected vicissitudes of their illness, an important step in the process of stripping "madness" of some of its intractability and terror.[5,14] Finally, consideration of BS may help the therapist in achieving insight into a patient's failure to master some problems that might be a reaction to BS.[14]

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