Revisiting unitary psychosis, from nosotaxis to nosology

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SUMMARY
The concept of psychosis as known today comes from the late nineteenth century, and was developed from ancient notions, such as insanity, alienation and dementia. Four dichotomies can be registered in the evolution of the concept: Psychosis vs. Neurosis, Unitary vs. Multiple, Functional vs. Organic, and Endogenous vs. Exogenous. The purpose of this research is to rethink the issue of unitary psychosis from a new scientific and epistemological reading. Toward this objective, the terms of nosotaxis, nosography and nosology are discussed, as well as the role of major classification systems of contemporary psychiatry. It also imposes a historical review of the concept from Aretaeus of Cappadocia to the present. Through a rigorous hermeneutic exercise, we discuss the problem of the positivist Kraepelinian conception of psychoses and its epistemological resolution through complex thinking theory, and chaos theory, with empirical reference to hallucinations and delusion as well as the biological basis of schizophrenia and bipolar disorder, but emphasizing their common components. Essential to perform this exercise are theoretical developments from Bartolomé Llopis and Henri Ey, enriched by the latest findings of neuroscience. It seems clear that mental illness is a loss of complexity, leaving little of the fresh and unexpected chaotic health behavior. While asserting the existence of a unitary psychosis is controversial with current available data, it is equally true that the assertion of a schizophrenia/bipolar disorder dichotomy is also difficult to sustain. However, the axial syndrome common to all psychoses, Bartolomé Llopis’s brainchild, remains a fertile idea, as well as the concept of Henri Ey, to understand mental illness as a condition of loss of freedom.

Key words: Unitary psychosis, hallucination, delusion, anankastic phenomena, nosology.

RESUMEN
El concepto de psicosis, tal como hoy se le conoce, viene del siglo XIX tardío, y fue elaborado a partir de nociones más antiguas, como insania, alienación y demencia. Se pueden registrar cuatro dicotomías en la evolución del concepto: psicosis vs. neurosis, unitaria vs. múltiple, funcional vs. orgánica y endógena vs. exógena. El propósito de la presente investigación es replantear el tema de la psicosis única o unitaria desde una nueva lectura científica y epistemológica. Para ello se discuten los términos de nosotaxia, nosografía y nosología y el papel de los sistemas clasificatorios más importantes de la psiquiatría contemporánea. Se impone también una revisión histórica del concepto desde Aretaeus de Capadocia hasta la actualidad. Por medio de un riguroso ejercicio hermenéutico, se discute el problema de la concepción positivista kraepeliniana de las psicosis y se plantea su superación epistemológica desde el pensamiento complejo, la teoría de sistemas y la teoría del caos, tomando como referencia empírica las alucinaciones y el delirio, así como los fundamentos biológicos de la esquizofrenia y el trastorno bipolar, pero haciendo énfasis en sus componentes comunes. Para realizar dicho ejercicio resultan fundamentales los desarrollos teóricos de Henri Ey y Bartolomé Llopis, enriquecidos por los más recientes hallazgos de las neurociencias. Parece evidente que en la enfermedad mental hay una pérdida de complejidad, quedando muy poco para lo fresco y caóticamente inesperado del comportamiento saludable. Aunque afirmar la existencia de una psicosis única resulta polémico con los datos disponibles en la actualidad, no es menos cierto que la afirmación categórica de una dicotomía esquizofrenia/trastorno bipolar también es difícil de sostener. Sin embargo, el síndrome axil común a todas las psicosis de Bartolomé Llopis, sigue siendo una idea fértil, como también la idea de Henri Ey de entender la enfermedad mental como una patología de la libertad.

Palabras clave: Psicosis única, alucinación, delirio, fenómenos anancásticos, nosología.

EPISTEMOLOGICAL INTRODUCTION
Nosological debate spans all the history of psychiatry and its offshoots. For the purposes of this article, we are more concerned with the concept of psychosis, and in particular, that of unitary psychosis. The concept of psychosis, as it is known today, comes from the late 19th century and was developed from older ideas such as insanity, alienation and dementia. There are four distinct dichotomies in the evolution of this concept: psychosis vs. neurosis, unitary vs.
multiple, functional vs. organic and exogenous vs. endogenous. The term “unitary psychosis” itself is derived from the German *einheitpsychose*. It is known in Spanish as both “psicosis única” and “psicosis unitaria.” The term has been used to mean several things: a) to refer to the idea that there is just one kind of psychosis, b) resulting from impairments to an invariable structure, and c) that clinical differences are pathoplastic effects of personal and environmental components. The debate on this issue is far from settled. For the Cambridge School, the concept of unitary psychosis refers to the collective denomination of a group of distinct doctrinal positions, whose central idea is that there is only one form of psychosis, whose myriad clinical expressions can be explained by the action of endogenous and exogenous pathoplastic factors.

