Psychosis and schizophrenia: effects of changes in psychiatric classifications on clinical and theoretical approaches to mental illness

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Abstract

This article discusses changes in the diagnostic classification systems for mental illness, especially the conceptual weakening of the "psychosis" category while schizophrenia became the only psychosis. Current pathological classifications prioritize a physicalist approach. Consequently, conditions that previously were associated with neurosis and subjectivity are being medicalized, conditions previously recognized as psychotic are relocated under the heading of personality disorders, and psychosis has been reduced to schizophrenia and considered a deficit of psychic functions. This article indicates the clinical and operational validity of the notion of "psychosis" as a nosographic category permitting a more complex approach to "schizophrenia", which in psychiatry is the last concept that bears the symbolic weight of madness.

Keywords: psychosis; schizophrenia; psychiatry; psychoanalysis; Diagnostic and Statistical Manual of Mental Disorders.

This article discusses the changes which have occurred in the diagnostic classification systems for mental illness, especially regarding the conceptual weakening of the psychosis category, at the same time that schizophrenia has become dominant as the only condition recognized as psychotic. Although the adjective "psychotic" remains in the classifications, since the third revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) published in 1980 by the American Psychiatric Association (APA, 1980), the notion of "psychosis" as a category was abandoned. This term had designated a class of disorders opposed to the "neuroses" (a concept which in turn was also discarded from the new classifications). This new inflection represented a paradigm shift, weakening the description of mental illnesses based on assumptions we could call psychodynamic in favor of a physicalist approach to mental pathology. At least three major consequences of this change can be seen, in terms of disease classification and clinical application. The first is the medicalization of conditions which had previously been associated with subjectivity, such as anxiety, sadness, obsessive thoughts, phobias, sexual behaviors and others – all of which had previously been approached from the framework of the neuroses as conceived by psychoanalysis. The second consequence is that conditions which had previously been recognized as psychotic have been relocated to fit under the heading of personality disorders. The third consequence, which we will discuss in detail, is the reduction of psychosis to schizophrenia; in other words, schizophrenia became the only condition which is currently recognized as psychotic. We will discuss this last aspect, emphasizing the consequences of the fact that the "only psychosis" remaining is a condition approached from the viewpoint of a deficit of psychic functions.

We are addressing the practical field of mental health in which we work, where we notice that the proliferation of diagnoses generated by the DSM has frequently had a disorienting effect in relation to diagnosis and the clinic – mainly the effect of a lack of familiarity with psychosis where it often appears. We will attempt to indicate, within both the description of diseases and psychiatric classification, how current leanings make psychosis more difficult to recognize, except when disruptive or deficit-related symptoms occur. In this sense, our approach lies within psychiatric doctrine and the dialog between psychoanalysis and psychiatry, although it does not neglect to consider and mention the convergence of economic and social processes which have contributed to the transformations we discuss. We know from Canguilhem (2012) that it is impossible to separate the internal reading of a scientific discourse from its external reading, since this latter creates the conditions which make the referred discourse possible, and that often the multiple processes which unfold in a particular historical, social, and economic context decisively determine the phenomena within that discipline (cf. also Latour, Woolgar, 1997).[1] Our objective is to indicate, in a way which can be useful to the work of mental health professionals, the clinical validity of the division between neurosis and psychosis, its great value in terms of practical guidance, and above all, the need to pursue a deep understanding of psychosis as a psychopathological condition that does not define a "handicap" type situation in terms of mental function, but instead a subject's specific logic for functioning in the face of the demands of life and subjectivity.

Psychosis as a category of psychiatry

The notion of psychosis was the category that determined psychiatry for almost two centuries. In its strong sense, it defined or defines a deep psychological structure – a specific mode of subjective constitution and functioning – as opposed to neurosis, and its expression in symptoms can vary greatly. In this meaning, psychosis demarcated the specific field of psychiatry, its most suitable object. However, this concept has been abandoned by current classifications – the DSM, currently in its fifth edition, and the World Health Organization's International Classification of Diseases (ICD) – for reasons which we will discuss. Instead, a "descriptive" or "empirical" classification of mental disorders was proposed, one that would abandon any psychodynamic reference, and limited itself to the supposedly objective identification and quantification of symptoms. Along with the abandonment of this conception and the opposition between neurosis and psychosis, the categories which had expressed the terms for psychiatry in culture for a whole century were also abandoned: paranoia, melancholy, manic depression, hysteria, and obsessional neurosis.

The stated intention of these modifications was to create as much consensus as possible in psychiatric classifications, regardless of which school the psychiatrist followed. To do this, the DSM and then the ICD declared themselves to be atheoretical, excluding the categories which involved theoretical and psychodynamic assumptions and intending to base classification exclusively on symptoms that could be empirically observed and quantified. Some works we will cite show that while this may not have been the intention, in effect these changes certainly suppressed reference to psychoanalysis. They also demonstrate how a diagnostic system exclusively based on symptoms has favored increasing emphasis on pharmacological treatment. It is not by chance that the only condition currently recognized as psychosis (schizophrenia) is a deficient condition which offers a biological interpretation, pharmacological action, and rehabilitation activities that can be both generous actions of social inclusion and at the same time can shift the balance toward a practice of normalization and adaptation, depending on the interpretation.

Psychoanalysis has been charged with sustaining the clinical and doctrinal validity of the psychosis category, to the point of spreading the feeling that this concept pertains more to psychoanalysis than psychiatry. But on the contrary, the "psychosis" category was created precisely to characterize psychiatry, initially with regard to the neurological aspects of mental illness, and later in relation to the "mild mental illnesses" that would become the *métier* of psychoanalysis itself.

The term "psychosis" was created by the Austrian psychiatrist Ernst von Feuchtersleben in 1845 to describe the psychological manifestations of mental illness, distinguishing them from the supposed alterations of the nervous system which caused them in some cases (and which were called "neuroses") (Garrabé, 1989, p.186; 2004, p.28). It should be mentioned that the term "psychosis" was created within the sphere of mental medicine precisely to differentiate the "psychic" from the neuronal, and as such was the object that characterized psychiatry. Despite the assumption that for every psychosis (every psychic manifestation) there was a neurosis (a modification in the nervous system that caused the psychic manifestations), the field that was delineated by the advent of this notion entailed the ability to describe, classify,

and treat "various psychoses without concerning ourselves with the changes in the nervous system that cause them" (Garrabé, 2004, p.29).[2,3]

At the end of the nineteenth century, the advent of neurology showed that for most mental illnesses, the previously assumed injuries did not exist, unlike in neurological diseases; the emergence of psychoanalysis explained neuroses by assigning them to certain psychological mechanisms, capable of modification through psychoanalytic treatment. Although Freud (1994b; 1994a) included paranoia in the "defensive neuropsychoses" he described in 1894 and 1896, he soon would introduce a watershed between paranoia and obsessional neurosis and hysteria: unlike the latter two, paranoia or psychosis were not curable through psychoanalysis. This established the terms psychosis and neurosis as antonyms, each hosting a certain group of psychological diseases. When it was introduced by Feuchtersleben, the term "psychosis" meant simply "psychic disease," representing practically any and all mental illness. Through the shifts we have mentioned, the term gradually came to define more severe mental illnesses, leaving the term "neurosis" to designate "milder" diseases in which the patient has "conscience of his morbid character" (Postel, 2003, p.373).

