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How Do We Define a Disease in Psychiatry? - Kurt Schneider's *Clinical Psychopathology*

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Abstract

Kurt Schneider's principal work *Clinical Psychopathology* is generally considered to be a comprehensive textbook of psychopathology similar to *General Psychopathology* by Karl Jaspers. However, Schneider's book focuses exclusively on the diagnosis and classification of mental disorders, and his methods assume that some mental disorders are diseases, while others are not. He defines disease in the context of psychiatry and introduces the key concept of "destroying the meaningful continuity of the individual's life history." He divides mental disorders into three major groups: abnormal variations of psychic life; psychoses with a clear somatic basis (organic, symptomatic, and toxic psychoses); and endogenous psychoses. There are four different types of psychiatric diagnoses, in decreasing degree of severity: differential diagnosis in psychoses with a clear somatic basis, differential diagnosis that assesses whether a disorder is psychosis; differential typologies in endogenous psychoses; and pure typologies in abnormal variations of psychic life. Schneider always keeps his eyes on the scientific aspect of psychiatry and strives to establish a practical clinical psychopathology, an approach that informs the essence of his book. Here, we examine the application of his views to current psychiatric thinking, as follows:

▶By recognizing critical differences between psychiatry and medical science, we can explain to patients the characteristics of their psychiatric diagnosis and classification.

▶When a mental disorder is assigned to one of the three groups described above, we

can recognize the direction research should proceed in and what we should pay attention to.

▶If a new disorder is proposed, we can refer to Schneider's work to confirm which of the three mental disorder groups it belongs to and discuss appropriate treatment and management.

▶We must gain perspective into the patient's life to examine the meaningful continuity of the individual's life history. In doing so, they can recover from low self-esteem. Providing such care every day can have a therapeutic effect on patients.

▶Mental competency should be evaluated in individuals charged with a crime who are suspected to have a mental disorder at the time of the crime. If the individual is diagnosed with a mental disorder, lawyers should emphasize the importance of confirming whether the mental disorder is a disease or not.

Keywords: clinical psychopathology, classification, Schneider, ideal type, Heidelberg school

Introduction

The author is devoted to traditional psychiatry and the Heidelberg school as represented by K. Jaspers and K. Schneider (6). Schneider's main work, *Klinische Psychopathologie* (Clinical Psychopathology) (7) seems like a textbook but is not as comprehensive as Jaspers's *Allgemeine Psychopathologie* (General Psychopathology) (2). Rather, Schneider's is a true work of *clinical* psychopathology with its focus on diagnosis and classification. The author's primary attraction to Schneider's book relates to its guidelines for certain diagnostic problems encountered by clinicians, including how far one can go in asserting their correctness. It is hard to say that Schneider's book is easy to read given how strict it is. In this paper, I will explain the main points using the author's own words, giving priority to clarity over strict rigor. This paper largely overlaps with Reference (6) in Japanese.

I. What is a disease in psychiatry?

1. Is every mental disorder a disease?

The question "Is every mental disorder a disease?" has two answers: "some mental disorders are morbid states (diseases) and some are not," and "all mental disorders are morbid states." Many clinicians would intuitively favor the former, but neuroscientists (brain scientists) would surely favor the latter. On reflection, this question has no right answer; we can only ask ourselves which answer we believe. With the

advancement of scientific technology, more physicians seemingly favor the latter answer. If that is indeed the case, we can simply define a mental disorder and shelve the question about how to define the word "disease." However, this idea must assume that mental abnormalities are always physical abnormalities and that the somatic basis common to them can be objectively ascertained. Today, schizophrenia and other major mental disorders are not at that level.

As Schneider assumes the former position, we must answer the question, "What is a disease in psychiatry?"

2. Definition of disease in psychiatry

The term "disease" has various definitions in physical medicine, but I will use the term "concept of existence" to define disease as "the presence of a somatic basis that is clearly distinguishable from normal health (and can be objectively grasped)." The concept of existence applies to almost all diseases in physical medicine. In psychiatry, the concept of existence easily applies to "psychoses with a clear somatic basis" (i.e., organic, symptomatic, and toxic psychoses). However, the concept of existence cannot be directly applied to endogenous psychosis. Schneider discusses a definition of disease useful for endogenous psychosis, introducing the term "destroying the meaningful continuity of the individual's life history," which is deeply connected with Jaspers's "understandable association" (un-understandability) (2).

