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The Phenomenological Method Applied to Acute Psychiatric Situations

Di Petta G, Vanacore R* and Tittarelli D
ASL Naples 2 North, Italy

***Corresponding author:** Raffaele Vanacore, MD, ASL (Local Health Authority) Naples 2 North, Italy, Tel: 3420620949, Email: raffaele.vanacore17@gmail.com

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Abstract

The most accepted definition of urgency in psychiatry is that of a situation of acute and severe mental and behavioral suffering, which requires immediate treatment. Therefore, in the situation defined as "psychiatric urgency", a descriptive and nosographic element (acute), a prognostic element (severity) and a therapeutic element (need for immediate treatment) coexists. In any case, it remains difficult and complex, sometimes enigmatic, to understand the acute episode within the course of a specific pathology. It is a matter of having to oscillate in front of the patient "between the madness of a moment and the madness of an existence" [1]. By the way, contribution from philosophical discourse may be helpful to clarify the psychopathological structure of acute psychiatric urgencies.

The World-of-Life in Psychiatric Urgency

The most accepted definition of urgency in psychiatry is that of a situation of acute and severe mental and behavioral suffering, which requires immediate treatment. Therefore, in the situation defined as "psychiatric urgency", a descriptive and nosographic element (acute), a prognostic element (severity) and a therapeutic element (need for immediate treatment) coexists. In any case, it remains difficult and at times enigmatic to understand the acute episode within the bear of a specific pathology. It is a matter of having to oscillate in front of the patient "between the madness of a moment and the madness of an existence" [1]. In medicine, however, the scientific revolution of modernity, enhanced by the computer revolution of hypermodernity, has completed the systematic demolition of that way of approaching the world of disease in a continuous manner with respect to the world of normality. The clinician's discretion, in the traditional approach, was sovereign with respect to predefined patterns of intervention. All this has led to the stigmatization of the subjective, the idiosyncratic, the invisible, of everything that cannot be measured according to the canons of Western rational thought. Phenomenology, on the other hand, enjoys a "privileged status" [2], since its philosophical perspective aims to grasp the experience before and beyond the disjunction between subject and object. But, to date, psychiatry is still lacking in assessments and guidelines based on "objective" findings (i.e. validated by data from instrumental and laboratory analysis). Therefore, the contribution of the phenomenological method, applied to the description of the fundamental structure of the acute psychiatric event, is crucial, since it represents, in fact, the rigorous attempt to grasp the acute clinical event in its immediacy and in its totality [3].

If the acute event is captured in its surface phenomena, as routinely happens, it risks ending up isolated from the world. But if the acute event is grasped in its phenomenology, then it is constituted together with the world which it generates and in which it is generated inextricably. And this

means being able to operate on his modal determinations, since the psychiatrist discovers himself within the "world" of the crisis. Beyond, therefore, the remote or cryptic causal determinants, the modal determinants of crises, that is, how the crisis is given, how it becomes worldly, and how it involves the clinician himself certainly mean having knowledge of its supporting structures, and therefore being able to operate on them to modify them in view of a resolution.

It is clear that no description can account for the stressful climate of the impact with acute. However, it can be decisive favoring the consideration of the event in its entirety and the massive involvement (sensory and "pathic") of the clinician as an active, integrated and embodied part (embedded and embodied). This favors the deployment of implicit devices of knowledge which, certainly, will not have the consensus and reliability (reliability) typical of standardized tools but, nevertheless, will condition the clinician, the patient and the other operators involved, to gain a way out of the crisis, through a special attunement and conferral of meaning to the same, which otherwise would be reduced to a mere symptomatological-syndromic (algorithmic) cascade, to be extinguished in some way. To this end, it is necessary to proceed to an accurate description of the existential (apriori) of the acute crisis, or how the psychiatric crisis becomes worldly (it temporalizes, spatializes, is corporealized, coexists or how it breaks coexistivity).

This method of approach will be deployed here through a series of embodied dimensions, which examine well-constituted (and constituting) phenomenological conceptualizations, such as the spectrum of perception [4], the landscape [5], the atmosphere [6], the situation [6,7], the eidetic vision [8], the praecox feeling [9].