Classificatory proposals, which have varied over time, such as the APA’s DSM and the WHO’s ICD, are designed to simplify and improve scientific communication, unify criteria, and shorten distances between the many theoretical positions. Such proposals receive strong criticism from different points of view, resulting in the need to make multiple adjustments over the course of time. While they are taken as atheoretical models, they all retain some element from the botanical naturalist classifications of Linnaeus’s time. Classifications must be understood as transitory models that express representations of clinical reality with virtues and defects, carrying the ideological and cultural markings of the spaces in which they are produced. So they are not to be seen as geologically consistent truths from which we might derive indisputable results. It is important this distinction be noted, given that (on behalf of these proposals) research of all kinds (clinical, epidemiological, biological, pharmacological, neurobiological, etc.) has been conducted, which tends to be presented as indisputable truth, ignoring the fact that their basis is epistemologically lax. We must recall that the “disorders” described in the DSM are not natural structures; nor are they discrete entities with no relation to other conditions. Rather, they are “groupings which are agreed upon based on algorithms, symptoms, and behaviors that disable the individual to a varying degree, and whose classification does not amount to an etiopathogenesis”. In addition, “not only are they compatible with the ideas that gave birth to the theory of unitary psychosis, but also they require these ideas be reestablished in many aspects (etiopathogenic, clinical, therapeutic, and rehabilitational, among others)”. A more humble approach would be to accept that there are no findings to be heralded as Truth, but only credible knowledge to be debated, as we see in the rest of the health sciences.

In light of this debate, it is appropriate that we revive three commonly used terms in medicine: nosography, nosotaxis and nosology. The common Greek origin of these terms is *nosos* (nosos), which means disease. According to the Spanish Royal Academy Dictionary (translated to English)*nosography* is the part of nosology that deals with the classification and description of diseases. However, it would be more accurate to say that nosography deals with description of disease, while *nosotaxis* deals with classification, although “nosotaxis” does not appear in the aforementioned dictionary. In reality, all three activities are inseparable, as they all form part of a diagnosis (from the Greek *diagnostikos*), while remembering that said concept has been expanded to multiaxial and idiographic diagnosis. When we speak of mental disease or disorder, we are conducting nosography, as it is necessary to describe the symptoms through which such disease manifests itself. Likewise, we are also conducting nosotaxis, in stressing that the central and common point to these disturbances is the mental impairment by which they are classified. Furthermore, we must also conduct nosology, because everything will be accompanied by an effort to explain and/or understand the relationships between symptoms and the personal, biological, genetic, emotional, experiential, social and psychological substratum that make these symptoms possible. In this way, the most inclusive practice of all is nosology, through which the clinician seeks to grasp the logic inscribed in nature, which explains the disturbance or condition. But logic requires nuance. Contemporary scientific debate admits that not all processes can be understood through the mechanistic logic that drives the natural sciences, born and structured within the positivism of modern times, now criticized and questioned by complexity theorists and systems theory. The innovation, as well as the difficulty, of complex thought, is that it does not aspire to eliminate contradiction, obscurity or uncertainty, but rather establishes these things as basic elements of the order/disorder of nature. We cannot ignore the chaos of madness (and nor can we assume they are synonymous). On this level of reflection, psychiatry must be heteroclite and heterological, that is, it must take its logical framework from both natural and spiritual sciences (heterological), while also assuming that among its subjects of study (in this case, subjectivity and its processes of disease), at times cannot be understood when combined in adherence to common standards, and so expressed only through language and metaphor (heteroclite). To perform nosography, statistics and frequency analysis have often been used. In following research that is based on a supposedly “atheoretical” model (as is the DSM), one runs the risk of defining the disease by its symptoms and the frequency with which they appear, and not by its structure. So we must advise that the most important thing is not necessarily that which is repeated, but that which is indispensable for the support of the structure. In no way is a disease more completely described by referencing the frequency with which its symptoms appear, as opposed to that which is essential to its process. It was toward this end that Karl Jaspers, making use of the phenomenological method, defined his *general psychopathy*. Therefore, mere symptomatological alliteration must not...
be confused with phenomenology, as the latter seeks and proposes to arrive at the essential and/or structural which cannot be achieved through simple analysis of frequency. It is for this reason that the clinician must make use of hermeneutic rigor to interpret the symbolic processes and contents that structure the psyche, which cannot be understood by conventional readings.

Other terms which deserve attention from a nosological angle include that of "spectrum" and "comorbidity." The former seems to derive from physics. When a beam of light is projected, one part can be seen as clearly illuminated, while another is faded, ending with darkness. This parallel with light would indicate that many nosological entities overlap along the edges, in many cases becoming indistinguishable. An example of these blurry edges lies in the concept of borderline. Regardless of whatever truth there may be in these assessments, the real difficulty lies in the fact that most of the time the resemblance is in the clinical core and not in the periphery, as we will discuss later with regard to bipolar disorder and schizophrenia. In this regard, it is very likely that there is more overlapping between disease and health than there is between mental disorders themselves. So, the term "spectrum" can also be confusing, both for its intentions and for the reality it seeks to describe. The psychoanalytic definition of spectrum, proposed by Tutte, is very interesting. He posited that "at one end are disorganized, invasive and paralyzing conditions, and at the other are conditions which are close to normalcy." Between these ends there are all kinds of intermediary conditions, situations that produce effects of greater or lesser mental harm, including more or less mild states forming symptoms in the organization of neurosis, to that which corresponds to veritable gaps in symbolization, which can lead to the psychic silence of psychosis.

