13 - 4. First Rank Symptoms

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 Kurt Schneider, a German psychiatrist and a pupil of Karl Jaspers, pointed out certain symptoms as being characteristic of schizophrenia and therefore exhibiting a "first-rank" status in the hierarchy of potentially diagnostic symptoms. The "first-rank" symptoms (FRS) have played an extremely important role in the recent diagnostic systems: in the International Statistical Classification of Diseases, tenth Revision (ICD-10) as well as in Diagnostic and Statistical Manual of Mental Disorder, (DSM-III-IV), the presence of one FRS is symptomatically sufficient for the schizophrenia diagnosis but FRS are not essential to diagnose schizophrenia. FRS may also be encountered in the nonschizophrenic conditions, and, therefore, they are not specific or diagnostic for schizophrenia (Palaniyappan, 2007). Kurt Schneider proposed an empirical cluster of symptoms, one or more of which in the absence of evidence of organic processes, could be used as a positive evidence for schizophrenia. He did not claim that they are comprehensive – but they are clearly identifiable, frequently occurring and occur more often in schizophrenia than any other disorder. FRS emphasizes on the form of the experience rather than content i.e. the feature that voices echo one’s thoughts is more important that what the voices actually said. Disturbance of self-image (ego-boundary) is the predominant underlying feature of all FRS. In a critical review of FRS studies published in English between 1970 and 2005, Nordgaard et al. (2008) report the following findings. The FRS are reported to occur in 22% to 29% of patients with affective disorders. Generally, the prevalence of FRS in schizophrenia is reported to range between 25% and 88%. This range remains equally high in the reports from western and developing countries and in studies of different ethnic groups. In some studies, delusional perception is the most frequent FRS, whereas the same symptom is the least frequent in other studies. A number of studies find no single dominating type of FRS. Assessment of the diagnostic weight of individual FRS is absent with the exception of Mellor and colleagues who suggest that "voices discussing" should be given less diagnostic weight than other FRS. The majority of the reports conclude that FRS do not affect the outcome. No study finds that the outcome is related to the number of FRS observed in the individual patient. FRS are not of any prognostic importance at all. They do not specify any subgroups with the differential treatment response or heritability.

© SPMM Course The First Rank Symptoms 3 hallucinations Audible thoughts (Thought echo) Voices heard arguing (3rd person) Voices heard commenting on one's actions (running commentary) 3 ‘Made’ phenomena Made affect (Someone controlling the mood/affect) Made volition (Someone controlling the action – usually a completed act) Made impulse (Someone controlling the desire to act –not completed act but the drive. If the action has been carried out, patient admits to

ownership of act, not the impulse behind it) 3 Thought phenomena (Experiences themselves are more important than later explanations or how patient interprets them) Thought withdrawal Thought insertion (External agency inserting thoughts upon the patient) Thought broadcast (Also called thought diffusion – as if in television broadcast, everyone comes to know about the patient's thinking as and when the patient thinks – refers to the loss of privacy of thoughts. Cf. referential delusion – 'people act as if they know what I am thinking') 2 isolated symptoms Delusional perception Experience of sensations on the body caused by external agency (somatic passivity) Totally (3X3) +2.

What is NOT FRS? Command hallucinations are not first rank symptoms. Somatic hallucinations are also NOT first rank symptoms unless there is a delusional elaboration and attribution of the origin of sensations to an external agency (i.e. unless they are presenting as somatic passivity). Note that somatic passivity can follow a normal sensation like a headache, ascribed to a 'Russian neurosurgeon who inserted a chip through my nose when I was sleeping'! Schneider described mood changes (depression or elation), emotional blunting, perplexity and sudden delusional ideas as symptoms of the second rank. Thought alienation:

© SPMM Course The three thought phenomena described above are sometimes grouped together as thought alienation or delusions of thought control. These are related to a primary disturbance in the subjective control of thinking. This is a high yield topic for MCQs – please study the table below. Phenomenon Self – nonself difference Where is the thought now? Who owns the thought? Who influences the thought? NORMAL THOUGHTS Preserved (we know that our thoughts are private) Self (in our subjective space) Self (it is our own thought) Self (we can stop thinking when we want) Thought insertion Violated Self (with the patient) External agency External agency produced and influenced the thought Thought withdrawal Violated Taken away (may be delusionally elaborated) Self Originally self-produced, now external agency influences Thought broadcast Violated Diffused everywhere Self External agency influences it as soon as it originated from self Thought blocking Not violated Unknown Self Self Obsessions (this is not a thought alienation) Not violated Self Self Self but disturbed (the thoughts may be against one's values – so egodystonic but not fully disowned) Thought alienation table is modified from Mullins, S. & Spence, S.A. Re-examining thought insertion. The British Journal of Psychiatry (2003) 182: 293-298

Revision #1
Created 2026-01-04 20:05:19 UTC by Omar Ayman
Updated 2026-01-04 20:05:19 UTC by Omar Ayman