What, in this perspective, we will try to highlight, is the correspondence between the structures of the world-of-life of the acute critical event and the pathic/gnostic structures of the psychiatrist who intervenes. It is only from this type of agreement, in fact, or concordance or tuning, that the modalities of practical management of acucies can arise. These, in fact, are marked by a conferment of meaning to the same by the clinician and its possible relocation in the biography of the subject. Only if the psychiatrist connects the supporting structures of his own world-of-life to the world-of-life of acute crisis, does he have any chance of engaging authentically with it. He has the possibility, that is, to understand the same crisis in the flow of life, like the anomalous wave that mounts, at a certain point, on the sea, and which is then included in its ripples.

The phenomenological method, applied to the dimension of psychiatric acuity, aims to lead the clinician to the appreciation of precategorical, prereflective and ante-predicative aspects. These aspects are usually not considered, so they riskbeing completely out of the possibilities of treatment. The focal point of this phenomenological approach is, therefore, to identify precisely in these elements lever points, on which to intervene to interfere, relate and modify the picture of acute. It is, in essence, here a question of looking for the foundations of the visible in the invisible. Phenomenology contributes to the experiential baggage of the clinician by founding the premises for a clinic of the invisible.

The "Acute" Atmosphere: Between "Landscape" and "Geography"

The distinction made by Erwin Straus [5] between sympathetic perception of the world, that is immediate, made up of profiles, contours, blurred and overlapping images, like the waves of the sea, and, conversely, the topographical (geographical) representation of a given place, that is "gnosic", where the self is constituted as a pole distant from the world, seems very opportune.

The psychiatrist is called, day or night, ex abrupto, when the patient refers to the PS or, in some cases, alerted before the arrival of the "agitated" patient. When he goes to the premises of the PS, he is immediately immersed in a direct atmosphere very far from that of university classrooms, or training courses, where, instead, the acute psychiatric crisis is explained, discussed, broken down in a didactic way. In general, beyond the title of a hypothetical lesson on "acute psychiatric states", the typical teaching on the crisis inevitably takes place by decomposition of the theme. For example: acute pictures of schizophrenia, acute pictures of bipolar disorder, acute pictures in the borderland etc. Oryet, conversely, starting from the symptomatology of presentation, the specific underlying pathologies derive from it. The final recomposition of all this analytical explication will inevitably be random. The clinician, summoned to the acuzie, usually intervenes in the second or third act of a drama, of which he does not know the origin, but in the outcome of which he is involved. Often, unless the patient is known, adequate information is not even available to those accompanying the patient. And often the patient, precisely because of the acuity, is not in such a condition as to be able to provide adequate information. Finally, the clinician has to face his own reactions, which are not ordinary ones but which can in turn provide him with direct information about the person he is meeting. In other cases, however, this information, if chaotic and disorganized, can affect its critical capacity. The clinician is, in other words, immersed in acuteness, and he himself becomes "acute". The challenge of this phenomenological approach is, instead, precisely to ensure that the clinician, although immersed, is not completely submerged by the crisis. That is, it does not

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become itself an object moved or acted passively by the forces in the field which, the more it believes it can dominate, the more they risk dominating it. In this sense, Straus's distinction between landscape and geography is very useful here. The encounter with the acute crisis takes place as the immersion in a "landscape" of which it is difficult to decode everything, but of which things or quasi-things are grasped [10]. The scene of screams, anger, disjointed and incoherent language, bizarre behavior, subexcitement, or the perplexed patient [11,12], is a very impressive representation that waits, just like a deus ex machina, for the decisive action of the psychiatrist. In fact, the psychiatrist who intervened is himself "in" the crisis, therefore inextricably immersed in the landscape of the crisis, and yet, at the same time, he is "facing" the crisis, that is, capable of abstracting coordinates such as to trace his position and that of the patient with respect to a context [13] that the position of the clinician, in these cases, passes from being with someone (intersubjective position) to being in front of something (objectifying position). In this the psychiatrist is required to oscillate from a contact boundary lost in the landscape to a logical abstraction from the context, to take a topographical and scale image of the same. An icastic metaphor, here, is that of a soldier equipped with a radio who is right inside the raging battle but, nevertheless, is lucidly able to transmit the precise coordinates to favor an air or artillery intervention with precision fire on that landscape "reduced" to objective.

