On the Concept of *Praecox Feeling*

Mauro Pallagrosi Laura Fonzi

Department of Human Neurosciences, Sapienza University of Rome, Rome, Italy

Keywords

Praecox feeling · Rümke · Schizophrenia · Intersubjectivity · Psychiatric diagnosis · Psychopathology

Abstract

Despite the development and widespread diffusion of modern nosographic systems, the diagnosis of schizophrenia continues to raise several epistemological issues. To address these issues, a number of researchers are currently pursuing the possibility of an integration between reliable, objective approaches and the intersubjective perspective in the clinical encounter. In the present article, we discuss Rümke's popular concept of *praecox feeling*, as introduced in 1941 and re-elaborated over the following 20 years. Our aim was to thoroughly analyze the author's original formulation and to identify the connections between his thinking and certain psychopathological developments, epistemological issues, and research perspectives on schizophrenia. The *praecox feeling* is presented by Rümke as a sensitive diagnostic tool for schizophrenia that is rooted in the peculiar subjective experience of the clinician when encountering a schizophrenic patient. This experience seems to be characterized by two essential dimensions: a subjective one, which reflects the failure of a clinician's empathic effort due to a fundamental alteration of the intersubjective space, a phenomenon related to schizophrenic autism, and a gestaltic, objective one,

which is grounded in the clinician's implicit typifying process as a consequence of collecting recurrent clinical observations over the course of his/her professional experience. According to Rümke, the diagnostic use of the *praecox feeling* should be limited to the acute phases of the schizophrenic process, as the clinician's experience of an intersubjective struggle is attenuated in interactions with older, chronic patients. The multifaceted nature of Rümke's proposal seems to have contributed to some theoretical critiques and to inconclusive results from empirical investigations, leading to a progressive devaluation of the scientific and diagnostic validity of *praecox feeling*. The present analysis of the original concept suggests that a renewed research interest in the role of the clinician's subjective experience with regard to the schizophrenic patient could be helpful.

© 2018 S. Karger AG, Basel

Introduction

In 1941, the Dutch psychiatrist and psychoanalyst Henricus Cornelius Rümke published an article entitled “Das Kernsymptom der Schizophrenie und das ‘Praecox-Gefühl’” (The nuclear symptom of schizophrenia and the *praecox feeling*) [1, 2]. In the article, he summarized the difficulties posed at the time by the process of diagnosing schizophrenia, and proposed his own diagnostic tech-

nique, which focused on what he called the *praecox feeling*. The article, just 6 pages long, met the interest of the scientific community, stimulating an intense debate that involved many pivotal psychopathological issues regarding schizophrenia and, more generally, the role of subjective elements in clinical evaluation. Over time, this debate gradually faded, especially in light of the spread of the operational perspective for diagnosis, firmly established by the publication of the consecutive versions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) [3–6].

Only recently, in response to growing interest in identifying and treating early-stage schizophrenia [7, 8] and dissatisfaction with the validity of the diagnostic entities defined by criteriological systems [9–11], researchers' attention has shifted back to a diagnostic process that includes subjective elements, particularly in the diagnosis of schizophrenia. This has occurred especially thanks to the reconsideration of proposals developed by the classical, phenomenologically inspired psychopathologists [12–16]. Consideration of the possibility of integrating different approaches to diagnosis has in fact led some authors to propose a model in which the descriptive and criteriological approach (third-person approach), which provides objectivity and reliability, would coexist with a method of psychopathological investigation aimed at grasping the patient's subjectivity without mediation (first-person approach) or analysis through hermeneutical processes (second-person approach) [17, 18].

Within this new phase of debate, Rümke's hypothesis of the *praecox feeling* as a possible useful instrument for diagnostic orientation seems to have regained a position as a worthy object of reflection and research [19–21].

The purpose of the present work is to investigate the potential of this instrument, starting from a detailed reading of the first conceptual articulation by Rümke, and moving through the examination of the critical debate that followed, towards the most recent empirical developments and operational perspectives. In particular, we will consider both the original 1941 article, in its English translation, and further elaborations of the concept, some of which are still not translated from German and are presented in the collection *Eine blühende Psychiatrie in Gefahr* (A flourishing psychiatry in danger) [22]. The reconstruction of the author's assertions will serve as a guideline to deal with an issue that appears very complex, as it implies the discussion of central aspects of the conceptualization of schizophrenia. Such a reconstruction will also support our effort to clarify some possible interpretative distortions of Rümke's original thinking that may have

contributed to the misreading of the concept of “diagnosis through *praecox feeling*” and to its consequent progressive disuse. In fact, our ultimate aim is to show that an in-depth reading of the concept might prompt a scientific investigation of the intersubjective aspects inherent in the diagnosis of schizophrenia.

The *Praecox Feeling* According to Rümke

Early Impression or “Schizophrenia Feeling”?

“It is remarkable that it is rare for a diagnostician to be able to indicate exactly how he arrives at a diagnosis of schizophrenia” (p. 335) [2]. With these words, Rümke summarizes the introductory part of his article, in which he exposes the uncertainties related to the diagnosis of schizophrenia, taking into account also the weight assigned to specific psychopathological signs by the different theoretical schools. Then, he introduces the concept of *praecox feeling*: “The conclusion will often be that the proponent has sensed a *specific schizophrenia or praecox feeling* during the interview of this patient – he has noticed that this patient's mental state has a specific schizophrenic colour” (p. 335, our italics). Wondering about what that *praecox feeling* is, he states: “I feel that this term is preferable to ‘schizophrenic colouration,’ as it implies that a *feeling, induced in the clinician*, is the final and most important guideline” (p. 336, our italics).