According to Postel (2003), the following psychiatric criteria became classic descriptors of psychosis: the severity of the disorders, leading to significant deficiencies or disability; lack of awareness of the morbidity of the disorder (for example, the delusional person's unwavering belief in his delusion, the absence of criticism of the maniac patient, neither one admitting they need treatment); the strange and bizarre character of the disturbances, which produce a malaise linked to this strangeness in the area surrounding them; difficulty communicating or even total lack of communication ability on the part of the psychotic patient; the retreat, or closing in himself, that accompanies a rupture with the surroundings and with reality; all this culminating in a profound disturbance of the subject's relationship with reality, of which the delusions and hallucinations are symptoms.

Bercherie (1989, p.150) notes that the work of Charcot and Magnan illustrates this process of delineating psychosis as a more severe condition than neurosis, as true insanity indeed. Charcot was trying to delineate the "permanent mental state" of hysterical patients as quite different from the hysterical patients admitted to psychiatric hospitals: instead of "hysterical insanity," he emphasized a hysterical "character" marked by "emotionalism, impressionability, and suggestibility," which was defined in relation to psychosis. During this same period, Magnan distinguished the mixed states (organic brain lesions, senile dementia, neuroses [hysteria], epilepsy, alcoholism etc.) from "true insanity or psychoses" (cited in Bercherie, 1989, p.150).[4]

Psychosis went on to be the most suitable object of psychiatry, separating neurological diseases pertaining to neurology on the one hand, from the neuroses, which became the area where Freudian psychoanalysis excelled. If a science or discipline is only characterized by describing its specific object, the notion of psychosis was the one which specified psychiatry from neurology, on the one hand, and psychoanalysis, on the other (even if the initial meaning of the term differed from how it was to be conceived eventually).

Regarding psychoanalysis, here we refer to the situation left by Freud, who despite maintaining a theoretical and clinical interest in psychosis, considered it inaccessible for psychoanalysis. Freud himself never had a regular practice with psychotic patients. As a

neurologist, he was interested in the enigma that hysteria represented for this specialty, and the invention of psychoanalysis corresponds to the rupture that Freud introduced into the understanding of this disease (hysterical neurosis). This rupture eventually inverted the very meaning of the term neurosis, which no longer alluded to the neuronal system but instead came to designate a psychopathological state characterized by the absence of organic disease in the nervous system. Regarding psychosis, Freud placed all his hopes into the work of his colleagues Karl Abraham and Carl Jung, both psychiatrists dedicated to applying psychoanalysis to this pathology. However, despite their significant contributions – first, regarding psychosis-manic depression (Abraham, 1970), and second, with regard to schizophrenia (Jung, 1986) – it can be said that only with Lacan did psychoanalysis come to develop a theory of psychosis that was not based on notions borrowed from the neurosis clinic. Another of Freud's counterparts in the area of psychosis, Eugen Bleuler, played a prominent role in psychiatry, but not in psychoanalysis, as we shall discuss below.

While the terminology was undergoing these adjustments, in which the notion of psychosis indicated severe mental diseases separated from neurological diseases and neurosis, Emil Kraepelin reordered the psychiatric classification of diseases in terms of three major clinical entities: "manic-depressive insanity," "paranoia," and "dementia praecox" (which Bleuler soon renamed "schizophrenia"). In this way, the term psychosis came to be used for this group of diseases. Psychosis (or psychoses) was understood to mean maniac-depressive psychosis, paranoia, and schizophrenia. It can be said that throughout the twentieth century, these three disorders characterized the field of psychiatry.

Emil Kraepelin: dementia praecox, paranoia, and manic-depressive insanity

The nosographic structure established by Emil Kraepelin around the turn of the twentieth century guided psychiatry for the next hundred years. By emphasizing the criteria for evolution and prognosis (introducing the dimension of the course of the disease over time), Kraepelin: (1) formalized maniac-depressive insanity as a single disease; (2) isolated paranoia as an independent clinical condition, reducing the extent of this morbid entity; and (3) grouped together into a single clinical entity diseases which had previously been considered separated: hebephrenia, catatonia, and much of what had been called paranoia. This new entity, dementia praecox, would later be called schizophrenia.

The condition that many authors recognize as "the schizophrenia before schizophrenia" (Garrabé, 2004, p.17-20) was described by Bénédict-Augustin Morel in his Études cliniques of 1851-1852, and was named "dementia praecox" ten years later, in his 1860 *Traité des maladies mentales*. According to Garrabé, Morel (cited in Garrabé, 2004, p.19) described this "curious intellectual degradation of the second age" that evolves by successive stages of torpor and agitation until reaching the "terminal phase of psychological dissolution", indicating the traits which even today are found in descriptions of the disease: suggestibility, stereotypy of attitudes, gestures, and language, catatonia, smirks and bizarre tics, negativity (which he called nihilism), and "the strange way of walking". Morel stated that "the outcome of idiocy and dementia is the sad crown of evolution." This princely description was renewed in 1871 by Ewald Hecker, who described this clinical condition as hebephrenia

(in reference to Hebe, daughter of Zeus and goddess of youth): a psychosis that erupts at puberty, characterized by intellectual impairment, psychomotor inhibition, negativism, irregular moods, with manic, depressive, and confused states, hetero and auto-aggression, progression to dementia, and, most notably, immaturity (cf. Nobre de Melo, 1979, p.237-238). What Hecker added was the identification of anomalies in syntactic construction and a tendency to deviate from the normal way of speaking and writing – formal changes in language that, according to Hecker, express a profound breakdown of the Ego and are early indications of the intellectual weakening that will occur later.

Meanwhile, catatonia was described in 1874 by Karl Kahlbaum (1999) as a psychomotor pathology characterized by loss of motor spontaneity and initiative, inertia, negativity, stereotypy of gestures, and catalepsy, which could sharply transform into agitation and impulsive violence, progressing to phases of melancholy, mania, stupor/confusion, and dementia.

Using the evolution criterion (clinical-evolutionary method), Kraepelin was able to recognize "intimate analogies" between the two diseases: "emergence in the second age, psychological breakdown, affective indifference, and finally, more or less rapid termination by dementia" (Nobre de Melo, 1979, p.238). Kraepelin made these similarities prevail over the phenomenological differences. The same criterion allowed him to separate these diseases from maniac-depressive psychosis, notwithstanding the occurrence of manic and depressive states in both, since an essential notion of maniac-depressive psychosis is the full recovery of the personality at the end of each episode, which does not occur in hebephrenia or catatonia.

Regarding to paranoia, as it was considered until that time, it encompassed all the psychoses in which there was chronic delirium, whether accompanied by other changes or not, and regardless of evolution. From one extreme to another (from the delusions of Magnan's degenerates to the mere hypertrophy of certain personality characteristics according to Krafft-Ebing), everything was paranoia (cf. Cacho, 1991). Kraepelin further refined the notion, distinguishing two types of chronic delusions: dissociated delusions, which are accompanied by sensory errors (hallucinations) and sooner or later end in psychic decline, and interpretative and systematically evolving delusions which are not accompanied by hallucinations, do not compromise other psychological functions, and never end in dementia. He only used the term paranoia to describe the latter case. He termed the dissociated delusions that move toward deterioration "paranoid dementia", and grouped them with the hebephrenic and catatonic form to complete the dementia praecox group.

With his work, Kraepelin established the precise definitions of "dementia praecox" (which represents what Bleuler will later call schizophrenia), "maniac-depressive psychosis" and "paranoia." In other words, he established the psychoses of the twentieth century, which would be the setting for psychiatric nosography for the next hundred years.

