

\* This English manuscript is a translation of a paper originally published in the *Psychiatria et Neurologia Japonica*, Vol.124, No.6 p.397-404, which was translated by the Japanese Society of Psychiatry and Neurology and published with the author's confirmation and permission. If you wish to cite this paper, please use the original paper as the reference.

## **Special Feature Article**

### **Pure Psychiatry: Returning to Traditional Psychiatry**

Hiroki KOCHA

Department of Neuropsychiatry, St. Marianna University School of Medicine

*Psychiatria et Neurologia Japonica* 124: 397-404, 2022

#### **Abstract**

There are two ways of thinking in psychiatry—one is biological psychiatry, which is research-oriented and based on the idea that mind is merely a reflection of brain function, and the other is pure psychiatry, which is clinically oriented and focuses on the mind itself. Current psychiatry is tilted strongly toward the biological perspective and has lost its balance. Arguments in favor of pure psychiatry are not new and are based on the Heidelberg School, a traditional school of psychiatric thought. It postulates that some mental disorders are morbid, and others are nonmorbid. It admits both causal relationships and understandable relationships, and appropriately applies one of them on a case-by-case basis. The Heidelberg School never denies the role of biological psychiatry because it is an important component of pure psychiatry. Biological psychiatry and pure psychiatry provide different viewpoints for each patient. In this presentation, I describe and compare each perspective. From the viewpoint of biological psychiatry, each patient is just one sample from a population of patients with a mental disorder. Conclusions are not drawn by considering an individual patient alone. From the viewpoint of pure psychiatry, every individual is the patient—we try to find something universal within them. I also discuss some problems in current psychiatric education that stem from the imbalance of psychiatric trends, and I describe the appropriate direction in which psychiatry should proceed based on the thinking of pure psychiatry.

**Keywords:** pure psychiatry, biological psychiatry, brain science, causal relationship, understandable relationship

## Introduction

Psychopathology and biological psychiatry were once likened to two wheels on a cart. This was more than 30 years ago, when the term biological psychiatry was still a novelty. Psychopathology could be replaced by the social sciences, and biological psychiatry by the natural sciences. Since physical medicine is essentially a natural science, the difference between psychiatry and physical medicine becomes clearer. The analogy of two wheels is a perfectly fitting phrase. Both wheels must be firmly on the ground in order to move in the right direction. If one of the wheels is floating, it is a one-wheeled vehicle, and the direction will not be determined. The two wheels must be parallel to each other in order to proceed smoothly. Parallelism also means that they never intersect. It means that they are neither superior nor inferior, nor can they be reduced to one or the other. The pure psychiatry<sup>9)</sup> advocated by the author is based on such a structure peculiar to psychiatry. It seems to me that the situation of psychiatry in recent years is such that this structure is in jeopardy. This article

reviews the history of modern psychiatry, contrasts the worlds of pure psychiatry and biological psychiatry (neuroscientific psychiatry), and discusses how these two trends have affected psychiatric education.

## I. Trends in Modern Psychiatry

### 1. Birth of DSM-III

Looking back over the past half century, the most epoch-making event in modern psychiatry was the birth of the "Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III)"<sup>1)</sup> in 1980. The following is a brief history of the birth of the DSM-III. There were a number of triggers. In the 1970s, the anti-psychiatry movement was ignited, and U.S. psychiatry found itself in a difficult position. The situation was such that American psychiatry was under pressure to regain its credibility, and the establishment of an objective diagnostic classification was urgently needed as a breakthrough. Spitzer, R. L., was entrusted with this task. A research paper on the classification of mental disorders<sup>4)</sup> published by a small group at St. Louis University in Washington, D.C., caught

