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What Do We Risk to SQuEASE by Making Psychiatric Phenomenology Too Efficient?

Florestan Delcourt[a] Jérôme Englebert[b, c]

[a]CRPMS, ED450, Université Paris Cité, Paris, France; [b]Université Catholique de Louvain, Louvain, Belgium; [c]Université Libre de Bruxelles, Bruxelles, Belgium

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Peut-être aussi schématisait-elle l'intrépidité apparente de quelqu'un qui veut montrer qu'il n'a pas peur et ne veut pas se donner le temps de penser.

Marcel Proust, Le temps retrouvé

Schizophrenia Bulletin has published a scale [1] to which we would like to respond, but not so much targeting the article itself as its trend, its *economical-pragmatic way to examine anomalous self-experience*; the neoliberal flow of standardization of psychopathological phenomenology.

As a reminder, this article is also the result of the great return of phenomenology in international psychiatry, the *return to the things themselves* experienced by the persons with a disorder, by understanding what each of them experiences in their daily life, what each disorder makes them live from a first-person perspective before explaining it from a third-person perspective, as the natural sciences usually do [2–4]. From this viewpoint, the schizophrenia spectrum has been the topic of numerous studies, even if, or perhaps because its experience has traditionally been reputed to be *incomprehensible* [4–7]. Another trend also permeates this return to phenomenology and responds to what Jean Piaget [8] called the hope and the need for a renewal of the "links between philosophy and science", which, as Wolfgang Blankenburg [9] hoped too, would help "to make fruitful, step by step, the whole arsenal of essence determinations of phenomenology, for empirical science (translated)"; namely, the development of the so-called phenomenological empirical scales and tools.

Among these tools, EASE [10] (Examination of Anomalous Self-Experience) is distinguished by the broad scope of its use and results, especially in the study of the schizophrenia spectrum [11–13]. However, before its diagnostic, predictive, and psychiatric value, EASE is specifically concerned with experiential alterations, the pre-reflexive anomalies of experience that can *sign* the first-person perspective of each person, or particular disorder, by using a 57-item scale. These anomalies, like *flats* and *sharps* [14], do not objectively alter the experience of this or that thing, its *real note*, so to speak, as hallucinations can, but the overall, pre-reflexive impression that conditions the *a priori* of its perception; in other words, the tacit and daily, *transcendental* experience of these person's self, their *lived self*.

The study discussed here [1] aimed to reduce in an *economical-pragmatic* way the minimum 2-hour EASE

karger@karger.com
www.karger.com/psp

Correspondence to:
Florestan Delcourt, florestan.delcourt@etu.u-paris.fr

administration time to 20 min, by developing the SQuEASE-11 scale (Screen Questionnaire for EASE); hence our reaction, and the question: what do we *squease* here? For the authors, the answer is simple: time, *squeased* by effectiveness. Møller et al. [1] insist on the time-consuming aspect of EASE, and this reduction from 57 items to 11 would, in fact, aim to "spread the use of this essential 'from-within' perspective of psychosis risk", with "a shorter, first-step, 'screening-like' instrument (preferably interview based, as in this study)". According to them, "the time is ripe to have a systematic look at this issue empirically", and it is therefore appropriate to see whether it is possible to study these phenomena, not here *specifically* related "to ipseity disturbance as such, but (which) are found to be particularly frequent and prototypical" clinically and statistically, and this, in a short, targeted and systematic way. This, we think, is the problem *behind* this work, which has its own undeniable qualities, but responds above all to the "real-world" requirements of care settings for subjects at risk of psychosis, as addressed by the parent study of SQuEASE-11, STEP [15–17] (Staged Treatment in Early Psychosis), which espouses, among other things, this flow of efficient standardization in psychiatry. The emphasis placed on statistics is revealing, since, coming from the German *Statistik*, the Italian *statista*, and designating *what a statesman must know*, statistics serve to satisfy this need for rapid, efficient, managerial handling of things and situations. But should psychiatry, enlightened by phenomenology, blindly follow this trend? And is not it too simple to say that such a tool simply meets a demand, follows an inescapable evolution in psychiatric care, without acknowledging, or even discussing its possible participation in this very evolution? The standardization of psychiatry, driven by the globalization and cost-efficiency of care [18], is tending toward this *squeased time*, a *neoliberal transmutation of time* opening the way to a *culture of urgency* [19]. However, we feel that this *lost time* remains necessary for the exploration of the phenomena that EASE is seeking to address, because of their "*fleeting*, perhaps even verging on something *ineffable*" aspects, "often so strange to the patient that he has never communicated them to anyone else" [10], and because of the very use of phenomenology, if we want to appropriate it *as it is* within any clinical apprehension [20].