Thus, right from the start, the *praecox feeling* is introduced by Rümke as an essential guideline for the diagnosis of schizophrenia. The author, in fact, seems to call the reader's attention to a particular clinical phenomenon that deserves a thoughtful and rigorous definition: a *feeling induced in the clinician* during the interview with a schizophrenic patient, a feeling that can be defined as a “*schizophrenia or praecox feeling*.” The terms are indeed not arbitrarily chosen.

It seems clear, also in light of the views expressed elsewhere [22], that Rümke uses the term “*praecox*” following the concept of “*dementia praecox*,” introduced in German psychiatry by Kraepelin [23]. This concept is in fact well known and thoroughly supported by Rümke, who describes it as the only “true schizophrenia,” the unique and well-identifiable morbid process that should not be confused with the less defined psychotic conditions included in Bleuler's looser term of “schizophrenia” [24]. In other words, Rümke posits, through his terminological choice, that the *praecox feeling* is a delimited concept, which, describing a precise perceptual phenomenon, should be intended as a sensitive diagnostic guide,

capable of discriminating between the “true schizophrenic” and any other patient.

This terminological choice, which was probably well understood in Rümke’s time, when the debate between Kraepelin and Bleuler was still ongoing, seems to represent the first nucleus of a possible ambiguity of the author’s concept. The use of the word “*praecox*,” in fact, seems to be particularly suitable for a semantic slippage towards the literal meaning of “precocious,” i.e. early emerging in the context of the clinical encounter. Meaningfully, in a recent paper on the core of schizophrenia [15], Joseph Parnas affirms that “the concept of *praecox* feeling gradually lost its theoretical and phenomenological baggage, and became trivialized into a notion of ‘instant’ or ‘first 3 minutes’ diagnosis.” Indeed, a tangible demonstration of such slippage is provided by the confusion, frequently observed in clinical practice, between the concept of *praecox feeling* and that of “diagnosis at a glance,” in which the temporal dimension is stressed. The same empirical literature on the topic, which will be examined in detail below, reveals this semantic looseness, particularly in the studies designed to explore the value of *praecox feeling* in the diagnostic process [25, 26], in which the examination of its emergence was carried out within the first minutes of the clinical interaction. Also, in one of the most cited epidemiological surveys on the use of *praecox feeling* in psychiatrists’ practice, the authors describe it as a tool for the diagnosis of schizophrenia “within the first several minutes of meeting a patient” [27].

How could Rümke’s words have contributed to these interpretations, which shift the emphasis from “*praecox*” as a reference to the true (kraepelinian) schizophrenia to “*praecox*” as an index of the immediacy of the diagnostic “feeling”? In actuality, within the 1941 article, there are two passages in which the author makes an explicit reference to the temporal dimension. First, when he states that “even after a brief mental state examination it becomes clear to the psychiatrist that his empathy is lacking” [2] (p. 336); second, when, more decisively, he affirms that “often the *praecox* feeling is felt even before one has spoken to the patient” (p. 337). In both cases, Rümke seems to explicitly single out the role of the very early stages of the interview. It seems arguable, however, that in both statements, he intends to draw attention to what appears to be an outstanding, not habitual, characteristic of the phenomenon. In the first case, there is the possibility that *even* after a short time the clinician could perceive a meaningful rupture in the building of the intersubjective space (see below); in the latter, there is the possibility that the clinician’s gestaltic perception of the patient’s pecu-

liar embodied presence could *even* emerge at first sight. The precocity of the clinician’s feeling seems then to represent only a potential characteristic of the main intuitive-cognitive process, and not its founding attribute.

An additional confounder may be Rümke’s reference to the ideal conditions for the emergence of the *praecox feeling*, i.e., during the first interview, when the lack of acquaintance with the patient allows a more “disinterested and neutral” attitude on the part of the clinician [2]. In this case, the author subtly introduces the idea of what Blankenburg [28] calls the “empirical amputation,” i.e., the situation in which the intersubjective space is not yet saturated by a long-established relationship, which can facilitate a “*praecox* experience.” It seems clear, however, that in this case the temporal factor is intended only as an element related to setting.

Rümke’s choice of the term “feeling” (*Gefühl* in German) seems not to have been intended as implying less accuracy or less weight. In fact, in an effort towards intellectual honesty, Rümke attempts to make explicit his peculiar way of diagnosing schizophrenia through the *praecox feeling*, providing as clear a description as possible of what is undoubtedly a complex intuitive-cognitive process.