his attention. At that time, when psychoanalysis was the mainstream of American psychiatry, the St. Louis School considered mental disorders as medical diseases and studied their classification under the motto of positivism, as in other medical fields. They are also called neo-Kraepelinian, and the origin of their philosophy, which led to the DSM-III, is found in a 1970 paper by Robins, E. and Guze, S. B.<sup>12)</sup>. The DSM-III was born in 1980 after the St. Louis Criteria<sup>4)</sup>, which caught Spitzer's attention, and the Research Diagnostic Criteria<sup>13)</sup>, which further expanded the scope of patient fields. The DSM-III is characterized by its operational criteria, its atheoretical nature, its primary purpose of use for research and statistical studies, the fact that the categories and diagnostic criteria are only working hypotheses, and, if I may add one more thing, there is the expectation that the repeated revisions will lead to the disease entities that we are looking for. The disease entities, defined by psychopathological features, appear to be implicitly assumed, although it is not explicitly stated because it is stated as atheoretical nature. The introduction of the DSM-III was the driving force behind evidence-based psychiatry, and it has allowed psychiatry to join the ranks of the natural sciences. Perhaps the greatest achievement of the DSM-

III is that it has successfully restored the prestige of American psychiatry, which had been in decline. For a detailed history of the DSM-III, refer to Reference<sup>10)</sup>. I recommend reading it.

## 2. Developments Since DSM-III

The DSM-III has had a greater impact on psychiatry worldwide than anyone, including those involved in its creation, could have imagined<sup>3)</sup>. The leadership of psychiatry shifted from Europe (Germany, France, and the U.K.) to the United States. Advances in science and testing technology, of which the U.S. is at the forefront, have made possible a succession of studies on receptors, genes, and functional brain imaging, as well as advanced statistical studies using computer technology. The synergistic effects of these developments have encouraged the rise of biological psychiatry (brain-based psychiatry), while psychopathology and psychoanalysis, which do not benefit from these advances (and are incompatible with natural science), have inevitably been forced into decline. Therefore, the trend toward the supremacy of evidence-based psychiatry was greatly promoted.

It seemed that psychiatry had a bright future ahead of it, but things did not turn out that way. While there have been some advances, the expected results have been slow to materialize.

For example, we have never been able to get close to the search for the physical basis of schizophrenia, which is directly related to the diagnosis. We began to wonder why, and over time, a major problem that had been a blind spot became apparent. That is the category validity problem. The DSM classification has undergone four revisions in the 40 years since 1980, but even the most advanced science and technology has failed to clarify the physical basis of the major mental disorders. As a matter of fact, from a historical perspective, this outcome may have already been predicted. The historical studies conducted long before the birth of the DSM-III, such as Bonhoeffer, K.'s exogenous reactions, Wieck, H.H.'s transitional syndrome, and Bleuler, M.'s focal brain syndrome and endocrine psychosis syndrome, had already shown that "the types defined by psychopathological symptomatology had never been established as disease entities in the history of the world". Of course, these studies and the present day cannot be considered the same because of the difference in the level of natural scientific methodology and technology. From a different perspective, however, it may be said that we have confirmed this historical fact once again over the past half century through grand social experiments on a global scale using the highest level of science

and technology.

### 3. Turning Point in the History of Psychiatry - 2013

As with the DSM-III in 1980, we who are still in the middle of great changes do not realize them. However, when we look back 50 or 100 years into the future, 2013 will be remembered as a turning point in the history of psychiatry. This is illustrated by a series of facts that revolved around the release of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).<sup>2)</sup> The DSM-5 was criticized both before and after its release. The DSM-5 is designed as a classification system that must meet all demands of clinical practice, statistics, research (including the pursuit of physical bases), as well as insurance and justice. Both natural scientific and non-scientific requirements, including social values, must also be satisfied. It may be said to be a compromise on both sides and has been the subject of much criticism from grand persons such as Frances, A.<sup>5)</sup> and Paris, J.<sup>11)</sup> Even greater confusion was caused by the de-DSM declaration of Insel, T., then director of the National Institute of Mental Health (NIMH), the top institute for biological psychiatry in the United States<sup>7)</sup>. He clearly stated that "DSM classifications are merely labels and are not useful in the pursuit of the causes of disorders". This is not

only a criticism of the DSM-5 at the same level as Frances and Paris, but also a challenge to the 100-year history of psychiatry based on categorization since Kraepelin, E. They began to move into the world of Research Domain Criteria (RDoC), a world without diagnostic categories<sup>6)</sup>.

