

Praecox feeling among Polish psychiatrists: a grounded theory study

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Summary

Aim. The study aims to identify the sources and components of the so-called praecox feeling (PF) from the perspective of Polish psychiatrists who experience it and can verbalize it.

Method. Qualitative analysis based on the grounded theory method, conducted on a set of open-ended statements provided by psychiatrists (N = 103) who described their feelings strongly suggestive of a diagnosis of schizophrenia in a nationwide survey.

Results. For most respondents (80.58%) PF stems from patients' behaviors and states but none of the identified PF components dominate clearly over others. Physicians referred most often (44.66%) to the patients' affect and emotional states, particularly shallowness and emotional coldness (22.33%). One in four (25.24%) referred to the patients' utterances, including incoherence and detachment of content from reality (14.56%), and indicated formal disorders of mental processes (22.33%). A post-hoc analysis showed that the main cross-sectional topic of the PF was the feeling of patients' separation from the surrounding reality and other persons (raised by 52.42% of respondents). The level of psychiatric expertise does not affect PF's contents. Physicians who can verbalize it consider it reliable for diagnosing schizophrenia more often than those who use PF in their practice but cannot verbalize it (82.52% vs. 67.62%, $\chi^2 p = 0.007$, $\phi_c = 0.186$).

Conclusions. PF is a complex and ambiguous phenomenon experienced by residents and specialists alike. It has mostly to do with affectivity and perceived detachment from reality. Further analysis may positively influence the ability of psychiatrists to articulate and apply PF in the diagnosis of schizophrenia.

Key words: diagnosis, schizophrenia, intuition

Introduction

Before standardized criteria for diagnosing schizophrenia were delineated, psychiatrists commonly relied on intuition. In 1941, Henricus Cornelius Rümke coined the term *Praecox-Gefühl* – Praecox Feeling (PF) to describe a psychiatrist’s intuition that a patient has schizophrenia [1]. According to Rümke, PF has nothing to do with the content of the patient’s thoughts and may appear even before the diagnostic interview begins. It is never fully explicit, so it is not easy to put into words. Gozé et al. [2], Moskalewicz and Gozé [3], and Moskalewicz et al. [4] provide a detailed description of problems related to the PF phenomenon.

According to Rümke, the symptoms of schizophrenia that can be read from an interview with a patient, whether negative or positive, are nonspecific and do not warrant an adequate diagnosis. In order to lead to a diagnosis, they must relate to something underlying them. That something is the patient’s elementary but indefinable “un-understandability”. It possibly arises from body posture, motor behavior, facial expressions, and a general lack of emotional contact. Rümke claimed that a physician perceives such un-understandability through one’s anxiety.

Surveys conducted since the mid-20th century have confirmed psychiatrists’ use of PF. A survey conducted in 1962 in West Germany [5], before the advent of the DSM classification, revealed that a large majority of respondents (85.9%) identified the feelings they experienced in contact with patients as a reliable indicator of a schizophrenia diagnosis. In New York in 1989 (when the DSM-III was already in operation [6]), 82.9% of respondents declared having feelings instantly suggestive of schizophrenia. In France in 2017, during the use of DSM-5 [7], 90.1% reported having such feelings. In a Polish study from 2019-2020 using the same tool, 89.3% of respondents declared having such feelings suggestive of schizophrenia [8].

Therefore, these feelings occur among psychiatrists from different cultural backgrounds and times. However, according to Rümke, having a PF and believing in its reliability does not entail its expressibility in words. In the French study mentioned above, 50.78% of respondents declared to be able to express a feeling suggesting a diagnosis of schizophrenia in words [9]. In the Polish study, described in more detail below, 44.9% of respondents admitted having such an ability.

