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People and places

The legacy of Dutch psychiatry

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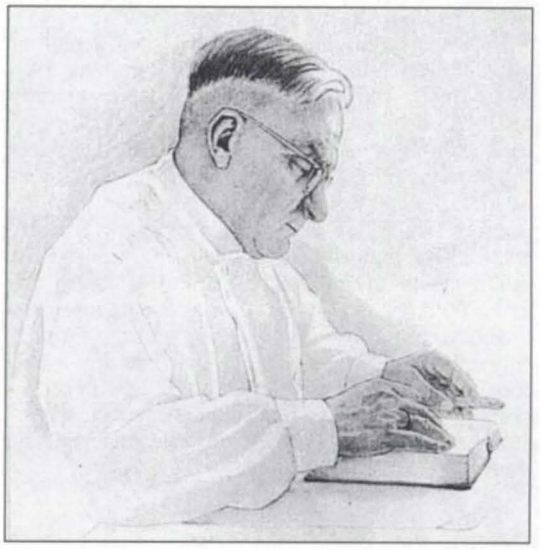
The library of the Institute of Psychiatry is undoubtedly internationally oriented; it stocks writings in languages ranging from German to Chinese. As a foreigner one is bound to be on the look-out for texts in one's own language. In my case this search has until now been unsuccessful. After the librarian asked me whether the Dutch write about psychiatry at all, I have actually given up but at the same time I decided that it was my task to increase awareness of Dutch psychiatry among my colleagues. Although it is true that the Dutch have accepted English as the international scientific language more than any other members of the European Community, Flemish and Dutch psychiatrists do continue to publish in their native language by means of the *Tijdschrift voor Psychiatrie*, a journal which differs from, for example, its British counterpart by the emphasis it puts on case studies, psychotherapy and philosophical/historical issues rather than on research in the internationally accepted format.

Before science was anglicised, several contributions in Dutch were made by psychiatrists from the Netherlands which, in spite of the language barriers, continue to be quoted, as classical texts, in the international literature.

Until DSM-III was accepted as the main framework around which psychiatry was taught in Dutch medical schools in the early eighties, the legacy of Professor H. C. Rümke (1893–1967) constituted one of the most widely accepted influences in Dutch psychiatry. If one pays attention, one comes across his name in the literature fairly regularly (Parnas & Jorgensen, 1989; Shafran *et al*, 1989).

Rümke specialised in psychiatry under Professor L. Bouman (1869–1936), who is known as the founder of 'psychological psychiatry' in Holland and who, for instance, established clinical psychology as a discipline. Bouman was interested in the soul as the subject matter of psychiatry; this was partly a reaction to a strong organic-neurologic tendency which, in its turn, served to fend off the anti-religious influences of psycho-analysis. In addition, Bouman himself was a Calvinist and he was actually given his



H. C. Rümke 1893–1967

chair by the Protestant government which was keen to increase confessional influences in psychiatry.

Through his teacher, Rümke was influenced above all by Jaspers and German psychologists such as Stern (1871–1938) who assumed that, even in the most devastating psychosis, the core of the personality remained intact. Obviously, psychiatry with a strong Protestant undercurrent needed such a constant factor to account for the soul which, after all, is the image of God (Belzen & Meulen, 1988). Rümke, who, in his *Handbook of Psychiatry* (three volumes), tends to classify according to levels of desintegration and therefore stands in a tradition initiated in psychiatry by P. Janet (Hasselt, 1977), wrote his dissertation on the phenomenology of happiness (1923). Here one recognises one of his interests, namely the occurrence of psychiatric symptoms and signs in healthy people. This notion was, outside psychoanalytic circles, fairly new at a time when thinking

was still largely dominated by the theories of degeneration and psychopathic constitution.

His main and best-known work appeared in 1941, dealing with 'The nuclear symptom of schizophrenia and the praecox-feeling' (Rümke, 1941). I find this beautiful, six-page article, which was never translated into English, deserving of review here, as the 'praecox-feeling', in spite of operational diagnostic criteria, continues to be mentioned, examined upon and used in clinical practice.

The article centres around Rümke's observation that the psychiatrist takes on the psychopathology of the patient he examines. He tends to lose decorum when talking to a dementing patient, becomes slightly manic when confronted with a manic patient ('infectious gaiety') and manoeuvres neurotically in his dealings with neurotic patients. Finally, he becomes 'somewhat' schizophrenic (i.e. withdraws and feels emptiness) if his patient is schizophrenic. Rümke says that the fundamental symptom in schizophrenia is a reduction in the instinct to establish relationships, and, in his loneliness, the schizophrenic patient behaves and feels exactly like we, who are not schizophrenic, do when we are alone and in the knowledge of not being spied upon; on the toilet our behaviour is catatonic, our silly smiles and monologues hebephrenic.

Carrying this line of thought to its end, Rümke concludes that schizophrenia is diagnosed by means of an ego-dystonic, mild form of schizophrenia, the praecox-feeling in the psychiatrist who feels lonely in front of a patient who will not establish a relationship with him. Rümke uses the praecox-feeling as the final touchstone of his diagnosis and rejects the possibility of objective, pathognomonic symptoms. Rümke does not mention the ethical implications of the use of the praecox-feeling, although they are formidable; does psychiatry diagnose (and treat compulsorily) in its patients its own lack of empathic capacity?

As far as I am aware, anti-psychiatry has never quoted this article in which a psychiatric authority has implied that psychiatrists treat their own psychopathology. On the other hand, however, Russian psychiatry, acquainted with Rümke's writings through the German translation, appears to make use of it merrily in its business of diagnosing "slowly progressive schizophrenia" (Smulevitch, 1989).

I have the feeling that Dutch psychiatry is still very much aware of the impact of Rümke's insights; the first item in the mental state examination as it was taught to me deals with the subjective feelings of the doctor in his confrontation with the patient.

An interest in biological psychiatry rather than psychotherapeutic aspirations does not serve as an advantage when applying for a psychiatric assistantship in Holland. Is there a fear that the selection of research-minded candidates would create a brand of psychiatrists with 'little capacity for introspection or for emotional response to others' (Storr, 1979), carrying so to say, a 'praecox-feeling' with them all the time, and therefore at risk of overdiagnosing mental illness and increasing the guilt of psychiatry? It appears that this mechanism (if I am right in supposing its existence) has actually increased the emphasis put by Dutch psychiatry on psychodynamics, case-studies and biographies, philosophy and social psychiatry. On the other hand, there is a feeling, recently ventilated by a leading Dutch professor, that Dutch psychiatry lacks clinicians who do internationally acceptable research (Tilburg, 1988). Is this inhibition symptomatic of an anxiety Dutch psychiatry has to cope with in the face of Rümke's sobering thoughts about psychiatric diagnosis? If this is true, Dutch psychiatry manages admirably well. For the application of the concept of the praecox-feeling to its full extent would mark the end of psychiatry as a scientific discipline and, indeed, turn all psychiatrists into disturbed mental patients.

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