We have entered an era in which two classification systems with completely different paradigms (frameworks of cognition) coexist: the RDoC, which will probably be used mainly in neuroscience, and the DSM-5, which covers a wide range of other applications. That is the year 2013.

## II. Two Trends in Psychiatry

Just as the brain and neuropathology were once divided into psychiatry and neurology, psychiatry may one day be divided again into two streams. These two trends are neuroscientific psychiatry (brain science), which is research-oriented and believes that the mind is merely a function of the brain, and pure psychiatry, which is concerned with the clinical study of the mind rather than the brain. It is not at all clear what kind of results RDoC will bring in the future, but as they admit, for the time being, no results that will contribute to clinical practice can be expected.<sup>6)</sup> However, the question arises whether the remaining DSM-5 is the best diagnostic classification system in

practice. Pure psychiatry should be based on the philosophy of traditional psychiatry<sup>9)</sup>.

Depending on the viewpoint taken, neuroscientific psychiatry or pure psychiatry, the world that unfolds before one's eyes is quite different. I would like to describe and compare the world from these two viewpoints.

### 1. The World of Neuroscientific Psychiatry

Neuroscience-based psychiatry is based on the belief that all mental disorders are diseases of the brain. From their standpoint, it is sufficient to define a mental disorder, and there is no need to answer the difficult question, "What is a disease for psychiatry?" In the United States, the phrase "from the Decade of the Brain to the Decade of the Mind" is uttered, and its motto is to understand the relationship between the mind and the brain, and to deepen our understanding of brain science. This is exactly what they claim to be doing in promoting neuroscientific psychiatry. This position requires the implicit assumption that "abnormalities of the mind are abnormalities of the brain", which can be grasped in a way that we can perceive. In many cases, "perceptually graspable" here means localization at various levels, and this idea applies without problems in the field of organic, symptomatic, and toxic

psychoses. However, neuroscience does not stop there. It tries to reduce all problems of the mind to problems of the individual, especially his or her brain. Vulnerability is a favorite term of theirs. For example, they do not see adjustment disorders as a plausible response to stress, but rather as a vulnerability of the individual that is caused by the brain.

There are several other characteristics that stand out when contrasted with pure psychiatry. Neuroscientific psychiatry, being a natural science, will be positivistic. It is not possible to say anything based on only one case because of its emphasis on evidence. They adopt a methodology in which a hypothesis is formulated, many cases are collected and statistically verified, and conclusions are drawn. For them, the patient in front of them is not "this particular patient", but is merely one of many samples with some kind of disorder. Their point of view is directed toward something that may be known in the future. In the world of brain science, even normal distresses and pains are easy targets for treatment. This therapeutic practice can easily lead to an attitude of trying to find and correct defects, which in turn can easily lead to the idea of trying to improve the state of mind by changing the state of the brain in its treatment. While some people deride this approach as "cosmetic

psychiatry", it can be said that the results are easy to understand and are easily picked up by the media because the results can be perceived using images.