This article presents a qualitative analysis of statements of Polish psychiatrists who participated in the above survey. The purpose of the paper is to answer the following question: What does the PF consist of from the perspective of physicians who declare to be able to express it in words? The article describes the components that psychiatrists consider constitutive to this feeling. Furthermore, it attempts to identify the “location” or the felt source of PF: to what extent it has to do with a specific type of atmosphere [cf. 3], i.e., what happens between a patient and a physician, and to what extent its sources are objective (arising from the patient’s traits and behavior) or subjective (arising from the physician’s own experiences, subjective perception of the situation)? The article also examines whether differences in the PF descriptions exist depending on the level of psychiatric expertise.

Methods

Survey

The 2019-2020 study used a simplified version of Irle's original survey [5], adapted by Sagi and Schwartz [6] and re-adapted by us for the 2017 French study [7, 9]. We kept most of the questions unchanged for cross-cultural and cross-historical comparisons. Key questions concerned attitudes toward schizophrenia, the possibility of providing a prompt diagnosis by a qualified psychiatrist, and declared feelings strongly suggestive of a schizophrenia diagnosis, which, according to prior interpretations from Irle, Sagi and Schwartz, and us, were considered an indicator of the PF presence. Those respondents who declared having the investigated feelings were asked to complete the second part of the survey. Therein they provided descriptions of their feelings, which are a data source for the present study.

Sample selection and respondents

The survey was completed by 243 psychiatrists – 152 females and 91 males, both specialists and residents in training, with self-declared professional orientations ranging from biological to bio-psycho-social to psychodynamic. At that time, there were 4,551 licensed psychiatrists in Poland [10] but the study used purposeful sampling, targeting those working in all major university clinics and mental hospitals where patients with schizophrenia were treated, located in Bialystok, Branice, Bydgoszcz, Drewnica, Gdansk, Gniezno, Katowice, Koscian, Koszalin, Krakow, Lodz, Lublin, Lubliniec, Miedzyrzecz, Olsztyn, Poznan, Plock, Pruszkow, Radom, Rybnik, Stronie Slaskie, Swiecie, Slupsk, Szczecin, Torun, Warsaw, and Wroclaw. In the invitation letter, there was no mention of either PF or feelings suggestive of a schizophrenia diagnosis.

A total of 217 psychiatrists (89.3% of the sample) reported having patient-related feelings that strongly suggested a diagnosis of schizophrenia. Statistical analysis showed that these feelings were independent of attitudes toward schizophrenia, professional orientation, or work experience and were considered reliable by psychiatrists. Intersubjective phenomena, such as problematic affective attunement, gestures, and body language, were found by psychiatrists to be fundamental to these feelings [8].

Of those 217 having the PF, only 109 were able to express this feeling in words (44.86%), and 105 actually answered the open-ended question asking to describe it. The present study outlines the results and key findings from a qualitative analysis of statements provided in response to this single question (103 responses were accepted for qualitative analysis; two off-topic responses were rejected).

The answers were not pre-structured by any categories imposed by researchers. They were unconstrained, self-directing expressions that allowed any length and form respondents found suitable. Such construction of the research tool allows trusting that the contents of the analyzed statements reflect the lived experiences and practices of psychiatrists expressed in a natural language, with a selection of topics that they considered important (and lacking those that they found irrelevant).

Table 1. **Sample characteristics (N = 103)**

Gender	Female N = 66 (64.08%)
	Male N = 37 (35.92%)
Expertise level	Residents in training N = 48 (46.60%)
	Specialists N = 55 (53.40%)
Professional orientation	Bio-psycho-social N = 59 (57.28%)
	Biological N = 23 (22.33%)
	Psychodynamic N = 11 (10.68%)
	Other N = 10 (9.71%)
Attitude toward schizophrenia	Improvable with remaining deficiencies N = 56 (54.37%)
	Occasionally reversible N = 37 (35.92%)
	Essentially incurable N = 10 (9.71%)
Conviction regarding the reliability of the Praecox Feeling	Praecox Feeling present N = 103 (100%)
	Praecox Feeling perceived as reliable for diagnosing schizophrenia N = 85 (82.52%)
	Praecox Feeling perceived more as reliable than all other symptoms N = 31 (30.10%)

Interestingly, the belief in PF reliability was significantly higher among psychiatrists who could verbalize it. In this group, 82.52% of respondents considered PF reliable for the schizophrenia diagnosis (compared to 67.62% of physicians unable to put PF into words, $\chi^2 p = 0.007$, $\varphi_c = 0.186$). The feeling was considered more reliable than other symptoms by 30.10% (vs. 20.95%) of respondents, but the difference was not statistically significant [8].

