Discussing Rümke's "Praecox Feeling" from the clinician's experience of schizophrenic contact

Discutindo o "sentimento precoce" de Rümke do ponto de vista da experiência do clinico no contato esquizofrênico

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Abstract

"Praecox Feeling" ("Praecox Gefühl") was a notion introduced by the Dutch psychiatrist H.C. Rümke as an attempt to emphasize schizophrenic gestalt as a key feature for diagnosis. Our purpose is to decrypt Rümke's work and to offer a critique based on a case study. From a phenomenological framework, we attempt to show the relevance and the limits of this concept in order to enlighten contemporary nosographic issues. Rümke suggested that symptoms themselves are not reliable for a rigorous diagnosis of schizophrenia. He proposed the term of Praecox Feeling to describe the bizarreness experimented by the clinician from the first minutes of the encounter with a person with schizophrenia. This notion refers to Karl Jaspers "radical incomprehensibility" of mental disorder. Our point is to take seriously this incomprehensibility to think a second person approach to diagnosis. To explore this track, we will focus our interest on the clinician subjective experience of schizophrenic encounter. In this regard, we will not think bizarreness as polarized on the patient's side, but rather as an in-between event. Since then psychopathologic comprehension call for an epistemology of human contact and minimal-social space. Schizophrenic encounter needs then to be revisited in a more dynamic and embodied way.

Keywords: Schizophrenia spectrum; Praecox feeling; Phenomenology; Embodied Intersubjectivity

Resumo

"Sentimento precoce" ("Praecox Gefühl") foi um termo introduzido pelo psiquiatra holandês H.C. Rümke em uma tentativa de valorizar a forma (*gestalt*) esquizofrênica como característica fundamental para o diagnóstico. Nosso objetivo é decifrar o trabalho de Rümke e oferecer uma crítica com base em estudo de um caso. A partir de um referencial fenomenológico, tentamos mostrar a importância e os limites deste conceito, a fim de esclarecer questões nosográficas contemporâneas. Rümke sugeriu que os próprios sintomas não são confiáveis para um diagnóstico rigoroso de esquizofrenia. Ele propôs o termo "Sentimento precoce" para descrever a experiência de estranheza experimentada pelo clínico

desde os primeiros minutos do encontro com uma pessoa com esquizofrenia. Esta noção refere-se à "incompreensibilidade radical" dos transtornos mentais, elaborada por Karl Jaspers. Nosso objetivo é levar a sério essa incompreensibilidade para pensar uma abordagem em segunda pessoa para o diagnóstico. Para explorar este caminho, focaremos nosso interesse na experiência subjetiva do clínico no encontro com o paciente esquizofrênico. A este respeito, não pensamos que a estranheza se apresente polarizada na experiência do paciente, mas como um evento intersubjetivo. Com isto, a compreensão psicopatológica exige uma epistemologia do contato humano e do espaço social mínimo. O contato com o paciente esquizofrênico precisa ser revisitado de modo mais dinâmico e levando-se em conta a corporeidade.

Palavras-chave: Espectro da esquizofrenia; Sentimento precoce; Fenomenologia; Intersubjetividade encarnada

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Introduction

A rebound of scientific interest has appeared during the last decades about a nosographic way of thinking psychiatric diagnosis. However, the clinical core of schizophrenia remains an enigma. A blind spot around which gravitates psychopathology since its beginning. Each theoretical breakthrough has always revealed new mysteries. "Praecox Feeling" was a notion introduced by the Dutch psychiatrist Henricus Cornelius Rümke as an attempt to emphasize schizophrenic gestalt as a key feature for diagnosis. The purpose of this article is to decrypt Rümke's work and to offer a critique based on case study. From a phenomenological framework, we attempt to show the relevance and the limits of this concept in order to enlighten contemporary nosographic issues. Rümke suggested that symptoms themselves are not reliable for a rigorous diagnosis of schizophrenia. He proposed the term of Praecox Feeling to describe the bizarreness experimented by the clinician from the first minutes of the encounter with a person with schizophrenia. This is not an objective clinical sign, but rather a pre-semiologic recognition of symptom's schizophrenic quality. Qualified as "indefinable" since it is non-verbal and then inaccessible to a third person perspective (Vargas, 2013).