Briefly, Kraepelin's dementia praecox (2004, p.19) is the mental illness defined by "a peculiar destruction of the internal connections of the psychological personality. The effects of this damage on mental life predominates in the emotional and volitional areas." It begins during youth and leads to a state of dementia; its three clinical forms are paranoid, hebephrenic, and catatonic dementia praecox.

The similarity between the fundamental clinical condition within this new disease classification and Morel's old description of dementia praecox allows us to confirm some link between the two. However, by grouping Morel's dementia praecox with other clinical conditions, and sidelining the many differences related to symptomology, Kraepelin gave new existence to a much broader range than Morel's classification permitted. Garrabé (2004, p.20) attributes this difference to the fact that Morel's French tradition favored nosology, or the clinical description of a clinical condition and its distinctive traits, while Kraepelin's German tradition favored nosography, the description and classification of diseases. For this reason, the German school was noted for producing broad categories of classification, while the French school was known for its description of conditions characterized by their differences and specific qualities. The pseudopods of Kraepelin's dementia praecox and especially of Bleuler's schizophrenia came to absorb and relegate to oblivion several conditions that the French tradition had isolated into their discrete elements.

Eugen Bleuler: schizophrenia

In 1911, Eugen Bleuler, a psychiatrist who followed Freud's ideas, proposed a new name, schizophrenia, for the morbid entity Kraepelin had grouped together. The word itself indicates the emphasis on psychological aspects, in particular the splitting of personality (from the Greek *skhízein*, to separate or split). In creating the name schizophrenia and proposing that it replaced dementia praecox, Bleuler (1993, p.38) stated that he sought to deepen the study of pathology by "applying Freud's ideas to dementia praecox." He proposed defining and naming the disease not for its evolution, but for its psychological dynamics: "Unfortunately, we cannot escape from the unpleasant task of forging a new term for this nosological group. ... I call dementia praecox 'schizophrenia' because ... the splitting of all types of psychological functions is one of its most important characteristics" (Bleuler, 1993, p.38; emphasis in the original).

Bleuler (1993, p.45) defines schizophrenia as a group of psychoses characterized "by a change in thought, in feeling, and in relations with the outside world of a particular type that we cannot find anywhere else." There is "a more or less distinct division of psychological functions," the personality "loses its unity," concepts lose their integrity and are often reduced to partial representations, and associative activity is fragmented and stops abruptly, losing its connection and instead leading to something bizarre. In the most serious cases, all manifestations of affect are abandoned; in less severe cases, affect is inappropriate. These so-called fundamental symptoms became known as the "three As" of Bleuler's schizophrenia: ambivalence, split associations, and inappropriate or flattened affect. Another symptom is added to these, which Bleuler (1993, p.55) introduced a new term to describe: autism, which is "a tendency to place their own fantasy above reality and retreat from the real world." Finally, "accessory" symptoms, which are not exclusive to schizophrenia, can also be observed: hallucinations and delusional ideas, confused and crepuscular states, manic and melancholic emotional swings, and catatonic symptoms.

With regard to this new term, "autism," Bleuler (1993, p.112, note 80) explains in a note that "autism is more or less the same thing that Freud calls autoeroticism," but that he coined

the new term to avoid misunderstandings that could stem from the Freudian concepts of libido and eroticism. Bleuler (1993, p.112, note 80) states that autism refers to a disconnect from reality, but that a term other than "loss of reality" was needed because this disconnect is selective; the schizophrenic patient does not disconnect from reality as a whole, he disconnects only from what is "in opposition to the patient's complexes." This is, therefore, a libidinal position that alludes to its causality in the psyche, but like other authors Bleuler preferred not to link it to the sexual as posited by Freud, transforming "autoeroticism" into "autism." In this case, the suppression of the sexual is literal: take "eros" out of the word "autoeroticism" and you have the word "autism."

What we refer to today as schizophrenia corresponds to Bleuler's description. In his *Manual of psychiatry*, Henri Ey gives this disease a systematic description which is worth summarizing here (Ey, Bernard, Brisset, s.d., p.534-536, 574-585).

Ey defines schizophrenia as a chronic psychosis characterized by a process of mental breakdown that can be called "dementia praecox," "intrapsychic discordance," or "autistic dissociation of personality." It is characterized by the manifestation of a deep tendency to stop constructing one's own world in communication with the other to get lost in autistic thought. According to Ey, the absence of a rigorous definition does not prevent most clinicians from understanding it in practice with regard to the diagnosis of schizophrenia:

> Generally, schizophrenic psychosis is understood to mean a set of disorders dominated by discordance, ideoverbal incoherence, ambivalence, autism, delusional ideas, poorly systematized hallucinations, and profound affective disturbances in the sense of detachment and strangeness of feelings – disorders that tend to evolve into a deficit and a dissociation of personality (Ey, Bernard, Brisset, s.d., p.536).

Faithful to Bleuler's classification, Henri Ey states that schizophrenia develops along a "negative" line, or a deficit of dissociation (dissociation syndrome), and a secondary "positive" syndrome, where delusional ideas, perceptions, feelings, and activity are produced. These two poles are complementary and connected by the following common features which are inherent to the disease: ambivalence, the bizarre, impenetrability, and isolation. The result of these two poles of symptoms is autism, taken to mean the "particular attitude of the schizophrenic," the "particular characteristic of schizophrenic psychosis" (Ey, Bernard, Brisset, s.d., p.585).

The first line, the one of the dissociation, consists of the breakdown of life related to the psyche, the internal discordance of psychological phenomena. It includes disorders related to the thought process (incoherent, disorganized, elliptical, long winded, and tangential thought, with loosening of the associative connections and the distinct symptom of the block), language (muteness, inappropriate responses, truncated or even inability to participate in conversation, obscene or insulting verbal impulses, neologisms or neological use of words and changes or even interruption of syntax, which can lead to unintelligible combinations or "word salad"), affect (leveling, fading, or even dulling of affect, or paradoxically, great sensitivity or vulnerability, inappropriate or inconsistent affection, ambivalence) and psychomotor abilities (catatonic symptoms: slowness, stereotypy, mannerisms, paradoxical occurrence of negativity and motor passivity, agitation, and stupor).

The second line, that of positive or productive symptoms, culminates in delirium, at least in paranoid schizophrenia, but includes the entire series of hallucinations and experiences that begin with the feeling of strangeness (or xenopathy) of thought and of mental functioning – delusional intuitions and perceptions, mental automatism, depersonalization, and the experience of influence. In paranoid schizophrenia, these phenomena are important and culminate in some delusional construction, but not to the extent of comprising systematic delirium, as they do in paranoia. Henri Ey's description (Ey, Bernard Brisset, s.d., p.584) mentions a fragmentary and disjointed delirium, "without discursive progress," which does not progress, and is labyrinthine and stereotyped, crystallized into its sparse fragments. Its evolution moves toward impoverishment. "The complete disagreement corresponds to an unspeakable delirium: it is this double regressive movement that imposes the notion of autism." Autism is, then, the "synthesis of what we have just described," the general position of the schizophrenic: "We have to understand this word [autism] as the establishment of a world into oneself, one which tends to close it in itself. In their complementary action, the negative and positive structures of schizophrenia will build this 'own world,' that is impenetrable, truly alienated" (Ey, Bernard Brisset, s.d., p.585; emphasis in the original).