The collected research material was qualitatively analyzed in three stages: preliminary, *a priori*, using categories described in the literature; inductive, applying selected procedures of grounded theory methodology; and reflective, consisting of recoding the material according to the main themes that emerged throughout the analysis.

Tools: a grounded theory

The grounded theory methodology is particularly suitable for creating the analytical description of the collected empirical data [cf. 11]. Such description is developed through a systematic, in-depth data analysis that leads to the emergence of research categories and links between them. The categories thus created are refined and verified by repeatedly revisiting the raw data. In this study, applying grounded theory procedures allowed to capture the richness and diversity of the themes raised by respondents with maximum comprehension. It also led to the identification of issues that were general enough to outline the distinctive components of the PF phenomenon.

Initially, three categories stemming from the literature were adopted to organize the respondents' statements [cf. 3, 12-17]. It was assumed that the declared feelings

could relate (1) directly to the patients and their symptoms, (2) to the sphere between physician and patient – their relation, and (3) to the physicians themselves. Therefore, these categories referred to the “localization” of the source of these feelings – to what extent they were perceived as arising from the patients’ symptoms, from interpersonal communication and atmosphere, or the physicians’ subjectivity. In addition, it was decided to investigate PF modalities understood as forms of experiencing it.

A working version of the coding key was created in the first stage. It consisted of categories that directly emerged from data. Thirty-two randomly selected statements were subject to open substantive coding that assigned labels to each piece of the statement that constituted a meaningful passage (these included whole sentences, shorter phrases, and single words). This resulted in several dozen labels, which were coded selectively in the next step. The aim of this coding stage was to reduce the number of labels by creating research categories that encompassed more codes and were more precise.

The coding key was revised and refined several times using the constant comparative method [11, 18]. First, previously generated research categories were compared with new empirical data until no new themes or concepts appeared. Next, the categories were compared with each other in order to identify the links between them and to achieve their conceptual separation.

The creation of the coding key was inductive. The process was based on repeated analysis of empirical material, with deliberate omission of concepts present in the literature so as to remain as faithful to the data as possible [18]. The result was an inductive coding key consisting of 40 research categories organized into three levels of generality.

The first-order categories are those identified at the initial *a priori* stage of material analysis, and they are the most general. They stem from the literature but were verified against second- and third-order categories as well as empirical data. The first-order categories organize the rest of the categories in line with the themes identified in the data, but at the same time remain consistent with the research questions posed. They include: modality, patient, relation, and physician. The second- and third-order categories present a lower level of generality and are more descriptive. Their content and the very way they are expressed emerge from empirical data. Second- and third-order categories include, among others, the so-called *in vivo* codes, i.e., terms adopted directly from the subjects’ language (e.g., “[patient] being «behind the glass»”).

The coding key was employed to analyze all collected statements’ content quantitatively. Quantitative coding was thus reciprocally deductive and determined whether a given category was present in the statement. A given statement could be coded as belonging to more than one first-order category. An example of coding a statement is shown in Table 2.