Before Rümke, Binswanger [29] had used, in 1924, the term “feeling” in relation to the intuitive diagnosis of schizophrenia, in a sense that the following passage makes clear:

Another thing: if we diagnose a case of schizophrenia “by feeling,” “feeling” is here (...) a vague and generic expression for *Erlebnis* of acts, and in this case of very specific acts of perception of others not yet, or not yet adequately, investigated. In this situation we do not actually diagnose according to the feeling, but *with* the feeling; that is, by means of a perceptual modality that has nothing in common with the term “feeling,” in the sense of sensitive or emotional feelings, apart from the name. (...) we primarily perceive a man as schizophrenic as a whole and only at a later time do we bring our attention to single schizophrenic traits. (...) What we call lack of relationship can sometimes be the only perception that I have of an unknown person, but nonetheless it can “surprise” me enough to make me wince deep inside when the door opens and he/she enters. Naturally, I must be able to distinguish such a wince and its motives from the attraction or the aversion that I can experience only for reasons of sympathy or antipathy, but it is precisely for that reason that I am a psychiatrist. (...) One can train to sense the other, to notice his/her own perception and to evaluate it in view of further judgments and conclusions proceeding with the same precision and level of criticality as with the body perception. (p. 319, our translation from the Italian version)

The “feeling,” in other words, has nothing to do with the emotional domain nor does it pertain to affective engagement with the patient; it pertains to the domain of

perception and intuition, and it deserves to be investigated as a specific clinical datum. Rümke indeed attempts to disclose its nature, arguing that “the phenomenon is most clearly interwoven with the affective disturbances, the anomalies of thought, and with the psychomotor symptoms. This undefinable attribute that surrounds all the observed symptoms induces the *praecox feeling*” [2] (p. 336). What, exactly, does he mean by “affective disturbances”? The author himself clarifies this point a few lines later, positing that the clinician’s perception concerns a lack of empathic capability, which, however, implies not only “the patient’s affect” but “his personality as a whole.” The clinician, in other words, acutely feels that “something” in the patient is lacking, and, “as interpersonal relations are not one-sided (...) notices something out of order within himself; *he cannot find the patient*” (p. 336, our italics).

Here Rümke introduces one of the core aspects of his reflection, going beyond Binswanger’s description and suggesting that the clinician’s *praecox feeling* can be connected with a specific disruption in the intersubjective field tentatively established with the patient. In his view, it is indeed the schizophrenic’s peculiar way of interacting with the Other – the so-called “lack of intercourse” (p. 336) – that reverberates in the clinician’s internal sense of isolation and discomfort.

The diagnostic power of the *praecox feeling*, therefore, lies in a specific perspective on the clinical interaction; that the clinical interaction is a *subjective* one. From this perspective, the patient is no longer considered as the object of an external observation aimed at collecting symptoms and signs, but as a subject who significantly contributes to the creation of the intersubjective experiential field within which the clinical encounter takes place. It is only in light of this perspective, in fact, that the same clinician’s subjectivity, being an element of that field, can be viewed as a potential observational window on the patient’s mental functioning.

This is presumably the reason why in the 1958 article entitled “Die klinische Differenzierung innerhalb der Gruppe der Schizophrenien (Clinical differentiation within the group of schizophrenias)” [22], Rümke partially amends his first definition, affirming that he lets himself “be guided by the presence of the ‘*praecox feeling*’ (*Praecoxgefühl*) – maybe better expressed as ‘*praecox experience*’ (*Praecoxerlebnis*) – because it is not a real feeling. Only a very experienced clinician can use this compass” (p. 205, our translation). The term “experience” (*Erlebnis*) seems in fact to better grasp the complexity of the interactive situation, as the term “feeling” may possibly be misinterpreted.

Since the patient’s pathological lack of “*rapprochement-drive*” is regarded as the first determinant, through a sort of resonance mechanism, of the clinician’s *praecox feeling*, it becomes clear that Rümke considers such an element as a fundamental phenomenon of schizophrenia. In this case, Rümke’s position is mostly in line with Bleuler and his successors, who identify *autism* as the core aspect of schizophrenia [24]. In particular, Bleuler uses this term to denote a very specific form of detachment from reality, typical of schizophrenia: “The most severe schizophrenics, who have no more contact with the outside world, live in a world of their own (...) This detachment from reality, together with the relative and absolute predominance of the inner life, we term autism” [24] (p. 63). The re-elaboration of this concept by Minkowski [30] makes even more evident its connection with Rümke’s thinking. Minkowski, in fact, prefers the definition of “loss of vital contact with reality” to that of “autism,” claiming that the generating disorder (*trouble générateur*) of schizophrenia is not simply a withdrawal into solitude or a pathological inclination to inner life, but rather a disruption in the basic human ability to prereflectively attune with the external world. Indeed, the “vital contact” represents the ability to experience a *syntony* with the world, i.e. to empathize and get involved with the Other and to act as a result of a prereflective immersion in the intersubjective world. Therefore, the *autistic quality* of the schizophrenic’s experience affects even the patient’s most common relational behavior, and this seems to be the reason why, as Rümke claims, the clinician can *feel* the patient’s schizophrenicity even in the absence of evident disturbances.

In recent times, the intersubjective dimension and its relation to psychiatric pathology have been deeply examined, especially by psychopathologists who dialogue with the disciplines of phenomenology and philosophy of mind. The concept of schizophrenic autism, in particular, has been reinterpreted as a basal pathological phenomenon which involves all the structures of human subjectivity: subjectivity in relation to oneself (*self-awareness*), to the world (*intentionality*) and to the other (*intersubjectivity*) [31]. The sophisticated research under way on the intersubjectivity domain, in particular, offers a renewed framework for Rümke’s intuition, as it strengthens the view that the *praecox feeling* sensitively grasps a crucial aspect of schizophrenia. This aspect may at times be the only detectable sign – like a litmus test – of subtle disturbances of the patient’s intersubjectivity experience.