In this regard , the construct of atmosphere defined by Tellenbach [6], and taken up by recent aesthetic philosophy [7] and the so-called new phenomenology [10], may be useful for the acute setting. The lights, smells, looks, sounds of the PS, the emotional emanations [5] that come from the patient, such as anger, despair, despair, despair, resignation, are important elements for a direct knowledge, by the clinician, of what is happening, not mediated by evaluation scales or, least of all, by instrumental or laboratory analyzes. The final response of the clinician with respect to the diagnosis and therapy to be practiced in acute can already arise from these first elements that orient, even if in a precarious way, towards a path of treatment.

This premise wants to give reason for the cascade of events generated in the context of the acute crisis and keep open in the clinic a sort of perception of horizon, on the border between figure and background. The atmospheric is something that is perceived by observing others while observing oneself. It always has to do with the relationship, with the 'tra' and the 'around' of the peopleinvolved. The atmospheric is very farfrom measurable in the objective sense, and the phenomenological method is the only way forward. When wetalk about "atmospheres", we refer, in general, to nuanced situations and almost devoid of objectivable elements and to sensations that characterize a relationship with a particular person and his world. The atmosphere is always something that fluctuates in the "tra" where it is more or less perceptible, not only depending on the observer, but also on the conditions of the observation.

The atmosphere of every interpersonal relationship is permeated with possible conditions of authenticity or instead of collision with the transversality of weirdness (the screw that gets in the way) or with the emptiness of schizophrenic existence. The full, the crooked, the empty modulate the interpersonal atmospheres on which the cut of the "feeling of schizophrenia" (Praecox Gefühl) can fall, like an axe, as an epiphany of the schizophrenic way of being in the world. Since the atmosphere is a space impregnated with emotion and affectively tuned, the psychiatrist's empathy is precisely towards the atmosphere. It is the atmosphere, in fact, that surroundsrand that spatiality neither internal nor external [14] that bears the emotional emanations of the patient. By testing the boiling atmosphere, the psychiatrist can immediately realize the level of seriousness of the situation.

The Acute Psychiatric "Situation"

The term situation is the most appropriate, even with respect to setting, to define the framework of the encounter between the psychiatrist, the patient, the phenomenon of acucies and the context. The term situation concerns, in fact, a tranche of the I-world relationship. The apex of the situation, the terminal part of the funnel cone, is the position of the clinician who pertains to the place of acute. The acutia stands out, instead, on the open section of the funnel. The clinician encounters a situation, of which he is a part, and which cannot be separated from the context. The clinician is, therefore, located in the acute crisis and located by the acute crisis. The term "context" separates, rather, the person in crisis from the world around him. The term "situation" envelops, instead, the clinician, the context and the acute patient in a multidirectional and open way. The clinician's awareness of being an intercorporeal part connected to the acute crisis , and not just a passive subent of the situation, can give his feeling and his work a different agency. Starting from his attitude, from the way he enters the scene of the crisis, from the interpersonal distance he maintains, from his gestures, changes in context will arise that, if congruous, guide towards the exit from the acute crisis.

In the kaleidoscope of acute crisis, the prevalence of implicit sensorimotor aspects, compared to the rational plane and the linguistic elaboration and metabolization of the event itself, puts and in particular emphasizes the importance of the plane of articulation and motor interconnectionto /

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cenesthetic. In a sense, the psychiatrist's way of moving will have to adapt to the milieu of the atmosphere. You have to move in harmony with the ground and with the background on which you move. The greater or lesser naturalness of movement of the psychiatrist in the milieu of the crisis will have a considerable influence on the attunement and on the restoration of meaning to the situation. Conversely, moving like "a fish out of water" represents a considerable loss of grip on the environment and, consequently, a reduction in containment of the patient in question. The psychiatrist is situated from the crisis in a certain position and, at the same time, he situates the crisis. And the patient lives the same condition. He is situated by the crisis and, in turn, himself able to situate the crisis. The waiting of the psychiatrist in the place where the crisis is manifesting determines the opening of a lived space that closes around the psychiatrist as soon as he appears. Bystanders depend on and move around him according to his feeling and attitude towards the patient. The psychiatrist must be aware of the suction that the space of the crisis exerts on him and of the fact that he, in turn, can impress a curvature, with his own being and with his own doing, on the space in which the situation takes place. Of course, we are operating in a space that welcomes the crisis, but that welcomes it to expel it, so it must be clear to the psychiatrist and bystanders that everything that will be put in place, as during a birth, must be aimed at the rapid progression of the crisis towards its terminal, decisive phase, and therefore at the evacuation of the place destined for the epicedence of the crisis (PS). After all, everything that is acute by definition carries within itself a short temporal launch charge. The action of the psychiatrist will have to favor the closure of this eruptive phase so to speak of "onset" and the continuation of the crisis possibly elsewhere, with its controlled course.