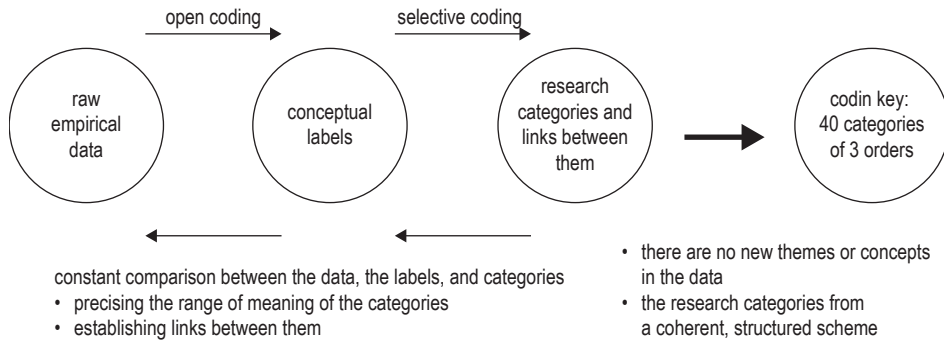


Figure 1. A flowchart depicting the inductive stage of creating the coding key

Table 2. Example of coding empirical data

Respondent #179: <i>Affective pallor, poor facial expression or amimic face, patient remaining behind the glass, rigid, limited contact. Lack of eye contact or staring at the interlocutor, insistent eye contact, gaze suggestive of hallucinations, difficulty focusing, deferring responses, delusions, psychotic anxiety. A certain strangeness felt during the examination.</i>			
Excerpt from a statement by a psychiatrist	1 st -order categories (<i>a priori</i>)	2 nd -order categories (inductive)	3 rd -order categories (inductive)
<i>Affective pallor, poor facial expression or amimic face, patient remaining behind the glass, (...) Gaze suggestive of hallucinations, problems with concentration, deferred responses, delusions, psychotic anxiety.</i>	PATIENT	Emotions, affect	Emotional shallowness/ coldness, poverty, pallor Suspicion, distrust, fear
		Non-verbal behavior, signals	Facial expressions, facial mimicry, including reduced facial expression Eyes, gaze, sight
		Statements	Form (pauses, deferrals, echolalia)
		Distance, being "behind the glass," absence	Not applicable – no 3 rd -order categories
Rigid, limited contact. Lack of eye contact or staring at the interlocutor, insistent eye contact.	RELATION	Non-verbal contact (including emotional)	Non-verbal contact: absent, stiff, poor
A certain alienation felt during the study.	PHYSICIAN	Not applicable – no 2 nd or 3 rd order categories	

Furthermore, even if a given statement was coded as belonging to a first-order category, it did not need to pertain to any of the more detailed codes from this category (e.g., overall, it was about contact, but its details were unique, not occurring in any other statement). For example, the utterance *is about the type of interpersonal contact, or rather, its deficit*, was coded as belonging only to the first-order category of relation (without the second- and third-order categories – since in the entire database no other statement referred to “interpersonal” contact, it was not clear whether it could be classified as “verbal” or “non-verbal”).

Results

Modalities

Modality is the only 1st-order category that is completely independent from the other categories and, as a result, can occur together with them in a single meaningful passage. For example, in the statement *flattening and incongruity of affect, feeling absent, more suspicious*, the highlighted passage was coded simultaneously in the modality category (with the 2nd-order category “feeling”) and in the patient category (“distance, being «behind the glass», absence”). Only one out of three respondents (33.01%) specified the form of PF in their statement, with the majority doing so in terms of “feeling, sensation” (23.30%), and a minority as “impression” (7.77%) or “desire” (3.88%).

Patient

When describing their strong feelings suggestive of a diagnosis of schizophrenia, the physicians that participated in the survey most often (80.58%) referred to the patient (their behaviors, reactions, and signals he or she sends). The patient category was the most elaborated in content, encompassing eleven 2nd-order and fourteen 3rd-order categories (see Table 3).

Almost half of the respondents (44.66%) referred to patients’ emotional states. Physicians in this group most often took notice of emotional coldness (50%) and emotional rigidity and inappropriateness (26.09%). Also, patients’ observed suspicion, anxiety, and fear proved vital to strong feelings suggesting a diagnosis of schizophrenia (the theme appeared in 23.91% of the statements that described patients’ emotional states).