When we say "understand," what exactly do we *understand* in the mind? It is not a static state of mind, but a flow of mind. For example, we understand as meaningful a series of events, beginning with a certain perceptual stimulus, the emotions and orientations that follow it, the thoughts it inspires, and the resulting actions or the decision not to act. Understanding is not based on individual elements such as perceptions, emotions, thoughts, or motivations, but rather on an integrated whole. The fact that the whole picture of the mind is generally in a continuous flow of meaningful change was termed by Schneider as "the meaningful continuity of the individual's life history." Even if great misfortune strikes you, dramatically changing your state of mind, the change is meaningful and the continuity remains unbroken. In the case of endogenous psychosis, Schneider noted that the meaningful continuity is cut off or interrupted before and after the onset of illness, which is the warrant of the disease. In psychiatry, disease is defined by two concepts. One is the concept of existence, which it shares in common with physical medicine. But if this is not the case, we must adopt

another definition of disease, the "interruption of the meaningful continuity of the individual's life history," which is unique to psychiatry. It is to Schneider's credit that he clarified the definition of disease in psychiatry.

The work of examining the meaningful continuity involves nothing less than tracing and understanding the mental history of a person. The author believes that the process of empathizing with the patient and tracing their meaningful continuity (understandable association) is itself deeply connected to psychotherapy (5).

II. Categories of mental disorders are ideal types

The fact that the categories of major mental disorders are types (syndromes) is a major difference from physical medicine, which has a well-established classification system based on disease entities. Although Schneider does not directly mention ideal types, he uses the verb "to be" for disease entities and "to call" for types. In this paper, I will focus on the role of the ideal type in psychiatry.

In psychiatry, each ideal type must have a real model case from which the concept was derived. The ideal type is a concept created by extracting characteristics that the proponent perceived as essential through clinical observation of the model case. It is not completely fictitious, hypothetical, or unrelated to reality because it is derived from an actual model case. However, the model case is no longer itself because all its non-essential parts have been discarded. The ideal type is a concept or ideologically created (derived) fiction, with its existence not guaranteed. In other words, giving patients a diagnosis of schizophrenia does not guarantee that the disease itself exists.

The criticism that ideal types are not valuable because they are conceptual fictions does not apply. On the contrary, ideal types are indispensable tools for us to evaluate, understand, and share information about the complex and diverse mental states of patients. We can evaluate a patient's mental status by applying various types like a scale to them. In doing so, certain characteristics of the patient's mental life are brought into focus. Some of them will fit perfectly, and others will not. The closest of the several types is given as a diagnosis, and an appropriate treatment plan is made based on it. Diagnosis using ideal types gives structure to a case by focusing on its characteristics. It is an indispensable tool in the treatment process.

Table 1 compares disease entities and types in psychiatry (3)(5). A disease entity is real, whereas a type is conceptual or hypothetical. In the case of disease entity, after collecting all necessary information, a case is

determined to be a disease or not. However, in the case of types, the question is to what extent the case applies. In the case of disease entities, the boundary is clear at the physical level, while in the case of types, the boundary is essentially not clear. To put it another way, a disease entity is like a "container" into which a case can be placed, providing a "boundary" to the case. In contrast, a type is like a "scale" for measuring cases, which can be described as providing structure to cases. Although disease entities have diagnostic criteria based on confirmed cases, clinical diagnoses other than disease entities are based on ideal types. To find the somatic basis of a type, one must transform the type into a hypothetical disease entity with clear boundaries. This process is called operational diagnosis.

III. The three groups of mental disorders

Schneider's theoretical classification of mental disorders is shown in Table 2. The whole is divided into "abnormal variations of psychic life" and "effects of illness (and defective structure)." In the latter category, there are mental disorders for which the somatic basis is clear and those for which it is assumed or required but not yet clear, including cyclothymia (manic-depressive illness) and schizophrenia. Thus, we can divide mental disorders into three major groups (Table 3). Abnormal variations of psychic life (the first group) are non-morbid mental disorders. Effects of illness (and defective structure) correspond to morbid mental disorders or psychoses. Psychoses are further divided into two groups: "endogenous psychoses" (the second group) and "psychoses with a clear somatic basis" (the third group).

1.The third group: Psychoses with a clear somatic basis (organic, symptomatic, addictive psychoses)

The third group consists of disease entities included in the organic, symptomatic, and toxic psychoses. The psychosis is characterized by acute confusion, chronic personality disorganization, and dementia, with a wide variety of transitional syndromes in between. The boundaries of each disease become clear only at the physical level (but they remain unclear in psychiatric syndromes). The history of psychiatry over the past hundred years has revealed that no psychopathology corresponds specifically to a single disease entity. In other words, there is no clear correspondence between symptoms and etiologies. In the case of psychosis with clear somatic basis, identifying the disease entity by psychiatric symptomatology alone is impossible,

with physical examination needed to establish a diagnosis.