The Problem of the Two Poles

Together with the “affective disturbances,” as we have reported, Rümke speculates in the 1941 manuscript that the nature of *praecox feeling* could be related to two other phenomena: anomalies of thought and psychomotor symptoms. He then describes all the somatic and behavioral aspects that contribute to the peculiar *presence* of the schizophrenic patient, taking into account particularly the rigid modalities of posture, facial expression, and motor behavior, as well as the flatness of language and prosody. Rümke suggests that these characteristics give to the patient an expressive *quid* which presumably plays a significant part in the clinician’s global impression: “It is *intuitively* felt that all these are disturbed, i.e. changed with respect to the norm” [2] (p. 337, our italics).

We want to draw attention to the word “intuitively” as it is, in our opinion, fraught with meaning. Speaking about the empathic interaction, in fact, Rümke had until this point implicitly placed his reflection within a subjective/intersubjective perspective, as we have posited above. In contrast, however, at this point the author makes a clear reference to an intuitive process which allows the clinician to immediately identify a peculiar embodied expression of the patient. This process implies a different experiential level, since the clinician is viewed as an external subject who observes, and quickly grasps, the patient’s *gestalt*. Indeed, Rümke seems to unwittingly shift his epistemological point of view on the *praecox feeling*.

Essentially, the intuitive process implied by the author is the one accurately described by Schwartz and Wiggins [32]. That is, the clinician’s act of rapidly typifying the clinical picture through an implicit comparison between the *gestalt* of the actual patient and the *gestalt* of all the schizophrenic patients examined throughout the course of his/her career. It is a well-known modality of diagnosis, which the current researchers would call “diagnosing by prototypes” [33]. From this perspective, as we have mentioned, the clinician-patient relationship relies on the objectifying model of “observer-observed,” where the empathic capacities of the clinician are not primarily involved.

This different epistemological level of the *praecox feeling* implies some characteristics of the process to which Rümke refers in his writings. The first is the above-mentioned issue of the possible early emergence of the feeling during the interview. As gestaltic recognition is a very quick process, not needing any reflective elaboration, it is likely that this component facilitates the rapidity of the clinical judgment. The second is the explicit reference of the author to the use of *praecox feeling* only by “very experienced clinicians” [22]. It seems clear that a perception

which is mostly based on the amount of clinical experience is better used by clinicians who have encountered a great number of patients [32]. On the contrary, the clinician’s sensitivity to the autistic nucleus of the schizophrenic patient seems to primarily rely on his/her human empathic capacities, which do not definitively arise from the clinical experience. Rather, it could be arguable that an experienced clinician, trained in being tuned in to his/her feelings during the clinical encounter, is able to rapidly integrate this subjective phenomenon with the other impressions about the patient.

Thus, the *praecox feeling* implies in a single concept, denoted by a single term, at least two different gnoseological poles: a “subjective” one and an “objective” one. In our opinion, this distinction, even if somehow factitious, is critical to the process of understanding the criticisms of the *praecox feeling* as a diagnostic tool and its poor appeal among scientific researchers.

From a phenomenological point of view, some authors, while recognizing Rümke’s original intuition and his contribution to fostering the value of the intersubjective experience, have highlighted the risk of an epistemological leap; that is, the shift of the *praecox experience* to a new “criteriological symptom” to be brought into an objective framework for differential diagnosis [34, 35]. It seems to us that this worry could be partially related to an unwitting merging of the two experiential poles so that the subjective pole can be improperly absorbed by the objective one. On the other hand, from a scientific-objective point of view, some authors have criticized Rümke’s apparent excessive confidence in the clinician’s subjectivity as a reliable datum. Hempel [36], in particular, questions the merit of Rümke’s formulation as a scientific idea, as the *praecox feeling* could be strongly affected by the clinician’s personal characteristics, rendering it unreliable as a reflection of the patient’s personality. Again, this observation seems to raise the question of the articulation of a proper dialectic between the two poles of the *praecox feeling*.

It should be noted, however, that Rümke himself was not wholly unaware of this issue, as we can discern from the last part of his 1941 manuscript [2]:

If one has rich and highly developed empathic capacities at one’s disposal, it may sometimes be possible to establish a mutual contact with understanding of the patient’s verbal and psychomotor expressions. One may feel that the possibilities of contact have remained within normal limits although in fact they have deteriorated to a subnormal level. If the doctor does not distinguish carefully enough his own reactions, confusion may arise between, on the one hand, the relation which in fact exists and, on the other, his own attempts to establish rapport; a pseudo-rapport may be mistaken for a real one. Faulty diagnoses will be made in both cases.