One in four respondents (25.24%) paid attention to patients’ statements. Their content (evasive, detached from reality, incoherent, or characterized by a tendency to rave or talk nonsense) was noted by more than half of this group (57.69%). One in four respondents (26.92%) in this group also looked at the form of utterances, particularly the presence of pauses, deferrals, and echolalia.

Peculiarities related to patients’ mental processes were noted by 22.33% of respondents. More than half of them (52.17%) wrote explicitly about the presence of formal thought disorders, including paralogies.

One in five respondents (20.39%) wrote about various non-verbal aspects of patients' behavior. The eyes proved to be an essential source of feelings suggesting a diagnosis of schizophrenia. More than half (57.14%) of this group paid attention to patients' gaze (described as blank) or stare (distracted, insistent). For a third of them (33.33%), patients' facial expression, usually described as poor, was also important.

Finally, physicians used the metaphor of "being «behind the glass»". Of the respondents, 17.48% described patients as remaining distant or even absent. In 15.53% of the statements, respondents indicated patients' bizarreness, and 12.62% indicated their inadequacy (this category was independent of "emotional inadequacy"; it pertained to those passages from the statements in which the nature of patients' "inadequacy" was not specified or was specified without reference to affect or emotion).

Relation

A total of 40.78% of the sample described their diagnostic feelings as having to do with the type of contact with the patient. The majority of this group (61.9%) paid attention to non-verbal and emotional aspects. At the same time, almost all statements describing non-verbal contact (84.61%) indicated its absence, rigidity, or poverty. In addition, among those describing contact or relation with a patient, about one-third (33.33%) indicated various forms of verbal communication. Half of these statements pointed to a deficit or lack of verbal contact (50%; see Table 3 for details).

Physician

The physician category appeared with the lowest frequency (14.71% of total statements) in the analyzed material. This means that the respondents perceived PF as flowing directly from their feelings, impressions, or emotions only to a small degree. Rather, they located its source in the sphere of relation or in their patients (if a given passage of the statement could, with no change to its meaning, be rephrased into "the impression/feeling/sensation that the patient....", it was not coded as belonging to the physician category).

Table 3. Content of statements by categories from the coding key (N = 103)

1 st -order categories	2 nd -order categories	3 rd -order categories	% (N)	% of higher-order category
MODALITY			33.01% (34)	n/a
	Feeling, sensation		23.30% (24)	70.59%
	Impression		7.77% (8)	23.53%
	Desire		3.88% (4)	11.76%

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PATIENT		80.58% (83)	n/a
Emotion, affect		44.66% (46)	55.42%
	emotional shallowness/ coldness, poverty, pallor	22.33% (23)	50.00%
	inappropriateness/ inadequacy/rigidity of emotions, affect	12.24% (12)	26.09%
	suspicion, distrust, fear	10.68% (11)	23.91%
	confusion, disorientation, anxiety	3.88% (4)	8.70%
Statements		25.24% (26)	31.33%
	content (evasive, detached from reality, incoherent, tendency to rave or talk nonsense)	14.56% (15)	57.69%
	form (pauses, deferrals, echolalia)	6.80% (7)	26.92%
Mental processes (reasoning, sense-making)		22.33% (23)	27.71%
	disorders other than paralogies	6.80% (7)	30.43%
	paralogies	4.85% (5)	21.47%
Non-verbal behavior, signals		20.39% (21)	25.30%
	eyes, gaze, sight	11.65% (12)	57.14%
	general face appearance, facial expressions, including – poor	6.80% (7)	33.33%
	way of moving around, gestures, posture	5.83% (6)	28.57%
	clothing, appearance, hygiene	4.85% (4)	23.81%
Distance, being “behind the glass,” absence		17.48% (18)	21.69%
Bizarreness, strangeness		15.53% (16)	19.28%
Inadequacy, inappropriateness (other than affective)		12.62% (13)	15.66%
Incoherence, ambivalence		6.80% (7)	8.43%
Lack of contact with oneself, inner chaos, insincerity, dissimulation		4.85% (5)	6.02%
Disorganization		4.85% (5)	6.02%