Although Bleuler's description was intended to emphasize the psychological aspect, it did not avoid referring to the idea of deficit: damage in the affect, breakdown in thought and in associations, loss of reality, and as a distinctive criterion, the impossibility of *restitutio ad integrum*. In addition, this description relied on psychological characteristics that were not exclusive to schizophrenia (notably, the idea of "splitting"). Consequently, schizophrenia extended "its pseudopods toward other 'atypical' mental disorders of all the other classes," (Rancher et al., 1993, p.34), and became a notion that was too encompassing, one could say "the only psychosis" (p.14).

Bleuler thought he was being Freudian in proposing the new name, saying that he was applying Freud's ideas to dementia praecox, but Freud himself soon objected to the new term. In the same year that Bleuler published his article, Freud (1995, p.70) writes that the term "schizophrenia" is not good since it bases the name of the disease on a psychological characteristic – splitting – which is not exclusive to this affection.

As a matter of fact, schizophrenia came to replace a wide variety of clinical conditions that can only be gathered into a single entity by their deficient nature. It became the dominant notion of psychiatry, while at the same time it established the prevalent idea of mental illness as a deficit. The cognitive slant of the DSM will reinforce this approach.

Freud and Lacan: psychosis is a condition of the subject, heterogeneous to neurosis

It is beyond scope of this work to go deeper into the psychoanalytic reading of psychosis initiated by Freud and formalized by Lacan. We will recall its fundamental bases that are sufficient for the argument we are pursuing here.

Not being a psychiatrist, Freud did not have a significant case-by-case analysis of psychotics, and could not take psychoanalytic theorizing of this disease very far. Yet this did not stop him from inaugurating the psychoanalytical approach to psychosis through the analysis of autobiographical memories of an eminent judge (Schreber, 1995), written during the nine years

of his psychiatric hospitalization, memories which brought in details the patient's paranoid delusions. In the words of Lacan (1992, p.18), this analysis of Freud's was more revolutionary than the discovery of the unconscious itself; it had "the boldness... of an absolute beginning." What was inaugural about Freud's analysis? Essentially, it asserted that the delusions and hallucinations of a psychotic are formations that arise from the same issues in face of which a so-called normal subject constitutes himself or herself (cf. Freud, 1995, p.18). And these formations are not, in relation to these issues, a merely haphazard reaction, but in fact quite the opposite: "The formation of delusion, which we consider to be a pathological production, in fact is an attempt at restoration, a reconstruction." (p.66)

In studying the pathology of the adult neurotic, Freud and Lacan were able to formulate that the human subject is produced as a subject by the response that, precociously, at an early time during his subjective constitution, he gives to the injunctions related to the symbolic paternal heritage, and the summons of the sexual (a summons related to both bodily satisfaction as well as the establishment of a position, of assuming responsibilities, of accessing the roles inherent to the subject's sex). Freud formulated that the formation of the subject corresponds to the introduction of these subjective elements into the psyche, although they are housed in the unconscious, as unconscious knowledge (i.e. repressed). This knowledge operates on the subject in absentia; it propels him (as desire) to respond to the requirements of life and desire, and produces (as symptom) points of impasse, of the impossibility of permitting a certain dimension, of the difficulty of doing something, or even in the form of symptoms identified by the clinical tradition (related to anxiety, depression, dissociation, obsession etc.). Hence the difficulty of establishing a sharp border between the normal subject and neurosis as a pathology in psychoanalysis. Therefore, the mechanism is the introduction via identification of unconscious knowledge about desire and the sexual, knowledge that forms the subject himself, but which remains inaccessible to him in terms of consciousness. In the matter of the psychosis, armed with this key of understanding, Freud was able to formulate that paranoid delusion inflected these same elements, but did not know how to explain why they did not appear in the psychological interiority of a subject who could be grappling with his desire, but, instead, appeared disconnected from reality, in the form of a delusion in which the subject was always placed as an object (of persecution, of delusional love, of sexual intent, of a voice in a hallucination that always injures, threatens or commands etc.). This is what is underscored by the *princeps* case of Freudian psychosis theory, which we have already mentioned, the Schreber case (Freud, 1995). That's exactly the question Freud uses to end one of his last works on this topic: "what is the mechanism, analogous to repression, by which the Ego disconnects itself from the outside world?" (Freud, 1993, p.159).

Freud's statements regarding not allowing schizophrenia an exaggerated reach, refusing a deficit conception of psychosis, and asserting that it consists of a specific mode of formation and functioning of the subject, different from neurosis, are very important for the purposes of this article. As a contemporary of Kraepelin and Bleuler, Freud (1995, p.69-70) appreciated the separation Kraepelin established in the group of paranoid delusions, preserving organized and consistent delusions as paranoia, separated from the schizophrenia group. And he criticized the term schizophrenia created by Bleuler, for being based on a psychological characteristic

that is not exclusive to this disorder, the splitting (p.70), foreseeing and criticizing the comprehensive character that this notion was destined to have. It was probably his interest in deciphering order and meaning where psychiatry tended to see disorder that led Freud to grant a higher status as paranoia in the field of psychosis (in other words, to organized delusion) to the detriment of schizophrenia (which implied disorganization, dissociation, deterioration).

Unlike Freud, Lacan was a psychiatrist and entered psychoanalysis through the psychosis clinic. An admirer of Kraepelin's clinical finesse and the descriptive rigor of his teacher Clérambault, Lacan also prized the distinction made by Kraepelin and corroborated by Freud, the "watershed" between paranoia on the one side and the area of schizophrenias on the other. What is at stake is the same distinction mentioned previously, which we will now call by the contrast of deficit *versus* structure: "What does the term psychosis cover in the domain of psychiatry? Psychosis is not dementia. Psychoses are ... what corresponds to that which has always been called, and legitimately continues to be called, insanities. It is in this domain that Freud makes the division" (Lacan, 1992, p.12). Psychoses are the insanities, and not dementia, which means to say that it is not a deficit, a delay in development, or something like neurosis but just "less." They are another means of functioning. This difference is illustrated by Lacan's provocation: "one cannot become mad by deciding it" (p.24). That is to say, psychosis and neurosis are functional logics to which the subject is submitted. Lacan showed the heterogeneity of these logics, and at the same time the main lines of psychosis as a structure.

Producing his work in the same intellectual environment that produced Saussure's structural linguistics and the structural anthropology of Lévi-Strauss, Lacan proposes that Freud's theses can only be understood in their full extent through the statement that the human subject is a result of language, that is, of a symbolic system. The subject is forced to exist in the language which precedes him and which is imposed on him as law. The Freudian terms of intersection between paternal inheritance and assumption of sex by the subject are considered by Lacan as dimensions established by language itself, by the symbolic, for every subject. Within the limits of this study, we will say that while neurosis (which is also our normality) is the structure formed by interiorization, by the subject, of the injunctions established by the symbolic system (father, generational chain, sexual difference), psychosis corresponds to the situation where the subject cannot create a psychological interiority from these dimensions, a symbolized experience of himself. Consequently, it is not that these dimensions do not exist for the psychotic, since they were also established in their injunctive character for him, and they are what constitute and move the social bond itself. However, they have a particular form of existence, existing outside the general symbolization that structures the subject, outside any symbolization that would allow the subject to have them as the elements of his subjectivity.[5] Thus, the psychotic phenomena (hallucinations, delusions, catatonia, the oscillations of an evolution, passages to act, etc.) can be read as responses that the subject produces "without subjectivity," so to speak, responses that occur by some sort of automated system of language, but are nevertheless articulated, they have logic, and connect a subject in this paradoxical condition of psychosis. This is what lies at

the heart of the distinction between neurosis and psychosis and supports the affirmation of psychosis as a structure, as opposed to the idea of psychosis as a deficit.