A *praecox* feeling will arise inappropriately if the doctor himself is inhibited in his rapprochement. This, however, is not the genuine *praecox* feeling but the usual feeling of unease which inevitably arises when one is confronted with people one does not understand. One's own feelings of sympathy not uncommonly cause an unjustified rejection of the diagnosis of schizophrenia. (p. 341)

Therefore, we can conclude that separate consideration of the two aspects of the *praecox feeling* may allow us to better address the questions raised by its multifaceted nature and to keep an open attitude in evaluating its clinical and experimental applications. Indeed, with regard to objectivity, in the absence of an adequate comparison with a critical test of the intuitive hypothesis, we must bear in mind that the *praecox feeling*, like the “expert eye” in medicine, should be regarded as an impressionistic, rather than a scientific, tool. In contrast, from the perspective of the subjective dimension, it is arguable that a tool like *praecox feeling* can grasp deeper aspects of the illness that elude objective examination, because of the involvement of a human prereflective sensitivity that is not dependent on a cognitive process of collecting experiences. This is why the *praecox feeling* should be studied and clinically tested using only appropriate methods that respect its double nature and are capable of assessing subjective elements, as currently occurs for the examination of subjective phenomena pertaining to the patient [37, 38].

A Stable or State-Dependent Feeling?

A number of years after the publication of his first paper, Rümke partially reconsiders his propositions in light of his long-term experience with schizophrenic patients. He considers an issue not addressed before; that is, the dynamics of the clinician's *praecox feeling* over the course of the patient's disease. In fact, in his paper “Über alte Schizophrene (On the old schizophrenic patient),” published in 1963 [22], Rümke makes a surprising assertion, claiming that the *praecox feeling* is a *reversible* and *state-dependent* experience. At first he states: “As I have considered the ‘*praecox feeling*’ [*Praecoxgefühl*] or the ‘schizophrenia feeling’ [*Schizophreniegefühl*], or even better, the ‘schizophrenia experience’ [*Schizophrenie-Erleben*], as of great importance for the diagnosis of schizophrenia, I have described it several times. It turned out to be completely unexpected that in the encounter with these old schizophrenic patients, this feeling did not emerge in me” (p. 220, our translation). Then he turns back to the description of the core aspects of the *praecox feeling*, in an effort to find a connection between its nature and the characteristics of the chronic pharmacologically

treated schizophrenic patient. Rümke identifies again the nucleus of the clinician's experience in the sense of “inner insecurity” (*innerlicher Unsicherheit*) induced by the lack of what usually imbues human interactions; that is, the implicit construction of a sort of “reciprocity” (*Reziprozität*). However, in chronic patients, Rümke seems to no longer perceive this lack:

The above-mentioned insecurity does not arise, because a certain reciprocity has been built with the patient. While the doctor may feel something alien with the patient, this alienation faces him/her in another way; a way I wish to call: almost pleasant. Empathy [*Einfühlung*] fails here too; but in this now quiet personality there is still a lot to empathize with. (...) This has become possible because the distance between the patient's ego and his/her delusional world [*Wahnwelt*] is much greater than at the onset of schizophrenia. (p. 221, our translation)

But do these affirmations question what Rümke established before, with regard to the diagnostic power of the *praecox feeling*? Hypothesizing that “it is possible that [the *praecox feeling*], in the face of the patient, develops only as long as the ‘process’ is still ongoing” (p. 221, our translation), the author claims the need, in these cases, of taking into particular account “all the anamnestic data” to make a precise diagnosis. His thinking, therefore, seems to be that the absence of the *praecox feeling* does not imply a change in the diagnosis of the schizophrenic patient, but is a consequence of the attenuation of the intersubjective disruption, which might be more marked in the early or acute stages of the disease. Indeed, schizophrenics whose personalities have developed, downstream of the schizophrenic process, a relational disposition grounded in a stable, though deficient, self, seem to induce in the clinician less of a perception of a strained human encounter. In other words, it is arguable that the greater coherence of the patient's lived experience allows the clinician to recognize himself/herself in a possibly shared, and no longer totally *alien*, experiential structure. Indeed, some authors have recently dealt with this topic, emphasizing the possibility that schizophrenic patients can, along the course of the illness, improve their relationship to reality by means of specific self-healing psychopathological constructs [39]. Also, this better relationship to reality, which presumably affects the clinical interaction, may contribute to an attenuation of the empathic rupture which induces the *praecox feeling*.

In light of the above discussion, it is evident that these considerations have a number of implications. The first is a theoretical implication. As Rümke stresses the concept of a rediscovered empathic possibility, it can be reasonably hypothesized that over the years he has implicitly

moved the center of gravity of the *praecox feeling* towards what we have called the intersubjective pole. The gestaltic elements inherent in the schizophrenic embodied presence, in fact, presumably do not substantially change along with the different phases of the disease. An expert clinician, in other words, should be able to grasp the typical signs of schizophrenia even in the stabilized phases.

The second implication is a clinical one. Rümke, and every clinician after him, must deal with the issue of *praecox feeling* sensitivity. He explicitly warns clinicians about the risk of false negatives, recommending cautious use and careful consideration when using this tool: “While there is no doubt that a patient is schizophrenic when the examiner feels the *praecox* experience [*Praecox-Erlebnis*], the opposite cannot be claimed. I cannot be sure that the patient is not affected by schizophrenia, when this experience is not elicited” (p. 213, our translation). The former is also an implication for research, as a detailed study of the *praecox feeling* in everyday clinical practice should not neglect the issue of the relationship between the emergence of the *praecox feeling* and the schizophrenic patient’s present condition.