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RELATION		40.78% (42)	n/a
	Non-verbal contact (including emotional)		25.24% (26)
		non-verbal contact: absent, stiff, poor	21.36% (22)
	Verbal contact		13.59% (14)
		verbal contact: deficient, none	6.80% (7)
		answers to questions	4.85% (5)
PHYSICIAN		14.71% (15)	n/a

In the end, we calculated the expected incidence of each of the first-, second-, and third-order categories between psychiatrists of varying levels of expertise (specialists and residents), proportionally to their size. The comparison of the expected and observed rates showed no statistically significant differences regarding any of the categories listed in Table 3 (χ^2 test, $p > 0.05$).

The contents of Praecox Feeling: results of post-hoc analysis

The findings presented above focused on identifying and outlining the “locations” of PF from the perspective of physicians participating in the survey. In order to reconstruct the content of this sentiment regardless of its sources, the existing coding key was further employed in a post-hoc analysis. Particularly, the post-hoc analysis provided better insight into those statements in which physicians referred to their internal states. In the previous analysis focused on the “location” of PF, such statements occurred too rarely to be subject to in-depth content analysis.

The post-hoc analysis proceeded in two stages. In the first stage, second- and third-order categories from the existing coding key were reordered. This operation revealed combinations of categories consistent in meaning (related to similar phenomena, states, or situations). This resulted in the identification of three main topics in the surveyed material:

- (1) an impression of detachment or deficit in contact with reality and/or the other person (a combination of the following categories: verbal contact – deficient, none; non-verbal contact – absent, stiff, poor; distance, being “behind the glass,” absence; emotional shallowness/coldness, poverty, pallor; gaze: empty, absent);
- (2) an impression of departure from the norm, from what is expected and/or consistent with logic (a combination of the following categories: incongruity/inadequacy/rigidity of emotions, affect; paralogies; bizarreness, strangeness; inadequacy, inappropriateness (other than affective); incoherence, ambivalence + statements in which physicians describe their feelings in this way);
- (3) a sense that the patient is confused, lost, feeling uncomfortable and anxious, or even threatened (a combination of the following categories: disorganiza-

tion; confusion, disorientation, anxiety; suspicion, distrust, fear; gaze: looking around).

In the second stage of analysis, the topics identified here were treated as research categories and served to recode the entire research material. The unit of analysis was a complete statement containing from 0 to 3 topics.

A total of 81.55% of respondents referred to at least one of the topics mentioned here, while 18.45% of respondents described entirely different issues, with almost one in two (47.36%) in this group expressing themselves vaguely, often in few words. Statements of this kind included, among others: *specific contact; affect; Patient evokes a lot of caring feelings; or Primary symptoms/negative symptoms.*