## 2. The World of Pure Psychiatry

What is the world of pure psychiatry? For the author, pure psychiatry is based on the thought of traditional psychiatry (Heidelberg School). First, it is important to emphasize that traditional psychiatry does not deny brain science. It is an idea that distinguishes between what should be understood in terms of brain science and what should be understood as the state of the mind (separate from the brain) and its reactions and developments. To put it simply, it is a position that recognizes both causal and understandable relationships and distinguishes between the two. This thought is based on the premise that there are two kinds of mental disorders: those that are morbid and those that are nonmorbid. The active treatment of "non-disease" is a major characteristic of psychiatry compared to physical medicine. At the same time, they can also include issues of life, destiny, and society that cannot be reduced to the individual, with the implication that they cannot be solved solely within the framework of psychiatry. In pure psychiatry, it is very important to apply the concept of

existence (organic disease process) common to physical medicine and, in cases where it is not applicable, the concept of understanding unique to psychiatry (meaningful continuity of individual life history) of the disease. This is an important point, but due to space limitations, I will refrain from explaining it in detail. For details, please refer to references<sup>8)9)</sup>. Table 1 shows the main points of traditional psychiatric thought, Table 2 shows the difference between "disease entities" and "types", and Table 3 shows the classification of the three groups of mental disorders.

The various types of endogenous psychoses, such as schizophrenia and manic depression, were proposed without knowing the relation to the underlying disease entity (organic process). While we are confronted with the historical fact that the types defined by psychopathological symptomatology have never been established as a single disease entity, we have continued our mission to pursue the physical basis of endogenous psychosis by starting from these types for the past 100 years without giving up. Herein lies the great dilemma in modern psychiatry.

In pure psychiatry, the patient in front of us is "the particular patient", and we try to find something universal in the observation of a single case. Our focus is not on the future, but on practical

treatment and assistance. Our starting point is to empathize with the "humanness" of the patient, rather than to correct his or her shortcomings. The goal is to understand the human mind (not the brain) more deeply and to restore each patient's self-valuation.

### III. Changes in University Psychiatry Departments

#### 1. Supremacy of Evidence

The bifurcation of the two trends in psychiatry is unintentionally affecting even our immediate surroundings. In this paper, I would like to focus on changes in university psychiatry departments. As you may know, most university psychiatry departments are currently devoted to neuroscientific psychiatry, with only a minority clearly advocating the practice of pure psychiatry. In clinical education, supremacy of evidence still prevails. The evidence-oriented mind of psychiatry began in 1970 with Robins and Guze<sup>12)</sup> and has been significantly promoted by the global standardization of the DSM classification and the active introduction of objective indicators and methodologies, such as symptom rating scales. The "appearance" of psychiatry has come closer to that of physical medicine, and it is finally treated on an equal footing with physical medicine. On the other hand, psychiatry has paid a heavy price. Areas such as

psychopathology and psychoanalysis, which are less easily evidenced, have declined, and the essential difference between physical medicine and psychiatry, which involves a shift of concern from the metaphysical (description of the mind) to the physical (description of the brain), remains unnoticed. As mentioned earlier, the evidence in psychiatry is constantly overshadowed by the great anxiety about the validity of categories. Without their validity, evidence based on categories will quickly lose its value.

## 2. Selection of Professors for University Psychiatry Courses

The professor who presides over the department has a great influence on psychiatric education (not only for students, but also for residents). The most important factors in the selection of professors for university psychiatry chairs are quantifiable factors such as the Impact Factor and the Grant-in-Aid for Scientific Research, which are results backed up by evidence. Compared to these figures, clinical and teaching abilities cannot be easily evaluated and tend to be secondary. Professor selection seems to favor researchers over clinicians and basic research over clinical research. The serious issue unique to psychiatry is marks of papers. English-language papers have higher value, and

Japanese-language papers without an impact factor, no matter how excellent they are in terms of content, are not easily recognized in terms of performance in the selection of professors. Doctors with excellent clinical skills but poor performance tend to leave the university because their efforts are not rewarded. There was a time when most professors were specialists in psychopathology, but nowadays they are very few. Now it seems that professorships are more likely to be filled by those with a track record in clinical pharmacology, brain science, statistics, or basic research. I do not intend to criticize such a trend itself. However, it is rare that a highly accomplished researcher is also an excellent clinician. One of the major problems caused by these multiple factors is the significant decline in clinical education capability at universities.