The *Praecox Feeling* in Empirical Research: History and Perspectives

Only a few experimental studies have addressed the issues raised by Rümke’s original formulations and by their subsequent criticism. These studies have shared an attempt to provide scientific integrity to the concept of *praecox feeling*, and to corroborate the widespread observation of this phenomenon among clinicians, who in everyday practice are faced with a number of impressions about schizophrenic patients. These impressions, even when not fully recognized, could affect their diagnostic reasoning. Some epidemiological surveys, the most recent of which is still in a preliminary phase [27, 40, 41], have in fact shown that a not negligible number of clinicians draw on the *praecox feeling* to identify schizophrenic patients. The same intriguing, albeit indirect, confidence had already emerged from a very extensive survey published in 1973 in *Science* [42]. This survey had revealed that the experience of a “poor rapport” with a patient by a clinician was among the 12 most widespread and reliable signs for making a diagnosis of schizophrenia.

Only 2 studies, however, have dealt with a detailed analysis of the sensitivity and potential of the *praecox feeling* in the diagnostic field. In the first study [25], one experienced clinician evaluated 67 new patients with para-

noid hallucinatory syndromes, and reported, after a few minutes of interview, his perception of *praecox feeling* on a scale ranging from “not present” to “high.” When compared with the diagnosis made according to ICD-10 and DSM-IV criteria, the *praecox feeling* showed high sensitivity (0.88 and 0.84) and high positive predictive power (0.94 and 0.93), and was also found to be significantly correlated with the degree of “affective disturbance” according to the AMDP (Association for Documentation in Psychiatry) system. In the second study [26], 5 clinicians with different levels of experience evaluated 102 new patients consecutively admitted to an acute psychiatric unit. The clinicians rated, at 30 s and 2 min of interview time, the presence or absence of the *praecox feeling*. The results of this study were not consistent with those of the first study. When compared with the standard diagnosis according to the DSM-IV, the *praecox feeling* showed a sensitivity ranging between 0.23 and 0.86 and a positive predictive value ranging between 0.35 and 0.40. The negative predictive value was found to be higher and more in line with the first study, ranging from 0.66 to 0.78. However, the agreement between the 5 clinicians was largely unsatisfactory, although the finding should be interpreted in light of their role in the interview, as they only attended the visit and did not personally interact with the patients.

Taken together, these studies have not allowed any conclusions to be drawn regarding the potential usefulness of *praecox feeling* in the diagnostic process. However, the authors have made a substantial effort in the direction of an operational test of Rümke’s concept, and their work has raised a number of significant methodological issues. Considering those attempts together with the central aspects discussed in this paper, we can identify some relevant methodological points which could help other researchers to design a valid and effective investigation of the *praecox feeling*.

First of all, as the *praecox feeling* implies a radically subjective experiential pole which is assumed to be grounded in the intersubjective space, it seems fundamental that the clinicians participating in a study on it have a personal interaction with the patients. Otherwise, only the gestaltic pole will be explored. Secondly, the same subjective experiential dimension of the *praecox feeling* implies, as the phenomenologists have claimed, that it should not be intended as a “symptom,” and then examined according to a presence/absence criterion. Rather, the multifaceted nature of the clinician’s experience should be considered through an accurate evaluation of its emotional nuances and its nature within the context of the clinical relationship, as was partially at-

tempted in the first of the two studies [25]. Finally, following Hempel's objection, the reliability issue should be addressed, both by examining the *praecox feeling* in a study population of a proper number of heterogeneous clinicians and by using standardized and reliable instruments.

Conclusions

At the end of the present discussion, we can affirm that Rümke's *praecox feeling* represents both a dense theoretical concept and a powerful instrument that hides its complex and multifaceted nature behind an apparent simplicity.

It gives a name to a specific clinician's experience that is elicited by an encounter with a patient suffering from a peculiar intersubjectivity disturbance that has been described as a specific dimension of schizophrenic autism. Since it belongs to the intersubjective field, it implies a clinician's real attempt to establish contact with the patient.

It is not merely an expression for the immediacy of the clinician's judgment. In fact, its early presentation seems to be a characteristic mainly dependent on the ability, typical of the experienced clinician, to rapidly typify a schizophrenic patient. It does include an objective element, which relies on the observation of the patient's bodily and behavioral characteristics.

It seems to be reversible: it may not occur with treated patients or when, due to the disease progression, a symptomatic stabilization has been achieved. It is therefore a state-dependent experience, mostly related to the initial or acute states of the schizophrenic process.

All these characteristics probably account for the popularity of Rümke's concept among psychopathologists who have studied, or are now studying, the phenomenol-

ogy of schizophrenia. Indeed, despite its alternating fortunes, the *praecox feeling* seems to have never really lost its attractiveness.

Our analysis aimed at clarifying the conceptual nature of the *praecox feeling*, dwelling on its characteristics with a view to prompting a careful reconsideration of it. It ought not to be forgotten, however, that Rümke's reflection should be included into a broader line of thought regarding the intersubjective phenomena in general and the clinician's inner world in particular. As we have mentioned in the Introduction, Rümke was a psychiatrist and a psychoanalyst, and this double grounding actually places him at the intersection point of two rich traditions [43]. On the one hand, there is the psychoanalytic reflection on the *transference-countertransference* dynamics, which, beyond its primarily belonging to the psychotherapeutic process, should be considered also by psychiatrists as a potentially discriminating factor in the patient's evaluation [44, 45]. On the other hand, there are the contributions coming from classical psychopathologists in the field of the diagnostic intuitive or empathic processes [29, 30, 46, 47], some of which have been introduced in this paper. A further examination of these conceptualizations, however, goes beyond the purpose of our discourse, and it can be referred to the recent literature on the subject [19–21, 43, 48, 49].