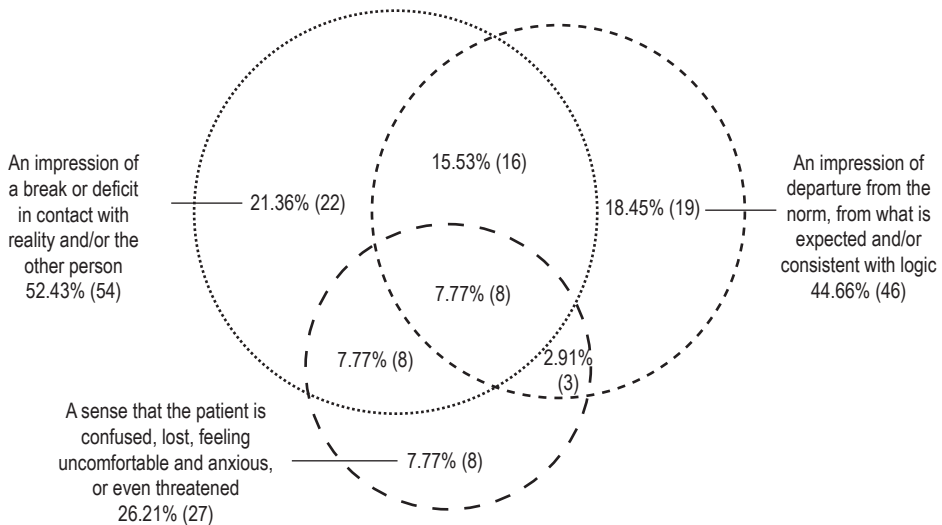


Figure 2. Results of post-hoc analysis – the content of statements by topic (N = 103). The size of the circles is proportional to the described incidence

When describing strong feelings suggesting a diagnosis of schizophrenia, more than half of the physicians surveyed (52.43%) wrote about some aspect of being separated from the surrounding reality, including the other person. This topic appeared both in relation to patients’ behavior and contact with them, as well as physicians’ own experiences. What drew the attention of some respondents was merely the fact that the patient kept themselves at a distance. Such occurrence was usually described in terms of coldness, shallowness, pallor, or poverty of emotion and/or affect, as well as inaccessibility and being “separated.” One respondent described his feelings in the following words: *A sensation that, when following the patient, you are “drifting away,” or an impression as if the voice was “coming from afar” (a metaphor).*

In this context, the metaphor of remaining “behind the glass” appeared relatively often (6 out of 103 statements): *The patient is as if in another place, absent, distant,*

cut off from his feelings, “behind the glass.” Other physicians described an impression that the patients were almost completely separated from reality: their alienation, absence, closure to the world, and maintaining focus solely on themselves.

The respondents also pointed to a peculiar break in contact with their patients. They referred to several difficulties resulting from deficits in verbal and non-verbal communication. These included evading an answer to the question or speaking in a way that was completely disconnected from the content of the conversation. In the non-verbal layer, the psychiatrists most often referred to a lack of emotional resonance and a general sense of being out of sync with the patient. As one respondent expressed it: *I don't feel fully understood and I don't fully understand myself, I feel as if the patient is not here and now.* The patient's blank or absent gaze and avoidance of eye contact were also an important indication of illness.

The second central topic appearing in statements describing PF was the impression of a break with what is considered normal, logical or expected. This topic occurred in 44.66% of all statements. The manifestations that particularly drew the attention of physicians were the patients' inappropriateness understood as the inadequacy of their emotional reactions, statements indicating a lack of logical succession of thoughts (paralogies), and displays of unusual behavior. The following statement can be considered typical of the way respondents described their impressions of detachment from norms and logic: *Disturbing gaze, affective incongruity, bizarreness, eccentricity, atypical reactions to questions asked (failure to understand seemingly simple questions about the causes of behavior; avoidance of answers/evasive answers).* Physicians described patients as bizarre, incoherent, and ambivalent; (...) *inadequacy in the relationship (excessive openness or distrust), bizarreness and disharmony, inconsistency in the patient's thoughts and/or words and/or emotions.*

The respondents also linked their feelings of PF to some kind of patients' disorganization, and the related confusion, disorientation, and anxiety. This topic appeared in 26.21% of all statements. What they found particularly arresting in patients' behavior was their suspiciousness, distrust, and anxiety. The following statement entirely relates to these issues: *in the transference one feels a sense of distrust, danger, massive anxiety, confusion, chaos resulting from the fragmentation of experiences, and more.* Again, the psychiatrists considered eyes a source of important cues; gaze was described in terms of *looking around* or precisely as *looking around the office without reason.*

In contrast, physicians who referred to their internal states and reactions relatively often declared feeling anxious and uncomfortable; *A feeling of uneasiness, of unspecified danger, which is not resulting from the aggressive behavior of patients.*

Discussion

The results of the qualitative data analysis show that physicians' understanding of their own PF varies highly in terms of its content and sources. The above findings lack dominant themes while many categories appear in the data concurrently.