## 3. Issues of Concern

The most important role of university psychiatry departments should be to train competent clinicians. Many medical students want to become good clinicians, and society's greatest expectation of them is that they will be good clinicians. The following are some of the problems with current psychiatric education that should be addressed.

- The tendency to neglect the parts of

psychiatry that cannot be evaluated by evidence.

- The tendency to promote "psychotherapy" that focuses only on the patient's defects and aims to correct them.
- Lack of good clinicians at universities to serve as role models.
- Few young physicians attend senior doctors' clinics.
- The value of "learning by experience" is underestimated.
- Paper case review meetings without patients.

#### IV. Necessities for Training Competent Psychiatrists

##### 1. Competencies of Competent Psychiatrists

Current university psychiatry departments do not seem to be sufficient for training competent clinical psychiatrists. What is necessary for their development? This naturally follows from the question, "What abilities do they have? It is of course essential to have sufficient academic knowledge of clinical psychopharmacology and brain science. However, competent clinical psychiatrists also possess the following outstanding abilities. Some of these abilities may be considered "non-academic" abilities.

- The ability to understand the patient's state of mind and condition

through communication.

- The ability to elicit information about family structure, occupation, educational background, and general life history (which can be used as material for understanding).
- The ability to determine if the patient has a mental disorder, if it is morbid or nonmorbid when he/she has one, and if treatment is necessary.
- The ability to empathize with the patient so that the patient feels that he/she has been listened to.
- The ability to give warm words to the patient in a way that restores their self-valuation (and gives them hope).
- The ability to work as a team with nurses, public health nurses, and caseworkers.

##### 2. First, Understandable Relationships Rather Than Causal Ones

How do we try to understand a patient in front of us? It is important to first try to understand the mind from an understandable perspective, rather than from a causal perspective. Then, when comprehending by understanding hits a wall, or when it becomes necessary, we shift our viewpoint to the causal relationship, in other words, we switch to explanations based on brain science. It should not be overlooked that the process of empathy and understanding itself promotes the recovery of the patient's self-valuation.

This seems to be the essence of psychotherapy. It goes without saying that the way to understand not only the patient, but also the patient's family and the patient's situation should be by the understandable relationship, not by the causal relationship from their individual brain. In this way, neuroscientific psychiatry does not seem to be very useful in training competent clinical psychiatrists, at least at the present time. In order to become a competent clinical psychiatrist, it is important to learn the various perspectives of pure psychiatry, and more effort should be made on this part as an introduction to psychiatric education.

### Conclusion

At the beginning of this article, I compared the unique structure of psychiatry to two wheels of a bicycle, and I would like to add a few words at the end. Again, the idea of pure psychiatry is not to deny biological psychiatry (neuroscientific psychiatry). Biological psychiatry is one of the wheels of pure psychiatry and an important component of it. Its role is to carry the natural science aspect of psychiatry, to be the driving force. Its energy can be used in any way, and it has no ability to set the direction. Sometimes it even deviates from the normative course it should take. On the

other hand, the social science component of pure psychiatry (including psychopathology in particular) is a robust construct, the essence of which is history. Although it has no driving force of its own, it plays an important role in setting the direction in which psychiatry should go. This is why I would like to emphasize the importance of pure psychiatric thought as the basis for psychiatric education. I have run out of space. If you would like to know more about the thoughts of pure psychiatry, please refer to the reference<sup>9)</sup>.

I have no conflicts of interest to disclose in connection with this paper.