Between "Contact" and "Check": Seeing, Hearing, Touching, Smelling, Tasting

Given the rush of time in urgency, the pressure of events, the catastrophic cascade in progress [15], the psychiatrist must be able to rely on himself for a profitable management of the situation. On the one hand, it uses the tools of medical semeiotics for a differential diagnosis with the organic. On the other hand, however, it moves with its own human fund for knowledge and a consequent management of the situation. Having overcome the two obstacles of the separation between subject and object and the problem of the measurability of the event, the psychiatrist has no choice but to carry out the phenomenological "reduction" and accept the "data" [16], coming from the situation. Working with the awareness of these pathic/sensory/aesthetic dimensions, in the interaction with acute psychiatric crisis, may seem like a step backwards compared to having in mind an algorithm of behavior, a protocol, a guideline. In reality, the pre-packaged scheme, little plastic to the reality of the continuous present of the acute crisis, risks letting the "handcuffed" clinician go to the encounter / clash with the emergency event.

Minkowski's work "Vers une cosmologie" [17] pioneeringly opens to a very powerful imaginal sensoriality, which is located in the space/time of a lived corporeity, which goes beyond the boundaries of anatomical bodies. Seeing, for example, is a way of describing a sphere of visual or visual knowledge that, although made of images, is not an exclusive product of the retinal-calcarine visual pathway. It is, here, a seeing that precedes and transcends the sight, and that allows the clinician to form an image of the situation, a thickening of meaning that will allow him to direct himself in a less blind way.

The vision that precedes and transcends sight, has the gift of instantaneity and imagination and has the characteristic of incorporating, capturing, trapping essential (structural) elements of the situation with which and against which the clinician is impacting. Sight, according to Straus [5], is the only sense that can be directed voluntarily and that can be turned off voluntarily (with the closing of the eyes). The other senses, on the other hand, cannot be controlled. Feeling is Minkowski's other "cosmological" sense, since it goes beyond and precedes feeling understood in the sense of hearing. The sense of smell has the same atmospheric quality and the same intensely material quality as hearing. A smell comes to us, a sound comes to us. We can decide, instead, to direct the view, or to close our eyes. In the same way touch. Tactility does not only concern the ability to discern what arrives on the epidermis, but it is also felt at a distance. Establishing how far to place, in the anguish of a PS, from a patient in acute crisis, for example, is purely a matter of tact, to be decided instantly, which can quickly change the evolution of the crisis. The term touch has the ancient Greek root of taxis, or location. Touch is the organ of our position in the world. To have touch or to have no touch means to be space-time related. In critical acute conditions, the distance that the clinician modulates with the patient also becomes a parameter of behavior for the other actors or extras on the scene of the crisis. The measure of distance is given to the clinician by his own feeling of otherness: he feels how close he can get at that moment, and this feeling derives from the lived spatial field that the vortex of the crisis, with the patient's epicenter, determines around him. Small variations or cracks in this space, obtained by the clinician thanks to his adjustment movements, can reverse the flow of the crisis, centrifugal and centripetal, and compact, in some way, even if temporary, the crushing of the patient himself. A group of actors or extras that surrounds the protagonist of the crisis, depending on this distance, can become persecutory

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and activate even more the escalation of the patient, or it can become containment, and help the patient to heal his presence. Generally the actors modulate themselves on the gastric and on the motoric of those who have become, at this point, the deuterogamists of the crisis, the psychiatrist and the patient.

The Essence of the Crisis: the "Lightning in the Night"

If it is true that the acute psychiatric crisis manifests itself "as a whole", it remains valid, in our opinion, the definition of EY [1] of the acute crisis as a destructuring of the field of consciousness. EY understands by field of consciousness an "organization of the present lived in the temporo-spatial field of the sensible experience of the subject's relations with his current world". An assumption of psychopathology is, in fact, to refer to the "totality" of the patient's person [18]. This is the diagnostic path more or less consciously followed by the expert psychiatrist, whose skill consists in the use of that cognitive modality indicated by Schutz [19] on the trace of Husserlian thought as "typification".