In this way, as a kind of confluence of work in psychiatry and psychoanalysis throughout the twentieth century, a distinction was established between neurosis and psychosis, with each designating a class of pathology, a background condition, that corresponds to a specific way of being in life and in relation to the other; in Lacanian terms, a structure. Neurosis and psychosis, each one means: a unity of structure ("the" neurosis, "the" psychosis, in the singular) and a variety of clinical manifestations (hysterical and obsessive neuroses, and schizophrenia, paranoia, and maniac-depressive psychoses, for example, if we want to stay within the broad "pre-DSM" psychiatric categories).

The Diagnostic and Statistical Manual of Mental Disorders, the International Classification of Diseases, and current inflection: "atheoretical"?

The advent of the third edition of the DSM in 1980 represented a milestone for psychiatry, a drastic change in course. The objective of the DSM-III was to solve the problem of the reliability of psychiatric diagnoses by establishing a global and "pragmatic accord" with regard to psychiatric nomenclature, a consensus founded on explicit criteria established on empirical foundations that would set aside issues pertaining to the psychopathological processes involved (Pereira, 2004, p.1). From this perspective, it adopted what was called a descriptive approach: "The DSM-III-R can be seen as 'descriptive' to the extent that the definitions of the disorders are generally limited to descriptions of their clinical characteristics," and clinical characteristics were understood to be only those "easily identifiable behavioral signs and symptoms" that required "a minimal amount of interference on the part of the observer" (APA, 1989, p.XXIV; emphasis in the original).[6] This approach is self-described as atheoretical: "The most important justification for the atheoretical approach of the DSM-III and DSM-III-R, with regard to etiology, is that the inclusion of these theories may be an obstacle to the use of this manual by clinicians with various theoretical orientations." (p.XXIV).

For this reason, the diagnostic classes of "neurosis" and "psychosis" were removed; the former, with good reason, since it is entirely associated with psychoanalysis and inseparable from psychodynamic assumptions. The manual's glossary of technical terms does not include the term psychosis, but only the adjective "psychotic" to designate "gross impairment in reality testing." Direct evidence of "psychotic behavior" is the presence of delusions or hallucinations (APA, 1989, p.425). The nosographic entity of maniac-depressive psychosis gave way to the notion of mood disorders. Paranoia was originally replaced by the paranoid disorder category in the DSM-III, but this latter classification did not survive the revision of the manual a few years later (DSM-III-R), since "the term paranoid has several other uses that may lead to confusion" (APA, 1989, p.213). The term adopted was "delusional disturbance [or disorder]" (p.213).

The notion of disease was replaced by *disorder* (initially translated in Brazil as *distúrbio*, and finally as *transtorno*). The definition of mental disorder was intended to avoid theoretical implications of the concept of "disease," and was the following: "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is

associated with present distress (a painful symptom) or disability (impairment in one or more areas of function) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom" (APA, 1989, p.XXIII). This pattern should be generally considered "as a manifestation of a behavioral, psychological or biological dysfunction" (p.XXIII).

This definition remained more or less unchanged in subsequent editions, including the recently published fifth edition (DSM-5), but the reference to social adaptation is less hidden in this latter edition, as we can see in two places in the quote below: the replacement of the expression "psychological" with "cognition" and "emotion regulation and behavior" (we stress the idea of regulation), and the deletion of the reference to suffering or discomfort in favor of an emphasis on difficulty or inability in occupational and social activities:

> A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities (APA, 2013, p.20).

Regarding to schizophrenia, which interests us more directly, there was an initial attempt to suppress the noun, replacing it with the notion of "schizophrenic disorders," but this attempt failed and the re-inclusion of this concept was one of the corrections that prompted the revision a few years later in 1987, the DSM-III-R (cf. Garrabé, 2004, p.211). We can say that the strength of the concept forced the DSM to include it again. Thus, "schizophrenia" (in the singular) is the only classification in the DSM that is not comprised of the designation "disorders" (bipolar disorders, eating disorders, anxiety disorders etc.).[7]

In the new classification, the diagnosis of schizophrenia is now based on two essential criteria: the presence of characteristic psychotic symptoms (defined as we have mentioned) and inferior functioning at highest previously-achieved levels (or, in children and adolescents, failure to achieve socially expected levels) (APA, 1989, p.199). The characteristic disturbances in the affect and way of thinking that we have already covered are also mentioned, and are detailed in a very classical manner. However – and this is very important – the criterion adopted "excludes diseases without manifest psychotic features" (that is to say, without delusions and hallucinations) (APA, 1989, p.199). Note how a century and a half of debate, during which the position that prevailed was to consider delusions and hallucinations less important than the profound splitting of mental and emotional functioning, was resolved in a reductionist manner. From this point on, this new inflection virtually blocked the ability to address psychosis as a background structure or deep mental function of which these manifestations are not the only symptoms, nor the most important.

On this point, the manual indicates: "Such conditions may be diagnosed in this manual as personality disorders" (APA, 1989, p.199). In other words, conditions that previously would have been considered psychotic, even in the absence of delusions or hallucinations, for revealing a specific way of responding to critical situations, so to speak, were attributed to the "personality."

The psychiatrist and historian of psychiatry Jean Garrabé (2004, p.211) notes that, since it was impossible for the DSM-III to avoid the reference to Bleuler, it was made in generic

terms that mask the psychoanalytic origin of their theses. The DSM states: "Some approaches to defining schizophrenia emphasize ... underlying disturbances in certain psychological processes (Bleuler)" (APA, 1989, p.199). Garrabé further stresses that one of the clinical criteria used by the DSM for schizophrenia is the response to pharmacological treatment (Garrabé, 2004, p.212; APA, 1989, p.199). The implications are clear: the prompting of a primacy of pharmacological treatment in the clinic, and a dangerous reversal in which the effectiveness of a drug may be the criterion for establishing nosography within classification and research. How can it be said that the positions of the DSM-III are not theoretical?

The impact of the DSM-III in the clinic, in research, and in the theorization of the field of psychiatry and psychopathology was enormous: "all posterior psychopathological elaborations bear the mark of its influence" (Pereira, 1996, p.44). The principles of the DSM-III "have become, in a short time, the foundations of all modern psychiatric research and the organizers of scientific and even lay conceptions of psychopathology" (Pereira, 1996, p.44).

The World Health Organization's International Classification for Diseases, in its tenth revision published in 1992, reflects this influence by adopting the path established by the DSM-III. In its introduction, the ICD-10 states that its "descriptions and guidelines do not contain theoretical implications," and are "simply a set of symptoms and comments on which there was agreement by a large number of advisers and consultants in many different countries" (OMS, 1993, p.2). The same term disorder is adopted from the DSM, "in order to avoid even greater problems inherent to the use of terms such as 'disease' or 'illness'" (OMS, 1993, p.5). The division between neurosis and psychosis is abandoned, as it implies an act of naming that extends beyond an empirical statement:

> Instead of following the neurotic-psychotic dichotomy, the disorders are now arranged in groups according to major common themes or descriptive likenesses, which makes for increased convenience of use. ... 'Psychotic' has been maintained as a convenient descriptive term... Its use does not involve assumptions about psychodynamic mechanisms, but simply indicates the presence of hallucinations, delusions, or a limited number of severe abnormalities of behavior, such as gross excitement and overactivity, marked psychomotor retardation, and catatonic behavior (OMS, 1993, p.3).