In conclusion, we think that a clear distinction between the intersubjective and the gestalt/objective pole might be helpful in the design of appropriate research strategies aimed at investigating the *praecox feeling*. Well-designed, thoughtful studies will serve to aid in scientifically verifying Rümke's final claim: "The doctor's internal attitude, induced by the patient, is a very sensitive diagnostic tool, and it would be helpful if we were more skilled in recognizing changes in our own internal attitude; it would certainly make us more self-confident in making diagnoses" [2] (p. 337).

References

- 1 Rümke HC. Das Kernsymptom der Schizophrenie und das "Praecox-Gefühl." *Z Gesamte Neurol Psychiatr.* 1941;102:168–75.
- 2 Rümke HC, Neeleman J. The nuclear symptom of schizophrenia and the praecoxfeeling. *Hist Psychiatry.* 1990 Sep;1(3 Pt 3):331–41.
- 3 APA. *Diagnostic and statistical manual of mental disorders.* 3rd ed. (DSM-III). Washington DC: American Psychiatric Publishing; 1980.
- 4 APA. *Diagnostic and statistical manual of mental disorders.* 4th ed. (DSM-IV). Washington DC: American Psychiatric Publishing; 1994.
- 5 APA. *Diagnostic and statistical manual of mental disorders.* 5th ed. (DSM-5). Washington DC: American Psychiatric Publishing; 2013.
- 6 Blashfield RK, Keeley JW, Flanagan EH, Miles SR. The cycle of classification: DSM-I through DSM-5. *Annu Rev Clin Psychol.* 2014;10(1):25–51.
- 7 Klosterkötter J, Hellmich M, Steinmeyer EM, Schultze-Lutter F. Diagnosing schizophrenia in the initial prodromal phase. *Arch Gen Psychiatry.* 2001 Feb;58(2):158–64.
- 8 McGorry PD. Early intervention in psychosis: obvious, effective, overdue. *J Nerv Ment Dis.* 2015 May;203(5):310–8.
- 9 Jansson L, Handest P, Nielsen J, Sæbye D, Parnas J. Exploring boundaries of schizophrenia: a comparison of ICD-10 with other diagnostic systems in first-admitted patients. *World Psychiatry.* 2002 Jun;1(2):109–14.