The aim of this study is to share a clinical account regarding the notion of *Praecox feeling*. That is to say the feeling of bizarreness experienced by the clinician during a meeting with a person suffering from schizophrenia and which could allow some very skilled clinician to make the diagnosis from the first sight. Praecox feeling covers notions of "*diagnostic by penetration"* from Eugene Minkowski (1927), "*atmospheric diagnosis*" from Hubertus Tellenbach (1968), or *"diagnostic by Intuition"* from Ludwig Binswanger (2016) and Jakob Wyrsch (1949). For Rümke, Praecox feeling allows to denote a specific unease, experienced in the encounter. Rümke claimed that Praecox feeling was an attempt to capture the clinical core of schizophrenia. It means a certain *gestalt* of first rank symptoms (Rümke, 1990) which signs their schizophrenic nature. This experienced unease is difficult to qualify in linguistic format (Rümke, 1958). However, in an article of 1942, Rümke suggested that Praecox feeling reflects an impossibility to establish a contact with the patient's personality as a whole because of some *"lack of exchange of affect"* in the patient and, consequently some *"impossibility for empathy"*. A kind of closeness to the investigator. This idea was almost as old as the notion of schizophrenia itself, and Eugen Bleuler claimed that we had no *"*affective

contact" with a schizophrenic person[1] by this statement he was referring to the radical unshareability of schizophrenic experience. But if schizophrenia is a radical otherness for the clinician, how can it be described in a first person perspective? How can there be an access, albeit precarious and fleeting, allowing the clinician to develop a genuine phenomenological description? Without any inter-affective contact, there is no basis for an intuitive empathic understanding. If it must be acknowledged, with Minkowski the central role of "*schizophrenic autism"* and the "*loss of vital contact with reality"*, we cannot deny that people with schizophrenia affect us, touch us, and often disturb us. This paradox appears in all its complexity with the phenomenon of *Praecox Feeling*, which aggregates all at once the radical otherness of the schizophrenic experience and the evidence of its pathological manifestation (Bleuler, 1950).

Methodology

To unfold this paradox, we wanted to submit the account of a clinical encounter from the perspective of the clinician. Very few recent studies had been made to explore the reliability and validity of Praecox Feeling as a diagnostic tool in clinical practice (Wiggins, 1987; Grube, 2006; Ungvari, 2010). These researches had intended to compare Praecox Feeling to operationalized diagnostic system as ICD-10 and DSM-IV, showing very incoherent experimental results. Both authors emphasized the very necessity of phenomenological studies on conceptual issues and qualitative methodology. There is no recent study decrypting the clinician's subjective experience from a first person perspective. This case study is presented here with a non-conventional methodology in that it is a tentative of a "perspectivist" approach to psychopathology. That is an account of the encounter situated on the clinician side, as the only accessible perspective. This methodology appeared necessary to be able to elaborate a knowing about the other from a second person perspective. Moreover, if psychiatric and phenomenological literature have insisted on that Praecox Feeling is only accessible to very skilled and experimented clinician, this present clinical narrative was conduct by a young psychiatric trainee.

[1] Reported by Minkowski E. in *La schizophrénie*, Petite Bibliothèque Payot, Paris, 1927, p. 94

Clinical encounter

Maurice, 35 years old; has been suffering from schizophrenia for a dozen years. This time he came to the hospital because he wasn't able to get out of his apartment. Everything in the outer world is problematic, complex and requires careful consideration. Actually everything changed for Maurice since he fell ill. Now nothing is simple. Maurice feels concerned by so many things, with details of his daily life. As though there were no hierarchy between the signs over which to rely to act and which to ignore as mere elements of the environment. *"It's hellish! I think too much*, he explains, *before it was so simple, I knew what to do or say. Now nothing is obvious."* When we met for the first time, he was mistrustful, secret and anxious. He didn't look into the eyes, took time to answer in a mysterious way. Later, he has been able to confide he had the feeling I could read his mind. He felt violated, naked and alone. It took time to get used to each other. In the ward he was discreet, invisible almost. He left without notice and returned at odd hours in the night to the nurses' utter despair. From then onward, we allowed Maurice to go back and forth between his apartment and the hospital. He was departing with some astrological predictability when the evening sun was waning and when the parrots in the hospital park burst into song. Sometimes he came back in the middle of the night, explaining that a car honked at the very moment when he had the idea of returning, this coincidence certainly meaning it was time to go. Maurice's suffering is about not being well anywhere. As though he were empowered by a secret force along the path of invisible stars nestled in the banality of things. He can't live in any place without being attracted elsewhere. During a month, Maurice was there in a game of presence-absence that didn't make any sense for us. It was just a co-presence without any real intersubjective contact.

Actually, our relationship changed when Maurice told me about his "*crazy*" project. He had seen at the hospital entrance, on the ground floor, a bar, with a counter, tables, everything. Except there was no one to enjoy this and no one to run the place. So, we worked on the project, we thought together about the creation of a café inside the hospital where it would be possible to host patients and families more warmly. This café should be handled by him. Of course, we had to negotiate with the administration, set up an association, etc. Anyway, some great work of imagination and audacity. This project was like a piece of world, crafted together. An *imaginary sub-universe* between us. The question wasn't to know whether or not it was possible. Whether or not it was reasonable or clinical. It was a play area.