It is a diagnosis of convenience, assumedly transitory, and openly disclaims deductions about deep functioning. The explicit goal is to be supported by global consensus. The discussion on etiology and psychodynamics is abandoned in favor of points of consensus, the symptoms that would supposedly be seen by any observer. Consequently, the diagnoses are "syndromic," in the weak sense of the term, and not "nosological" (Aguiar, 2004, p.77), in other words, they are intended to be the mere objective description of the occurrence of a specific group of signs and symptoms. As we have said, the term "disorder" responds to this new understanding, despite or even because of its inaccuracy.

As in the DSM, the diagnosis of maniac-depressive psychosis is no longer used. The category that appears in its place makes no commitment to the distinction between neurosis and psychosis: bipolar affective disorder requires the specification "with" or "without" psychotic symptoms. Names like melancholy and paranoia were abandoned in favor of depressive disorder (mild, moderate, or severe, with or without somatic symptoms, with or without psychotic symptoms) and persistent delusional disorder, respectively.

In both classification systems, among the categories that comprised the field of psychosis (or psychoses) as opposed to the field of neurosis, only schizophrenia remained as the single disorder still recognized as psychotic, although "psychotic" refers only to the occurrence of symptoms of delirium, hallucinations, and widely disorganized or catatonic behavior. The description of the clinical condition of schizophrenia has generally been based on the same set of symptoms since Bleuler's time, but with one crucial nuance: any of the manifestations listed, for which Bleuler sought a psychodynamic connection linked to the psychological "complexes," is now taken as "cognitive or emotional dysfunction," especially in the DSM, and the association with a "social or occupational dysfunction" is central to the diagnosis (cf. APA, 2002, p.304).

A critical analysis

Several studies have demonstrated that the DSM-III and its successors are far from being "free of theory." Pereira (1996) articulates some of them precisely, summarizing many of the criticisms of the new classification model. The first is that although it claims to be free of theory, the DSM actually is related with the pragmatism of Peirce and empiricist theses. This pragmatism shows itself "in the precept of conclusively excluding all unconfirmed theory," according to the "empirical validation criteria" (Pereira, 1996, p.50). The very supposition that such an objective description of the clinical facts would be possible, to the point that the intervention of the observer's gaze would become insignificant, itself is a theoretical assumption affiliated with empiricist theories. It begs the question: is it possible for this gaze to be neutral? With regard to the psychiatric and psychotherapeutic clinic or psychoanalysis, this assumption is even more absurd, since the clinical fact only reveals itself and is constituted in the relationship between the patient and the clinician, and did not exist before in the natural state (cf. Czermak, 2013).

An important line of criticism concerns the following: the practical commitment that the DSM intended to establish – excluding of the classification and communication among peers the theoretical specificities of each point of view of the psychopathological thought, so that everyone would use the same vocabulary – obliges researchers to abandon the very concepts of their own fields of knowledge. Of course, not only does psychopathology itself depend on the contradictions between different schools and traditions to progress (and we tried to show above that this is how psychiatry progressed), but also each specific discipline can only exist and progress depending on "its ability to theoretical and formally construct its object and its own methods" (Pereira, 1996, p.51). The DSM-III and its successors eventually proposed, to such different disciplines as those linked to psychopathology and mental illness, "one same object, operationally defined, i.e., an object that is common only from a descriptive point of view" (Pereira, 1996, p.51). This should call the limits of this type of manual into question.

As the DSM-III progressed into its subsequent editions, these limits expanded, an expansion we can consider serious. The DSM-III carried the warning that it was not a teaching manual, precisely because it did not include theories about the etiology, management, and treatment of mental disorders (APA,1989, p.XXVI). The next edition, the DSM-IV, ignored this prudent caveat by incorporating the "additional goal" of facilitating research and being "a didactic

tool for the teaching of psychopathology" (APA, 2002, p.21). Finally, the recently published DSM-5 arrived, proclaiming itself "an essential educational resource for students and practitioners, and a reference for researchers" (APA, 2013, p.XLI). In conclusion, as a matter of fact, the DSM replaced the old "psychiatry manuals" that contained a variety of theories surrounding a mental illness, the etiologic hypotheses, controversies between authors, and a broader psychopathological approach.

If in 1996, Pereira (p.52) stated that a pragmatic system of classification is not a deep psychopathological discourse, and that the DSM could not claim to be or to found a psychopathology, we must ask ourselves why the field of psychiatric and mental health consented so widely to abandon the entire tradition of debates in favor of a system based on statistics, cognitive adjustment, and the exclusion of subjectivity.

Russo and Venancio (2006) observed that it was not just the professional field that adhered to the DSM. Culture and society also followed suit. These authors point out a paradigm shift that is not limited to the classification of mental diseases, and reaches the question of hegemony among the knowledge that constitutes the psychiatric and psychological clinic, and the sphere of social representations relative to the individual and to the normal and the pathological.

With regard to the first question, the authors demonstrate that the empiricist assumption, which requires so-called objective evidence, has obvious affinities with the physicalist view of mental illness (Russo, Venancio, 2006, p.465). More important: the format of diagnosis through lists of clearly objectivized symptoms that create clear criteria for inclusion and exclusion in the categories perfectly converges with the randomized clinical trials conducted by the pharmaceutical industry to test the effectiveness of new drugs (p.465). At this point, it is important to point out the aspects that we previously referred to as an "externalist" reading of the processes in question (Canguilhem, 2012, p.7): the success of the DSM-III is linked to a process that involved medicine as a whole, research in pharmacology, and the pharmaceutical market. In the 1960s, randomized double-blind studies were instituted in the United States as the proper procedure for establishing the scientific validity of drugs so that their sale could be authorized by the Food and Drug Administration (cf. Healy, 1997; Aguiar, 2004). In these studies, patients with the diagnosis for which the drug is being tested are divided into two groups, one receiving the drug and the other receiving a placebo, and neither the doctors nor the patients know who is receiving the active substance (hence the name double-blind). At the end of the study period, participants are evaluated to see if their symptoms have improved, to assess whether the medication has a therapeutic efficacy that is statistically superior to the placebo. One prerequisite for this type of study is the "reliability" of the diagnosis, the standardization of diagnostics, to avoid variation according to the particularities of doctor's approach or the doctor-patient relationship. The patients being tested must be diagnosed in a homogeneous manner. The new classificatory logic of the DSM-III made this possible for psychiatry.

The demand for large-scale studies permitted them to be carried out simultaneously in different countries ("multicenter" studies); financing aspects obliged research in these countries to follow the DSM nomenclature. Also at this point, production of a diagnostic which was "uncontaminated" by regional idiosyncrasies and the unique characteristics of

doctors and patients was a key condition, made possible by the DSM. Additionally, the fact that any multinational company eager to get its medications approved for the American market must present effectiveness and safety testing according to these same requirements finally led to global compliance with the new manual, promoting the global expansion of American psychiatry at the expense of the French and German traditions which had constituted psychiatry up to this point. In this sense, if one of the objectives behind the origin of the DSM-III was standardization of language in global psychiatric communication, this goal could be considered fully achieved, and catalyzed the rise of biological psychiatry as a dominant aspect not only in American psychiatry but around the world. Randomized studies have become the mark of "scientific" medicine, and the DSM-III allowed psychiatry to apply the same research methodologies as other areas of medicine, thereby driving a process known as the "remedicalization" of psychiatry.