From this point of view, the metaphor of "lightning in the night" is useful to understand what can happen to a clinician who phenomenologically approaches the acute crisis. Just as a flash in the middle of the night allows us to understand if we are at the sea or in the mountains, and who is in our immediate vicinity. The flash in the night is an eidetic glow that allows us, in difficult moments, where a certain speed of action is necessary, to avoid first of all automatic or short-circuit reactions. If the clinician lets himself go to a perceptual flow like the one described so far, without forcing himself and without drowning in it, at a certain point, like a gift [20] an imaginative flash springs in his mind, an image that contains together the totality of the crisis and its way out.

What we call lack of relationship, in some cases, may be the only perception one can have of a stranger, but a perception that can "hit" me (just like lightning in the night) to the point that I dragliscor inwardly when the door opens and it enters of course, one must be able to distinguish this transfusion and its reasons from the attraction or rejection one feels solely on the basis of sympathy and dislike. A necessary condition for this sort of enlightenment or gift to happen is that the clinician practices the epochè, that is, clears and recalls, as far as possible, his mind from prejudices and disposes himself to the meeting in a free and open way. The eidetic vision represents the moment from which the action of the psychiatrist involved in the crisis escapes the dynamics of action and reaction, of defense and attack, and begins to unravel a thread of meaning that, like Ariadne's thread, will lead him and the patient out of the magmatic and dizzying field of the crisis.

Differential Diagnosis and "Praecox Feeling

One of the most pressing problems of acute crisis is that the pathology does not manifest itself in its clear, expanded, evolved form. The acute crisis, whether it is an onset or an acute recurrent episode during a syndrome now structured, has magmatic characteristics that escape any classification. Historically, the same phenomenological and psychoanalytic devices have always treated clinical cases starting from the diacrony and the unfolding of the temporal / historical plane. Scrolling through the phenomenological and psychoanalytic literature, it seems that the acute crisis, as a world endowed with its own structure, does not exist [21]. From this perspective, and in front of an unknown or poorly plowed field, the praecox feeling device [9] can be extremely useful. We could propose that schizophrenia and the basal phenomenon of autism that characterizes it, revolve around the two concepts of "atmospheric" and "intersubjectivity". There is no doubt that the appellation of atmospheric is particularly suited to the autistic condition, just as the theme of the intersubjective constitution in the world life is the core of the fracture of the relationship that Ruemke [9] and indicated as "feeling of schizophrenia" (Praecox Gefuhl). The normally unproblematic everyday life in its silent foundation of ontological security, of "basic trust" Erikson [22], of naturalness of intersubjective evidence, appears bizarrely cracked, bizarrely bizarre in an incomprehensible way.

Autism can be the catchable expression, the atmosphere that surrounds this way of being, even more upstream of the possible delirium or other symptoms such as the disorders of "belonging to the ego" " or "half" from this disjunctive leap, from this intuition suffered from the impossibility to share, from this lightning and repeated failure of the encounter with the autistic person, the psychiatrist in PS can take the moves to illuminate autism, placing himself on a transcendental-eidetic plane. From this sudden jolt derives a perception of alienity, transversality and strangeness of the ways of being of the person encountered. This is alluded to by the term "Praecox Gefühl" [9] or "feeling of schizophrenicity. That is, the intuitive diagnosis of schizophrenia, as a global apprehension of being met and the modalities of the encounter. We realize, therefore, how extraordinarily effective the enhancement of this special sensitivity can be precisely in the contexts of acuteness. And how much this sensitivity falls within a specificity of the clinical psychiatrist, the result of discipline, study, training, and not already entrusted to volatile impressions or sensations. The training work of the young clinician consists in removing the prejudicial and prepackaged load to that "human" part of the clinician that is totally involved in the reaction to the patient as a human being. In acuteness, therefore, we do not evaluate so much the individual symptoms, moreover submerged by the pyroclastic experience of the acucie itself, as the human

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"residuality" of the patient, or how the patient's humanity disposes and situates itself towards the morbid event that, evidently, in the acute, is manifesting the fullness of its expression.