As shown in Table 2, diagnosis of this group consists of two main series: somatological (etiological) and psychological (symptomatic). An example is a hallucinatory delusional state due to systemic lupus erythematosus or a manic state due to steroid psychosis. In fact, the treatment is carried out according to these two series. If a patient with hyperthyroidism presents with hallucinations and delusions, antipsychotic drugs are administered in accordance with schizophrenia, alongside physical treatment of hyperthyroidism. The treatment of psychosis is carried out using the various types of endogenous psychosis as a frame of reference.

2. The first group: Abnormal variations of psychic life

The first group, abnormal variations of psychic life, is a collection of non-morbid mental disorder types. These include psychogenic reactions (stress-related disorders), so-called neuroses, personality disorders, mild intellectual disabilities, developmental disorders, and eating disorders, to name a few. The fact that psychiatry actively addresses these "non-morbid disorders" is an important difference between psychiatry and physical medicine and is related to the role of psychiatry and psychiatric care in society and its limitations.

Although diagnostics of psychoses are based on the somatological and psychological series, no somatological series exists for abnormal variations of psychic life (Table 2). Of course, one can assume a biological basis for each type in this area, but such a claim would not be essentially different from the claim that a biological basis exists in normal psychology. The meaningful continuity of the individual's life history is consistently maintained, and no clear line of demarcation can be drawn between it and normal psychology. The difference is only relative (and should be recognized as a variation). We tend to think of patients in this group as having "poor social adjustment because they have a mental disorder." In fact, they are more accurately thought of as having poor social adjustment, which is why we consider them to have a mental disorder. Judgments of abnormality or non-abnormality (mental disorder or not) are closely linked to social values, with a handful of people with similar characteristics not considered to have a mental disorder if they are socially successful.

Let me give you an example. The ICD-11 recognizes gaming disorder as a mental disorder. Gaming disorder refers to people who spend so much of their

daily life immersed in (dependent on) games that it has a significant impact on their social life, including work and schoolwork. They want to have more control over it but they cannot. Undoubtedly, such cases are being highlighted in society, and it is easy to understand why gaming disorder is recognized as a new mental disorder. In the world of e-sports, those who spend their daily life playing games and winning cash prizes are greatly admired, and many young people aspire to be like them. In this case, it is natural that they do not want to stop playing. Rather, they want to practice and train harder in order to earn as much money as possible and make a living. Of course, e-sports players are not diagnosed as having gaming disorder. When you think about it, there is no clear difference between a patient diagnosed with a gaming disorder and a young person who wants to become an e-sports player. The young person's fate is completely dependent on how well they play games. Although gaming disorder is a newly recognized mental disorder, gender identity disorder was removed from the list of mental disorders due to increasing social acceptance. These stories clearly illustrate that mental disorders are deeply connected to social values. This area is strongly influenced by non-biological factors such as culture, time background, generation, and the state of the world. At the same time, it goes without saying that an individual's upbringing and life history are also important.

It is therapeutically important to separate this first group from psychosis, and treatment should in principle revolve around psychotherapy. At the same time, one must recognize that problems in the patient's life or fate are involved here and there are limits to what can be done for problems brought into the field of psychiatry. More emphatically, medicalization does not necessarily solve the problem.

3. The second group: Endogenous psychoses

Understanding would be made easier if all mental disorders could be categorized as either psychosis with clear somatic basis or abnormal variations of psychic life. However, it remains a mystery why even after so much scientific progress, no clear somatic bases for the diagnosis of major mental illnesses (e.g., schizophrenia) have been found.

The second group of mental disorders in Table 3, namely "endogenous psychoses," corresponds to all psychoses except for those in the third group. The somatic bases are known for all of the psychoses in the third group; those in the second group are furthermore assumed and required, even if they are

currently unknown. This is a major dilemma faced by modern psychiatry, where it is empirically understood that mental symptoms do not correspond to etiology but must begin with psychiatric symptomatology in pursuit of their somatic basis (4). We can say that the struggles of modern psychiatry over the more than 40 years since the publication of DSM-III (1980) have demonstrated just that fact again.

Understanding the inner world of patients with endogenous psychosis has its own difficulties, as represented by Schneider's first-grade symptoms, because their experiences include things we cannot relive. In the first place, patients are not given words to accurately describe their pathological experiences. They try their best to explain something they have never experienced before by using everyday language. For example, the word "depressed" somehow differs between the depression that arises as a psychogenic reaction and that of endogenous psychosis. A patient in a catatonic stupor reminds us that there are so many unspoken experiences. When trying to understand the inner world of patients with endogenous psychosis, we must keep in mind that there are limits to what language can express.