"There is nothing more serious than playing," Winnicott (1971) wrote. In this regard, sociologist Alfred Schütz (1976) states that it is possible to stand a sincere social relationship with someone if and only if you give one's experience the nature of an authentic reality. So that the inter-subjective experience, the sharing of something common is only possible with "*faith in the veracity of the other."* The phenomenological approach in care in general and in psychiatry in particular therefore opens onto an ethic of encounter. Which necessitates a deconstruction of the commonly accepted hierarchy between usual reality and delusional reality. Having a sincere relationship means sharing a sphere of reality in which an exchange is possible on equal terms. It's necessary to be able to build up some chimerical world, probably this does not often happen; but make this inter-subjective event possible is a horizon that we should aim to in psychotherapeutic setting.

In this sense, inter-subjectivity doesn't merely deal with psychological exchange between two isolated Egos but with the field of a possible communication. In other words, this raises the question of the existence of a common world of experience which could be shared. Therefore, empathetic feeling doesn't cover all the meanings of the phenomenological notion of inter-subjectivity. Danish philosopher Dan Zahavi (2001) argues that empathic situation where I attempt to thematically grasp the experience of others is the exception rather than the rule. My everyday relationship to the world is a relation to a shared world, where everything refers to others. Self-world relatedness is always mediated by the reference to other persons regardless of whether or not they are actually present. It is a world *always-already* used by the others. That's why Heidegger (1962) said *Dasein* was always *being-with*. In fact, it's when the usual daily experience of reality is broken that we refer to empathy to thematically grasp the emotions or the experiences of others. For example, in a care situation, when the other person experiences an unshareable pain, imminence of death, delusion, etc.

Metaphorization and mutual confidence in a shared world

Slowly Maurice and I have started to build mutual confidence. The elaboration of this therapeutic cafe project as a chimerical instance of reality has thus allowed for a first inter-subjective contact. Later, I asked Maurice to help me with my thesis owing to his subjective experience regarding schizophrenia. I suggested to do EASE scale, developed by Josef Parnas et al. (2005), for phenomenological exploration of anomalous self-experience. I quote the authors:

"The Examination of Anomalous Self-Experience (EASE) is a symptom checklist for semi-structured, phenomenological exploration of […] subjective anomalies that may be considered as disorders of basic or 'minimal' self-awareness. […] the purpose of description is predominantly qualitative, striving for a detailed account of phenomena that have in common a somehow deformed sense of first-person perspective [that is to say] the sense of being a subject, a self-coinciding center of action, thought, and experience." (p.236)

"The experiences that are targeted here are often so strange to the patient that he has never communicated them to anyone else. […] The experiences may be fleeting, perhaps even verging on something ineffable. They are not like material objects that one can 'take out of one's head' and describe them as if they were things.[…] The patient may be short of words to express his own experiencing [because] these experiences possess a pre-reflective quality. They are not explicit in the focus of thematic attention but constitute more the overall background of awareness." (p.237)

The issue of this exploration is to make some very intimate experiences intersubjectively shareable. The authors therefore emphasize the use of metaphor to describe pre-linguistic pathological self-experiences. So that an experience, especially if it is pre-reflexive, is brought to be linguistically thematised by the subject in a poetic language type. The role of the evaluator is to accompany the patient in this process of symbolization. This exercise calls for creativity and confidence between the patient and the evaluator. So that shareability of pathological self-experience must be crafted together.

During our interview for EASE, Maurice told me about what he lived in daily life. "*I think too much, constantly. I feel concerned by a mass of details."* He had to think of everything because everything may have meant something. Everything held a hidden secret that a mere detail could reveal. But, you know, the world is swamped with details! *"It's unbearable*, he said, *I don't have direct access to things".* For Maurice, everything happened as if the immediate contact with the things of the world had lost their dynamism, their spontaneousness. All that was usually evident and implicit could call for explicit attention and thematical thinking. Maurice had lost the acquaintance we have with our familiar world. How to understand this?

For French phenomenologist Maurice Merleau-Ponty (1964), subjectivity usually works as the cement that holds the structures of the visible world together. This cement isn't itself visible. It fades behind what it reveals. Subjectivity slides into the interstices of the

visible, and tints our usual environment with familiarity. And there is always a correlation between the seeing subject and the visible object. The intentional act is the subjective determination of the visible world. So that the visible world is woven from my invisible subjectivity. That's why there are no really surprising events in our usual relationship to the world. And we will see that it is this invisible part in the visible which takes up the function of an intentional object in delusion. In continental psychopathology, delusion doesn't affect object or visible environment. It corrupts the invisible and what belongs to minimal subjective awareness. It is in the interstices of the visible world that subjectivity becomes objectivity. And thereby loses its aliveness. Subjective determination of the visible could then become some really disturbing otherness, a dead, supernatural or mechanical thing. That's why there is no coincidence in the delusional world. Daily life appears as a theatre play where everything is set, calculated, manipulated by some impalpable force.