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表 1 伝統的精神医学の思想

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- ①精神障害には「疾患的であるもの」と「疾患的ではないもの」があることを前提としている。
  - ②疾患の定義は身体医学と共通する存在概念とそれがあてはまらない場合に精神医学固有の了解概念（生活発展の意味連続性）を適用している。
  - ③分類体系には疾患単位と類型が混在していて、主要な精神障害は類型である。
  - ④類型は形而上の水準で定義されたもので社会科学の方法論である理念型である。
  - ⑤精神障害は「疾患的ではないもの」「身体的基盤が明らかな精神病（器質性・症状性・中毒性精神病）」「身体的基盤が要請されている精神病（内因性精神病）」の3つの群に分類される。
  - ⑥「疾患的ではない精神障害」の類型は、自然科学的に見いだされたものではなく、社会的価値の視点から取り上げられたものでさまざまな形で現れている社会的不適応の類型である。
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Table 1: Thought of Traditional Psychiatry

- (1) It is assumed that there are two kinds of mental disorders: "morbid" and "nonmorbid".
- (2) The definition of disease applies the concept of existence (organic disease process) common to physical medicine and the concept of understanding unique to psychiatry (meaningful continuity of individual life history) in cases where the concept of existence is not applicable.
- (3) The classification system is a mixture of disease entities and types, and major mental disorders are types.
- (4) Types are defined at a metaphysical level and are ideal types that are the methodology of social science.
- (5) Mental disorders are classified into three groups: "Nonmorbid mental disorders", "Psychoses with a definite physical basis (organic, symptomatic, or toxic psychoses)", and "Psychoses with a required physical basis (endogenous psychoses)".
- (6) "Nonmorbid mental disorders" are not found in natural science, but are social maladjustments that have been taken up from the viewpoint of social values and manifested in various forms.

表 2 精神医学における「疾患単位」と「類型」の違い

	疾患単位	類型 (理念型)
性質	患者に実在する	われわれの思考のなかにある
個々の症例への適用の仕方	であるか, でないか	どの程度あてはまるか
境界	身体的水準での境界は明瞭	精神症候学上の境界は曖昧
たとえるならば	症例を入れることのできる「容器」 症例に「境界」を与えるもの	症例を測るための「物差し」 症例に「構造」を与えるもの
診断をつけるためには	確定された症例に基づき作成された 診断基準を使う	理念型を物差しのようにあてがう 必要があれば操作的診断を用いる

Table 2 Difference Between "Disease Entities" and "Types" in Psychiatry

Disease Entity

Type (Ideal Type)

Nature Real in the patient

In our thinking

How it applies to individual cases

To be or not to be

To what extent does it apply

Boundaries

Boundaries at the physical level are clear

Boundaries at the of psychopathological symptomatology are unclear

For example

A "container" in which a case can be placed, What gives a case "boundary"

A "measure" to measure the case, What gives a case "structure"

To make a diagnosis

Use diagnostic criteria based on confirmed cases.

Applying an ideal type as a yardstick.

Operational diagnoses are used when necessary

表3 精神障害の3つの群

群の名称	疾患単位か類型	身体的基盤	カテゴリーの性質	診断の性質
第一群： 心的あり方の異常変種	疾患的ではない 類型	想定されない	理念型	診断とは呼べない 類型学
第二群： 内因性精神病	疾患であることが 想定されている類型	要請される	理念型	「心的あり方の異常変種」との 境界は鑑別「診断」  内因性精神病の なかでは鑑別類型学
第三群： 身体的基盤が明らかな精神病	疾患単位	明らかである	実在	鑑別診断

Table 3: Three Groups of Mental Disorders

Name of the group

Disease entity or type

Physical basis

Nature of category

Nature of the diagnosis

Group 1: Abnormal variant of mentality, Not a disease

Non-disease type

Not assumed

Ideological type

Typology which cannot be called a diagnosis

Group 2: Endogenous psychosis

Type of disease that is assumed to be a disease

Requested

Ideological type

Boundary between "abnormal variant of mental state" and "abnormal variant of mental state" is differential "diagnosis".

Differential typology among endogenous psychoses

Group 3: Psychosis with a clear physical basis

Disease entity is clear Existence Differential diagnosis

Obvious

Exist

Differential Diagnosis