Another part of this process was the transposition of the medical notion of the syndrome, or the syndromic diagnosis, from general medicine to psychiatry (Aguiar, 2004, p.76 e s.). A syndrome is a set of signs and symptoms that manifest in the occurrence of disease. They themselves are not the disease, they are part of it, but in general they are nonspecific and may belong to other diseases. In general medicine, the passage from syndrome to nosological diagnosis ("disease") usually takes place by identifying a "biological marker" (for example, using a test to identify the causative agent of a communicable disease, identify an injury etc.). In psychiatric disorders, the biological marker is not found, so diagnoses are "syndromic": they designate a set of signs and symptoms while ignoring the pathological process (whether this is biological or psychological). The very substitution of the term disease with the term disorder, as we have stated earlier, is part of this process. However, as we have seen, the DSM-III was a change in order to eliminate the high degree of openness and indeterminacy that psychiatric diagnosis previously had, making it more "objective," so to speak. In this sense, and for all the reasons we have just mentioned, the process of "remedicalization" in psychiatry raised medications to the status of being themselves the biological marker that scientifically proved the existence of a particular disorder (Aguiar, 2004, p.82-84).[8]

It is very suggestive of a biological remedicalization in psychiatry that, regarding the "organic mental disorder" category (that is, one with identifiable organic causation, for example, by intoxication, or vascular, metabolic, or senile causes), the manual has asserted that the existence of this category does not imply that the other disorders do not have an organic origin. "On the contrary, it is supposed that all normal or abnormal mental processes depend on brain function" (APA, 1989, p.106). In other words, the manual is able to proclaim itself "atheoretical", in the sense of excluding etiological theories, and at the same affirm one, and operationally function in a way that favors this theory.

As for the effects in the sphere of social representations of the individual, Russo and Venancio (2006) stress that the physicalist assumption that permeates the entire logic behind the manual's approach to mental illness has spread throughout society. The extreme objectification of diagnostic categories has led to a proliferation of categories. The deletion of the neurosis category "unleashed" the various subjective malaises that affect all subjects so they could be "allocated" into these new, hyperspecific categories. "Transforming them [the subjective malaises of subjectivity] into discernible, delineated, and tangible diseases

means abandoning the entire enterprise of self-knowledge and introspective work which are involved in psychoanalysis" (Russo, Venancio, 2006, p.468). The malaises of life were gradually being defined in terms that were no longer subjective but medical, and as the individuals themselves expected, they were treated medically. On a collective level, this contributed to the engenderment of identity groups, bringing together subjects identified by the fact that they belong to a certain pathology (p.465), which not by chance is a typically American phenomenon, and quickly spread around the world. At the clinical level, this has led to the primarily pharmacological treatment of anxiety, depression, neurotic-obsessive conditions and even the vicissitudes of sexual life, a transition reinforced by the media which reify notions such as "panic syndrome," "obsessive-compulsive disorder," "erectile dysfunction," "post-traumatic stress disorder," and "attention deficit and hyperactivity disorder," among others. The greater or lesser clinical validity of these categories deserves to be discussed separately, and is obviously beyond the scope of this article. Among these categories, however, attention deficit and hyperactivity disorder (ADHD) is especially delicate, as it involves the medicalization of children whose individual idiosyncrasies are converted into the diagnostic criteria for an allegedly neuropsychiatric disease, and has specific effects on relationship between the parents and the child's subjectivity, as demonstrated by Lima (2005).[9]

The abandonment of the strong nosographic entities of the psychiatric tradition in favor of a classification which is allegedly error-free is full of consequences in the clinic. This is indicated by psychiatrists themselves. Banzato (2011, p.1) affirms that "the type of diagnostic model" practiced by the ICD-10 and the DSMs "leaves clinical judgment in the background" and produces a certain "superficiliazation of psychopathology, as if the symptoms were evident and only needed to be counted." Aguiar (2004, p.22) cites countless psychiatrists, mainly Americans, who converge in their assertion that with the advent of the criteria based solely on symptomatic descriptions, "the field of psychiatric intervention is progressively restricting itself to pharmacological control of symptoms, setting aside the clinical tradition that placed the therapeutic relationship at center of treatment." Lima (2012) specifically examines the effects that eliminating certain categories associated with psychoanalysis has on clinical thinking, for example, child psychosis (which was replaced by the class of "global development disorders") and neurosis: "When this occurs, there is a direct influence on the everyday use of this notion by the professionals – and, secondly, also by the patients and the general population – they use it less and less and, in the end believe that the neurosis 'does not exist'" (Lima, 2012, p.105; emphasis in the original). This is the same statement we have maintained regarding psychosis.

The disappearance of the psychosis category as a noun, that is, as the name of a psychiatric condition, has produced a growing difficulty in recognizing psychotic functioning, which previously was identified even when hallucinations and delusions were absent. One of the effects that can be felt at work in psychiatric institutions (for example, in reception and emergency psychiatric services) is an increase of the diagnosis of "personality disorder." We have seen that the DSM-III suggested that certain conditions which were previously recognized as psychotic but did not exhibit delusions and hallucinations might "possibly" be diagnosed as personality disorders (APA, 1989, p.199). This is one of the most controversial categories of clinical practice, and for sure carries the most risk of a moral approach to the

patient. Although it is also necessary to consider the current existence of different types of personality disorder (borderline, schizoid, antisocial, histrionic, and others), Dalgalarrondo (2000, p.165) observes that this has already been called "moral insanity," "psychopathy," and "character neurosis or disorder." In mental health services, this diagnosis eventually comes along with a certain reservation regarding the patient, like: after all, is personality a disease or character? The personality disorder category deserves a more rigorous approach, which is beyond scope of this work, but we hope to address it at some other opportunity.

In an earlier work with the psychiatrist Eduardo Rocha (Rocha, Tenório, 2004), we observed that the fact that schizophrenia has become the model for psychoses lent relevance to an approach to mental illness in terms of the contrast between a break (or crisis) *versus* stabilization. This favored the view that psychosis is a phenomenon which is always disruptive, and that its treatment addresses rearranging what the break threw into disarray. What is lost is the idea of continuity, a link between the elements that are present underneath and beyond the break. Treatment was reduced to the suppression of productive phenomena, added to "normalization" or psycho-social rehabilitation. In this matter, the goals of psycho-social rehabilitation that, for good reasons, guide the mental health care finish to be reduced to a functional adjustment. The functional adjustment itself is positive, but the clinical reading of psychotic phenomena as a kind of signature of the subject cannot be left out. This may allow different splits to be produced, artificial separations in the approach to cases. For example, between treatment (reduced to medicating) and care (reduced to "rehabilitation"); the psychiatrist treats, in other words, reduces the break, and other mental health workers take care of social rehabilitation. Or the reverse: the idea that treating is equal to social rehabilitation, with the consequent disdain for psychopathology and the work of the psychiatrist.