This group has traditionally been dichotomized into schizophrenia and manic-depressive illness (called cyclothymia by Schneider). Although the idea dates back to Kraepelin, Schneider clearly acknowledges the existence of transitional and intermediate forms of both mental illnesses, and he explicitly states that he does not consider each to be a single illness in a physical sense. He most likely adopted this dichotomy because of the lack of a more compelling differential typology.

IV. Meaning of diagnosis in psychiatry

In psychiatry, differential diagnosis is used in the same sense as in physical medicine and applies only to psychoses with a clear somatic basis. The only other thing that can be called a differential diagnosis would be the differentiation between abnormal variations of psychic life and endogenous psychosis, that is, the differential diagnosis of "psychosis or not" (quotation marks are used because this is not a viewpoint found in physical medicine). In comparison, only a differential typology exists between schizophrenia and cyclothymia in endogenous psychosis. Furthermore, although the typology of personality disorders appears to be a "diagnosis," it should not be called as such if it is used in the sense of diagnosing a disease. Types of personality disorders are only typologies: They don't really exist as

personality disorders, but rather as "people like that."

Diagnoses are weighted in the following order: psychosis with a clear somatic basis, endogenous psychosis (of which schizophrenia is hierarchically deeper than cyclothymia), and abnormal variants of the mind. For each case, diagnosis of the deepest layer that has been reached is then assigned. This is called the hierarchical principle (*Hierarchieregeln* or *Schichtregel*) (2). Jaspers clarified this principle and Schneider followed it.

Conclusion

How should we utilize Schneider's *Clinical Psychopathology*? Always conscious of the natural science aspect of psychiatry, Schneider aimed to establish a practical clinical psychopathology. This book contains the essence of his thinking. Let me list some of its potential applications.

We can explain the diagnosis and classification of mental disorders by recognizing the essential differences between psychiatry and physical medicine.

We can then identify a research direction as well as points for consideration based on which of the three groups a particular mental disorder falls into.

Proposal of a new category will serve as a reference frame to identify which of the three groups it corresponds to.

Empathy is essential for examining understandable associations and meaningful continuity of the individual's life history. This process effectively restores the patient's damaged self-worth, with daily diagnostic procedures producing psychotherapeutic effects by itself.

Mental competency evaluation emphasizes the discrimination between "morbid mental disorders" and "non-morbid ones".

Future-oriented research and practical treatment will require their own appropriate diagnostics and classifications, respectively. Toward the ultimate goal of psychiatry as a natural science—that is, to find the cause—the Research Domain Criteria led by the National Institutes of Mental Health (NIMH) might be increasingly adopted (1). However, Schneider's diagnostic and classification system is an excellent system for the practical treatment of the patient before us. To take full advantage of its usefulness, it is essential to fully understand its philosophy and account for its limitations. My previous article (6) discusses psychiatric disorders and diagnosis based on Schneider's book and serves as a reference for those

interested.

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Table 1 Difference Between "Disease Entities" and "Types" in Psychiatry

	Disease Entities	Types
Characteristic feature	Reality	Ideal type
Case application	Yes or No	Extent to which a case matches the type
Boundary	Clear at the physical level	Vague at the symptomatologic level
Explanatory analogy	A "container" to hold the case Provides "boundary" to a case	A "scale" to measure a case Provides "structure" to a case
Diagnosis	Utilizes diagnostic criteria based on definite cases	Applies an ideal type to a case Utilizes operational criteria to pretend a disease entity

Table 2 Theoretical Classification of Mental Disorders

Group I. *Abnormal Variations of Psychic Life* Abnormal intellectual endowment Abnormal personality Abnormal psychic reaction	
Group II. *Effects of Illness (and Defective Structure)*	
Somatic etiology	*Psychic symptomatology*
Intoxication G.P.I. Other infections Other internal disorders Cerebral defect Cerebral damage Cerebral arteriosclerosis Senile disorder Other cerebral disorders Idiopathic epilepsy	Acute: Clouded consciousness Chronic: Personality deterioration (where innate, arrest of personality) and Dementia
? ?	Cyclothymia Schizophrenia

Table 3 Three Groups of Classification of Mental Disorders

Groups		Disease Entity or Type	Somatic Basis	Category Characteristic	Diagnosis Characteristic
Abnormal variations of psychic life (First group)		Non-morbid type	Not be assumed	Ideal type	Typology not to be called a diagnosis
Endogenous Psychoses (Second group)	Cyclothymia ---------- Schizophrenia	Morbid type	Postulated	Ideal type	Differential diagnosis between the first and second group Differential typology within the group
Psychoses with a clear somatic basis (Third group)		Disease entity	Clear	Reality	Differential diagnosis