- 10 Jakobsen KD, Frederiksen JN, Parnas J, Werge T. Diagnostic agreement of schizophrenia spectrum disorders among chronic patients with functional psychoses. *Psychopathology*. 2006;39(6):269–76.
- 11 Andreasen NC. DSM and the death of phenomenology in america: an example of unintended consequences. *Schizophr Bull*. 2007 Jan;33(1):108–12.
- 12 Kraus A. How can the phenomenological-anthropological approach contribute to diagnosis and classification in psychiatry? In: Fulford KW, Morris KJ, Sadler JZ, editors. *Nature and Narrative*. Oxford: Oxford University Press; 2003. pp. 199–216.
- 13 Parnas J, Zahavi D. The role of phenomenology in psychiatric diagnosis and classification. In: Maj M, Gaebel W, López-Ibor JJ, Sartorius N, editors. *Psychiatric diagnosis and classification*. Chichester: John Wiley and Sons; 2002. pp. 137–62.
- 14 Parnas J. A disappearing heritage: the clinical core of schizophrenia. *Schizophr Bull*. 2011 Nov;37(6):1121–30.
- 15 Parnas J, Sass LA, Zahavi D. Rediscovering psychopathology: the epistemology and phenomenology of the psychiatric object. *Schizophr Bull*. 2013 Mar;39(2):270–7.
- 16 Pallagrosi M, Picardi A, Fonzi L, Biondi M. Psychopathological dimensions and the clinician's subjective experience. In: Biondi M, Pasquini M, Picardi A, editors. *Dimensional Psychopathology*. Berlin: Springer Verlag; 2018. pp. 267–86.
- 17 Stanghellini G. The grammar of the psychiatric interview. A plea for the second-person mode of understanding. *Psychopathology*. 2007;40(2):69–74.
- 18 Fuchs T. Subjectivity and intersubjectivity in psychiatric diagnosis. *Psychopathology*. 2010;43(4):268–74.
- 19 Kraus A. The significance of intuition for the diagnosis of schizophrenia. In: Maj M, Sartorius N, editors. *Schizophrenia*. Chichester: Wiley & Sons; 1999. p. 47–9.
- 20 Srivastava A, Grube M. Does intuition have a role in psychiatric diagnosis? *Psychiatr Q*. 2009 Jun;80(2):99–106.
- 21 Varga S. Vulnerability to psychosis, I-thou intersubjectivity and the praecox-feeling. *Phenomenol Cogn Sci*. 2013;12(1):131–43.
- 22 Rümke HC. *Eine blühende Psychiatrie in Gefahr* [A flourishing psychiatry in danger] Berlin, Heidelberg, New York: Springer Verlag; 1967. <https://doi.org/10.1007/978-3-642-86491-9>.
- 23 Kraepelin E. *Psychiatrie: Ein Lehrbuch*. 5th ed. Leipzig: Barth; 1896.
- 24 Bleuler E (Zinkin J, translator). *Dementia Praecox or the Group of Schizophrenias*. New York (NY): International Universities Press; 1950.
- 25 Grube M. Towards an empirically based validation of intuitive diagnostic: Rümke's 'praecox feeling' across the schizophrenia spectrum: preliminary results. *Psychopathology*. 2006;39(5):209–17.
- 26 Ungvari GS, Xiang YT, Hong Y, Leung HC, Chiu HF. Diagnosis of schizophrenia: reliability of an operationalized approach to 'praecox-feeling'. *Psychopathology*. 2010;43(5):292–9.
- 27 Sagi GA, Schwartz MA. The "praecox feeling" in the diagnosis of schizophrenia: a survey of Manhattan psychiatrists. *Schizophr Res*. 1989;2(1):35.
- 28 Blankenburg W. *Der Verlust der natürlichen Selbstverständlichkeit: Ein Beitrag zur Psychopathologie symptomarmer Schizophrenien* [The loss of natural self-evidence]. Stuttgart: Enke; 1971.
- 29 Binswanger L. Quali compiti sono prospettati alla psichiatria dai progressi della psicologia più recenti? [Which tasks are presented to psychiatry from the most recent developments of psychology?] in: Per un'antropologia fenomenologica. Milano: Feltrinelli; 1989.
- 30 Minkowski E. *La schizophrénie*. Psychopathologie des schizoïdes et des schizophrènes [Schizophrenia. Psychopathology of schizoids and schizophrenics]. Paris: Payot; 1927.
- 31 Parnas J, Bovet P, Zahavi D. Schizophrenic autism: clinical phenomenology and pathogenetic implications. *World Psychiatry*. 2002 Oct;1(3):131–6.
- 32 Schwartz MA, Wiggins OP. Typifications. The first step for clinical diagnosis in psychiatry. *J Nerv Ment Dis*. 1987 Feb;175(2):65–77.
- 33 Westen D. Prototype diagnosis of psychiatric syndromes. *World Psychiatry*. 2012 Feb;11(1):16–21.
- 34 Müller-Suur H. Das sogenannte Praecoxgefühl. *Fortschr Neurol Psychiatr*. 1961;29(3):145–52.
- 35 Barison F. Considerations on "praecox feeling" (in Italian). *Riv Sicil Tuberc Mal Appar Respir*. 1961 Sep-Oct;31(5):505–8.
- 36 Hempel CG. *Aspects of scientific explanation and other essays in the philosophy of science*. New York: Free Press; 1965.
- 37 Parnas J, Møller P, Kircher T, Thalbitzer J, Jansson L, Handest P, et al. EASE: Examination of Anomalous Self-Experience. *Psychopathology*. 2005 Sep-Oct;38(5):236–58.
- 38 Sass L, Pienkos E, Skodlar B, Stanghellini G, Fuchs T, Parnas J, et al. EAW: Examination of Anomalous World Experience. *Psychopathology*. 2017;50(1):10–54.
- 39 Hartwich P, Grube M. *Psychotherapie bei Psychosen: Neuropsychodynamisches Handeln in Klinik und Praxis. Dritte überarbeitete und erweiterte Ausgabe*. Berlin, Heidelberg: Springer-Verlag; 2015.
- 40 Irle G. Das "Praecoxgefühl" in der Diagnostik der Schizophrenie. *Arch Psychiatr Nervenkr Z Gesamte Neurol Psychiatr*. 1962;203(4):385–406.
- 41 Moskalewicz M, Gozé T, Broome M, Schwartz MA. The "praecox feeling" in the diagnosis of schizophrenia. 19th International Conference on Psychiatry and Philosophy: "Contributions of Neuroscience"; 2017 Nov 13–15; Madrid.
- 42 Carpenter WT Jr, Strauss JS, Bartko JJ. Flexible system for the diagnosis of schizophrenia: report from the WHO International Pilot Study of Schizophrenia. *Science*. 1973 Dec;182(4118):1275–8.
- 43 Rossi Monti M: Psicoanalisi e psicopatologia. Controtransfert e sentimento precoce di schizofrenia. *Comprendere* 2008(16-17-18): 325–45.
- 44 Heimann P. On Counter-transference. *Int J Psychoanal*. 1950;31:81–4.
- 45 Reik T. *Listening with the third ear: The inner experience of a psychoanalyst*. New York: Farrar & Straus; 1948.
- 46 Wyrsch J. Über die Intuition bei der Erkennung des Schizophrenen. *Schweiz Med Wochenschr*. 1946 Nov;76(46):1173–6.
- 47 Tellenbach H. *Geschmack und Atmosphäre. Medien menschlichen Elementarkontaktes*. Salzburg: Otto Müller Verlag; 1968.
- 48 Ballerini A, editor. *Psicopatologia fenomenologica. Percorsi di lettura*. Roma: CIC Edizioni Internazionali; 2002.
- 49 Stanghellini G. *Lost in dialogue. Anthropology, Psychopathology and Care*. Oxford: Oxford University Press; 2017.