This is undoubtedly one of the main interests of EASE, but also of psychiatric phenomenology, which deserves more research: the clinical effect of the time it takes, the time that must be taken (and *lost*) when using these scales, or others, renowned for their pragmatic efficiency with regard to symptoms or other psychiatric aspects, that are abundant in studies and are beginning *to flower* in research programs, but which, if their time only follows this standardization, may miss the interest of the margins and the aside, *in the shadow*.

Certainly, supporting these persons, those suffering from a psychotic disorder, and more generally from a psychiatric disorder, requires a certain degree of efficient standardization, and the persons directly concerned, suffering from the disorder, belonging to their entourage, or their carers can testify subjectively to this need, but also to the necessity of a humane approach of it, inclined to compassion, understanding and confidence in their own recovery [21–24]. Indeed, the idea of preventive *universal interventions* for psychotic disorders seems, at least for the time being, out of grasp [25], and this state of affairs urges us to continue to target each possible risk within each concrete clinical situation with this population, on a case-by-case basis. However, if this does not invalidate the research motivated by this need for the standardization of care, it urges us to revalue, scientifically and clinically, the long *lost time* of the human encounter. In our view, the current resurgence of interest in phenomenology can assist this reappraisal of time and nuance the flow of standardization urgently requiring speed and efficiency.

To make our concern more explicit, we'll extend this trend by allowing the use of self-rated scales. While the authors of SQuEASE-11 state that these scales are "inadequate and insufficient for capturing psychosis risk" [1], others have suggested "their potential as screening measures for SD [Self-Disorders]" in a meta-analysis [13]. Now, even if it is against the will of its authors, this is a trend to which SQuEASE-11 conforms, and in fact contributes despite its caution. And so, why not even consider the 12 items of the Self-Experience Lifetime Frequency [26]? This tool follows the same goals and the same trend, and the *time saved* for "screening of self-disturbance phenomena", in a "feasible and possibly clinically relevant" way [26] would respond more effectively, through its number of items, to this *economical-pragmatic* trend. And why not consider, given that "the path of least resistance for the imagination is not the same as for mathematics" as Bachelard [27] warns, *single-item measures of self-rated mental health* [28]? These tools can be seen as statistically effective, and therefore likely to meet this *realistic* need in current psychiatric practice, but in trying to get to the core, the heart of efficiency, it seems obvious that this trend, taken here to the extreme, misses its aim by squeezing out the time needed to encounter these phenomena and these persons.

Thus, perhaps it would be judicious for one of the possible evolutions of phenomenological psychopathology to contribute to the study of this other

temporality of care, to which clinicians and patients seem to aspire. Do clinicians want better, faster tools, or more time to meet their patients? And what kind of clinician does the patient, particularly with a psychotic disorder, but also more broadly psychiatric, want to meet? It could be fruitful to undertake *a new in search of lost time*, no longer focused on the rational rationalization of time (and contributing, by legitimizing it, to this squeeze), but based on the permanent concern to preserve what always goes beyond therapeutic tools, which have their usefulness, and open us up to the encounter with each *concrete* person [29].

Conflict of Interest Statement

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Author Contributions

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