Out of the categories that point to specific aspects of the feeling described, “emotion, affect” stands out. It appeared in 44.66% of the statements. Apart from this

category, only four more second-order categories appeared in more than 20% of the statements. These were: 1) “statements” [of the patient] (25.24%); 2) “non-verbal contact, including emotional contact” [between doctor and patient] (25.24%); 3) “mental processes” [of the patient] (22.33%); 4) “non-verbal behavior, signals” [of the patient] (20.39%). The next most common categories included: “distance, being “behind the glass”, absence” (17.48%) and “bizarreness, strangeness” (15.53%). All other categories occurred in less than 15% of statements.

The post-hoc analysis also failed to provide a clear answer to the question of what PF actually is from the perspective of surveyed psychiatrists. More than half of them (52.43%) described a feeling of separation from reality and/or the other person; 44.66% also referred to a sensation of a break or departure from the norm, from what is expected and/or consistent with logic. In 26.21% of statements, descriptions of a sensation that the patient was confused or lost or felt discomfort, anxiety, or danger were present.

These results can be contrasted with those obtained in a previous quantitative analysis conducted on a full sample of survey respondents [8], where in a multiple-choice closed question the vast majority of psychiatrists as the source of PF indicated problems with alignment with the patient on the affective level (83.6%, 173 out of 207 having PF, including those who could not describe it in words). More than half of respondents referred to gestures and body language (58%, 120 of 207), trouble with social cognition (56.5%, 117 out of 207), and gaze (55.1%, 144 of 207). The least respondents indicated delusions or hallucinations (36.6%, 80 of 207) and other (8.7%, 18 of 207). The current more detailed analysis of the statements in the open-ended question yields a far more diverse picture of PF and its sources.

Finally, the previous quantitative analysis on a complete sample of respondents (N = 243) showed minor differences in responses depending on the level of expertise. Specialists more often than residents believed that the presence of PF resulted from their experience as psychiatrists (80% vs. 64.3%, $p < 0.05$, $\phi = 0.175$) and they were also more likely to consider PF reliable (84.2% vs. 71%, $p < 0.05$, $\phi = 0.157$) [8]. When it comes to the PF contents, however, the present qualitative analysis showed no notable differences in how specialists or residents described their feelings.

Conclusions

The most significant source of feelings suggesting a diagnosis of schizophrenia are the behaviors and states of the patients mentioned by 78.64% of those surveyed, with more than half of all statements (50.49%) describing patients alone. In this context, psychiatrists most often describe emotions and affect as well as non-verbal signals given by the patients.

As for the components of PF, it is a feeling of separation from the surrounding reality that prevails in psychiatrists' statements (52.43%). A significant number of respondents also mention a sensation of detachment from what is normal, the inadequacy of patients' reactions (44.66%). Frequently, both topics are simultaneously present in a single statement.

The quantitative analysis showed that despite the prevalence of operationalized diagnostics, PF is relatively common in the sample of Polish psychiatrists working in major hospitals and university clinics, yet for most this phenomenon remains challenging to express in words. Notably, the ability to put the feelings suggestive of schizophrenia in language present in 44.86% of respondents fosters the use of intuition in diagnosis and increases confidence in its reliability. PF is considered reliable for the diagnosis of schizophrenia by as many as 82.52% of doctors who can verbalize it.

Nevertheless, the qualitative analysis showed that PF is a very complex and ambiguous phenomenon. To deepen our knowledge of PF, we need experimental research assessing its reliability against official operationalized diagnostic criteria. Perhaps realizing that intuition is present in schizophrenia diagnostics in Poland as well as a commitment to its possible articulation, may serve to increase its accuracy and, as a result, lead to a more open attitude toward treating it as an auxiliary tool in diagnostic practice [cf. 19].

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