Two major movements have occurred: with schizophrenia, psychosis was equated to the loss of reality (through delusions and hallucinations), dissociation, disintegration, and deficit. With bipolar disorders, psychosis was reduced to the accessory presence of hallucinatory or delusional phenomena. The unity of the psychoses based on the structural elements that delineate their specificity has been lost, along with the clinical rigor that required psychiatrists to pursue the presentation of symptoms and particularities of evolution in every patient, in an attempt to locate the moments of psychosis and the terms with which it was equated (cf. Rocha, Tenório, 2004). Finally, what has been lost is any approximation to the idea of psychosis as a subjective functioning that, unlike a deficit of psychic functions (affection, sensory-perception, thought, language, will, movement etc.), is a specific way by which the subject responds to the demands of life. In this last sense, the psychotic phenomena presented by a patient, unlike being without order (we allude here to the term disorder), should be read as a production with its own logic and which makes a subject singular, different from others.

Final considerations

The fact that schizophrenia has encompassed almost everything that still is considered as psychosis has relegated to oblivion several important semiological references and accurate descriptions of the various clinical forms of psychoses. The near-ubiquity of schizophrenia in the current psychiatric clinic of psychosis, particularly in the field of mental health,

forces us to use this category to address patients and clinical developments that, in some situations, would be much better elucidated by other references of the psychiatric tradition. An important task in the current work with psychoses, therefore, is to take back an approach that recovers the diversity and complexity of what schizophrenia finished to encompass and is now considered as "behavioral, psychological, or biological dysfunction." In order to do so, we must retake the understanding of psychosis as a one unique condition, along with the diversity of its clinical forms.

Accomplishment of this task, initially, demands maintaining the distinction between neurosis and psychosis as designating two ways for a subject to constitute himself or herself and to respond to life. Psychoanalysis has shown that psychopathology is always a symptomatic response to greater requirements which constitute a subject: those concerning the relationship with the other, the relationship with the object of desire, the position in the generational chain, and the responsibilities of subject. Depending on whether the subject is psychotic or neurotic, he or she will tend to respond to the capital injunctions of life differently. Psychosis is characterized by the subject's inability to integrate these dimensions into a unified experience as a subject. The hallucinations, delusions, and corporal occurrences of psychosis, according to a Lacanian reading, come in place of the symbolic framing of these elements, which is impossible for the subject. Rather than being mere "errors" by relating to normal functioning, they can be read as not only the subject's failure, but also the subject's specific response to the demands of life.

Accordingly, a second step is the following: considering the diversity of the clinical forms of psychosis that we know, how can we understand it in reference to the assumption of psychosis as a deep fundamental psychopathological process? How can we make this diversity compatible with the assumption that psychosis is unique? Paranoia, schizophrenia, mania, melancholy, mental automatism, false recognition syndromes, sexual or passion delusions, hypochondriac delusions and its extreme form, Cotard's syndrome: through a psychoanalytical reading, these conditions describe the subject's relationship with the fundamental elements of our experience as subjects that emerge directly from our dependence on language, which we have already mentioned – the relationship with the other, with the object, with the body, with the sexual, with reason, with the image, with language itself, with experience as oneself. In all these clinical manifestations of psychosis, we can recognize a subject with the inability to integrate and develop these dimensions of the human, but who is still concerned with them.

It is interesting to note how paranoia and melancholy are still cultural terms, even though for at least twenty years they have been disowned by official psychiatry. This shows the symbolic weight that these terms carry and transmit. The strength of these terms – that's our statement in this article – may have to do with the fact that paranoia and melancholy are dimensions that concern us all, that can happen to everyone at one time or another, even to the "normals;" they are not dimensions we can get rid of by saying that they belong only to the other, so distant. If we draw attention to this fact, it is not in order to cultivate nostalgia for these terms. It is instead to emphasize the consequences of the formal reduction of psychosis to schizophrenia, which seems to remain as the last notion of psychiatry that may, due to its symbolic weight, still be able to remind society of the gravity of madness. At least

as long as it is not entirely neutralized as a mystery by the biological-cognitive perspective. By reducing psychosis to a deficit-type condition or to the occurrence of accessory delusions and hallucinations, not only a clinical ignorance of this condition created, but an operation is produced that separates it from our own condition. To prevent this, the practical and theoretical knowledge constructed around and based upon the notion of psychosis must continue to be developed for those who are interested in madness, not as a syndrome or a disorder that can be regulated, but as a phenomenon that illuminates the fundamentals of the human condition, and touches its limits and contradictions.

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NOTES

[1] Within the scope of this article, it would be impossible to address the complexity of issues involving the constitution and genealogy of psychiatric discourse, as well as psychiatric power (Foucault, 2006). Our emphasis lies in its recent transformations in terms of the description and classification of diseases and their consequences for the comprehension of the major mental illness, psychosis.

[2] It is curious to see how today, at the same time that modern psychiatry is getting rid of the psychosis category, it is beginning to lose its specificity in relation to neurology. By its own initiative, psychiatry has been reduced to neuropsychiatry, and risks becoming a lesser form of neurology. As stated by the French psychiatrist Jean-Jacques Tyszler (personal communication, April 15, 2009): "Psychiatry is the discipline of how subjects live their big questions. Not each pathology, but that lady or that gentleman. How each one tells us about the way he or she faces their issues. If the doctor doesn't care about this, he should work in neurology."

[3] In this and other quotes from texts published in other languages, the translation is free.

[4] It lies beyond scope of this work to reconstitute the trajectory of the term "neurosis" from its creation by William Cullen in 1769, to affirm the organic origin of nervous diseases in the nascent field of neurology, to the time of Freud, who gave the term its definitive nosological status in designating a condition of psychological origin linked to unconscious conflicts, which came to comprise part of the triad that from that point forward classified the clinic of mental diseases: neurosis, psychosis, and perversion. For an initial approach, we refer to Postel (2003, p.304-308).

[5] This particular form of existence "outside the subject," without subjectivity, corresponds to the Lacanian notion of foreclosure, the mechanism he considers to underlie psychosis. In neurosis, the subject is comprised by the internalization and symbolization of these elements, which are repressed. In psychosis, they are not symbolized, they remain "foreclosed," and according to Lacan they return in the register Lacan calls "the real," that is to say, as delirious hallucinatory phenomena, which are characterized by their appearance as external to the subject and by the absence of subjective dialectics. We cannot go into detail here about Lacan's theory of psychosis, and instead refer to Lacan's work (1992) which we have already cited herein.

[6] We cite the revision published in 1987 known as the DSM-III-R (the third revision edition).

[7] This situation becomes more complicated in the recent DSM-5 (APA, 2013), in which the chapter on schizophrenia is entitled "Schizophrenia spectrum and other psychotic disorders." The problem of a spectral diagnosis of schizophrenia deserves a more careful approach, which we hope to undertake eventually,

following the repercussions and the practical effects of the DSM-5, which cannot yet be measured, especially in Brazil. Another point of the DSM-5 that requires rigorous analysis is the category "attenuated psychosis syndrome" (APA, 2013, p.783-786), which consists of the presence of attenuated psychotic symptoms which are psychosis-like but do not cross the line into a complete psychotic syndrome. The dark horizon in this category is preventative medicalization. This category is placed in the chapter on "Conditions for future study," without official recognition for clinical use. It is known that it replaced "psychosis risk syndrome," which was initially proposed (cf. Oliveira, 2012).

[8] On the subject of medication in psychiatry, in medicine and in society, we refer to Healy (1997) and Pignarre (1999).

[9] We will not address the notion of biopolitics here (Foucault, 1997), which underlies what we are studying. Although this power exercised by the idea of promoting health and the "normalization of the abnormal" (Birman, 2007), leading to the medicalization of the social, is present in the DSM, it would not be possible to conceptually address this theme in the scope of this article with the rigor and extent required. We hope to be able to approach this discussion at a later time.

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