When Maurice looked toward what should not be visible, the contact with reality instantly lost its vitality. In such a way that this unremitting reflection about his insertion into the living world was immediately correlative of a terrifying feeling of being dead. Something is forbidden in perception. And Maurice, like Caesar, crossed the Rubicon. The perceptual law had been broken, and no return was possible. By looking Medusa into the eyes he was immediately petrified. What did he see? His eyes turned inwardly. Lost in a secret fascination for the invisible. French psychopathologist Henri Ey had seen the tragedy of the hallucinated, derogating to perceptual law. *"Hallucination breaks out as a scandal, contravening to perceptual law"* Henry Ey (2012) wrote. The hallucination causes a scandal because it is a perception without any object to be perceived. Henri Ey insists on the fact that the object on which hallucinatory perception is engaged is a non-object, that is to say something that would never have become an object. So that the living subjectivity is for the hallucinated taking a wrong path and turning over to catch itself as an object of awareness.

Towards the end of the interview, Maurice had expressed something he had never been able to share before. The moment everything had changed for him. Twelve years ago, one evening he was driving his car. That night suddenly *"something changed in the sky."* A tiny little thing, a *"je ne sais quoi"*. *"It was frightful",* he said. He threw his car against a tree. He remembered every detail. Rescue services arrived, he was mute. When emergency doctors told him to go back home because there was nothing serious, he thought he was dead. *"I was cold; my hands were frozen, as when you're dead."* In the emergency he remembered his

room, his bed, the door. He was focusing on his saliva in the palm of his hand. An experience of apocalypse. The end of the world and a terrible weight on his shoulders. As if the survival of the entire world depended on him. Was it hell? He didn't know. Actually he wasn't sure he had got out of this alive. Since then, nothing was as before. He kept saying: "*It was frightful*". It wasn't a metaphor, it wasn't a stylistic device. I (G.T.) felt this freezing death inside me. At that critical moment of the interview, the cataclysm appeared to me. As if I had been able to catch a glimpse, for one tiny moment, in the course of a phrase, of the great disruption of his life. During this EASE interview, I felt some very brutal variation in affective contact match the rhythm of the scansion impulsed by the questions. Even though EASE is focused over the patients' subjectivity, their sick self, body experience, etc. A very dense atmosphere appeared in the interview setting. A *gestalt*, which I noticed only in hindsight. At the time, I felt ill at ease. It was hard to bear this moment of a rare intensity. I felt in a very precarious position. An upsetting back and forth close to him. I felt intrusive, forced to justify my approach again and again. What I was doing exactly, actually why I was there. In this situation, no anonymous observer. You get bodily involved, entwined in the encounter. I was upset, deranged. But what was actually deranged? Me, obviously, my secure and steady relationship with the world, my usual and unproblematic presence.

I think Praecox feeling appears at this moment. Praecox feeling cannot be trivialized to the first 3 minutes of an interview. Rather it is a *gestalt* that can appear after several months, arising mainly passively in the course of a phrase, a mimicry, etc. But only if a first intersubjective contact had been able to be craft as the condition of emergence of this event.

To conclude and return to Rümke's Praecox feeling. I think there is indeed some trouble with empathy in the encounter with a schizophrenic subject. But this disorder is perhaps not on the patient's side as Rümke suggests. It is likely that sometimes the "supposedly healthy subject" cannot maintain this empathetic link. I haven't been able to maintain a sincere openness to him because what was here at play was for me unbearably bizarre. The question of Praecox feeling is perhaps not so much about what it clinically means regarding an underlying psychological causality. Hadn't we better ask why the radical bizarreness of madness forces us to need to make some diagnosis? Perhaps to keep away, or keep under thematical control what is most disturbing about madness?

In this sense, we could hypothesis that the phenomenon below the manifestation of Praecox Feeling is of more ubiquitous expression in the encounter. We propose that future phenomenological studies focus more on the bizarreness in schizophrenic contact than on the notion of praecox feeling which is limited to the situation of the doctor-patient relationship and to the diagnostic decision-making situation. From this point of view, it is a matter of undertaking a "reduction" of the clinical situation to its most minimal determinants in order to reveal phenomenologically the experiential structure of this "bizarreness".

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