The Way Out: An Esthesiological Approach

The phenomenology of the acute crisis unfolds, therefore, in a restricted space-time context (the PS), generally more suitable for the organic emergency (ie with the patient reduced to an immobile body that allows itself to be passively treated), with a trend that presses, like a cone or like a funnel, sometimes violently towards resolution. By definition, it is proper to the temporal structure of what is acute, to undergo rapid devolution, just as it has undergone rapid evolution. The task of the psychiatrist is therefore threefold: 1) to support the outflow of the crisis; 2) avoid its degeneration by securing the patient and bystanders; 3) throw an anchor into the whirlpool of the storm in order to then hook the patient to the treatment. The best therapy of the acute episode is to consider the patient in treatment even after the acute, therefore, prevent the other acute episode, or otherwise mitigate the violence of the manifestation. In order for the patient to be considered in treatment, it is important that already during the acute phase a maintenance treatment project is in place, at least within the psychiatrist and the treating team. A sort of affiliation or loyalty of the patient, even if not structured as the actual taking charge. Sometimes even the structuring of a weak bond pays off. And often, given the disorganization of the territorial services, the lack of resources and personnel, the best connection that can be proposed to the patient is the weak one.

The crisis has exploded in the street or in an apartment, and has already developed, with its manifestations, in the context of first aid at home or on the street and transport to the hospital. The event in which the psychiatrist is involved in PS is therefore a terminal event, and a decisive attitude awaits us from the psychiatrist. The clinician at the same time must evaluate the space of dialogue with the patient, the possible context and explosive modalities of the crisis, the pharmacological treatment he has previously done, if and when it is appropriate to practice drug therapy and, finally, the opportunity for hospitalization, voluntary or compulsory. The unit of measurement is given by the quality of the contact that the clinician manages to structure with the "critical" conscience of the patient and with the alarm surrounding him. A series of decisions depends on the diagnosis, which, even before being a diagnosis of the underlying disease, is a provisional and state diagnosis. The psychic examination of the patient cannot follow, in this case and in these situations, a pre-established scheme and a series of psychopathological elements must, inevitably, be more presumed than ascertained. Time is missing, and space is lacking. A differential diagnosis with organist is necessary, especially in cases of psychomotor agitation. In some cases the patient is not cooperative and it is therefore advisable to put him in a position to be available to practice venous access for sampling, an electrocardiogram, a chest X-ray or a cranial CT. In some cases this procedure cannot be practiced if the patient is not previously sedated, since he is not cooperative. In some cases the patient is inside his hallucinatory or delusional world, which becomes inclusive of others, who are reduced to the role of actors of his persecutory parts. Sometimes it is easier for the medical or nursing staff of the hospital to have access to the patient and administer drug therapy, since the patient tends to live as more neutral hospital workers, and to connote, instead, as persecutors psychiatrists and psychiatric nurses.

Especially if it is a chronic psychiatric patient in the process of exacerbation and decompensation. The main anchor of the psychiatrist is his own feeling. The acute modification of the psychotic presence is articulated and is given, above all, as a modification of feeling. Or in some cases, acutia is manifested by a complete involvement of the patient's state of consciousness. This entails a radical catastrophe of the patient's situation of existence and of the relationship with the other, which sinks simultaneously with the relationship with himself. Conrad's capital text on incipient schizophrenia [23] can become a sort of compass, still very valid, in the course of acuteness. The anguish experienced by the patient in acuteness, for example, may be proportional to the degree of stabilization or crystallization of the experience. If the patient experiences a magmatic phase, such as the tremor phase described by Conrad [23], superimposable with Wahnstimmung (WS) or with the experience of Weltunterganserlebnis (WUE) of Callieri, his anguish is maximum. If, on the other hand, the patient accesses the acute situation already with a productive superstructure (consolidation phase), then his anguish is somehow channeled. The very acute phase (trembles) is characterized by exponential anguish, the patient lives a universe that loses ordinary meanings and has no new ones, but the atmosphere is sinister and pregnant with negative omens. The patient at this stage has a perplexed, hypervigilant or detached attitude, questioning and pervaded by anxiety. Growing tension (Spannungstimmung), indeterminacy, inexplicable, incomprehensibility are constants, along with the premonition of catastrophe. At this stage, the attitude of the psychiatrist must be marked by reassurance, at a distance, avoiding starting a dialogue without gravity.

The clinician must never stop thinking, with responsibility, that there is a moment of negotiation in which the patient gives in, delegates, in some way, beyond the symptoms and beyond appearances, trusts a stranger, who at that moment perhaps knows more than him what is

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happening. If this happens the clinician sees the light at the end of the tunnel. Life can begin again, for him and for the patient, even a minute later, beyond the end of the world.

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