With regard to "comorbidity," there are a few critical points to be made. When we treat a bipolar patient with a severe personality disorder and abuse of addictive drugs, must we consider this person to suffer from three or four "comorbid" pathologies? Or is it more accurate to consider that the entire condition comes from a common thread, which our nosotaxic parceling does not allow us to see? Can it be that the patients we so often see suffer from schizophrenia, anxiety disorder, depression and obsessive compulsive disorder? Is the terrible anxiety suffered by our depressive patients "comorbid," or is it as central as the deep sadness they experience? We will try to discuss these questions in more detail later in this article.

The need to measure, weigh, and quantify the "facts" of science, as well as the exclusion and confiscation of subjectivity have been imposed restrictively since the times of Auguste Comte. We can state that traditional scientific positivism epistemologically governs the better part of biomedical research. However, thanks to psychoanalysis, phenomenology, existential analytics, medical anthropology, and other qualitative developments, we have managed to open a space for subjectivity in medical research, and (in particular) in psychiatry. Thanks to this knowledge we have a hermeneutic tool that allows us to better penetrate psychotic existence, without which neither communicative efforts nor therapeutic relationships would be possible. Today, it is accepted that the data from positivist research are useful in explaining many biological regularities. However, they are insufficient when used to analyze more complex phenomena, such as human behavior and its myriad determinations. This occurs because the linear mathematical systems lose their predictive capacity in the complex systems that require the logic established in Chaos Theory. According to Edgar Morin and his theory on complexity, the positivist method presents us with a reality that is cut into slices, which while producing knowledge, also produces ignorance. So, the alternative to the simplistic, reductionist and disjunctive thinking of positivism, must be complex thought.

**HISTORY OF THE CONCEPT OF UNITARY PSYCHOSIS**

The notion of unitary psychosis began much earlier than the founding of psychiatry as a medical specialization, dating back to the 1st century in the work of Aretaeus. Bartolomé Llopis affirms that the Cappadocian suggested a fundamental form of madness (melancholy) from which all other forms derived. The approach is complex. Let us follow an already fruitful path to understand this history. If we seek to define this concept in a simple way, we could say that he affirms that the different psychotic conditions represent no more than different levels of intensity of the same fundamental disorder. It was in the 18th century that Vincenzo Chiariugi (1759-1826) wrote, in 1793, his famous "Della pazzia." It is important to note that the term "pazzia" is the equivalent to madness in English, and he used this word despite the fact that in Italian the word for insanity did exist. This Italian author, unjustly criticized by Pinel, proposed that "madness" follows an evolution that spans from melancholy to mania, and from mania to dementia.

Heinrich Neumann (1814-1884), who is considered by some to be the "father" of unitary psychosis, said in his *Lehrbuch der Psychiatrie*, published in 1859: "There is one sole form of psychic impairment, we call it madness (das Irresein). Madness does not have different forms, but rather different stages, which are called: the delirious stage (der Wahnsinn), mental confusion (die Werwirtheit) and mental breakdown (der Biodsinn)."

Georget EJ (1795-1828), one of the disciples of Esquirol, defined madness as "an idiopathic brain disorder, whose symptoms can vary greatly." This definition appeared in "De la folie", which was published in 1819, and translated by Heinroth to German just one year later. It had signifi-
cant influence on psychiatrists such as Zeller, who was later a teacher to Griesinger and Neumann, the latter of whom became the most passionate defender of the paradigm of unitary psychosis in Germany. Hence the famous phrase attributed to this Berliner, that "mental diseases are diseases of the brain," also attributed by some authors to Georget.21

Another francophone author, the Belgian Guislain J (1797-1860), believed that all mood disorders were a result of one morbid excitement of one’s sensitivities (feelings), which constitute the origin of all mental pathology. He greatly influenced German psychiatry, which at the time was still governed by knowledge developed on the other side of the Rhine, although not long after this was to change radically.

It was through Albert Zeller (1804-1877), a teacher of Griesinger, that the concept of unitary psychosis became German. The consolidation of the idea of unitary psychosis was enshrined in a text by Griesinger W (1817-1868), written in 1845 when the author was just 28 years old, which quite soon became the most important psychiatry book of its time. The "Pathology and Therapy of Mental Diseases" would be translated to French in 1864, to English in 1867, and to Spanish by 1880, later seeing many subsequent releases in all these languages, evidence of its broad influence.22 There would be questioning of this hypothesis, one of the most important being the concept of "paranoia," a term which was proposed by Kahlbaum.

According to Lanteri-Laura, "until the middle of the 19th century, all the world followed the paradigm of absolute unitary psychosis, and the works of JP Falret and others were what opened the door to the idea of a plurality of mental conditions."23

Also in France, and almost simultaneously, in 1854, two prominent "alienists" used the names "folie circulaire" (Falret JP) and "folie à double forme" (Baillarger) to describe the entities which later would be detached from the root of unitary psychosis and Kraepelin would subsequently call "manic-depressive madness." Later, the enormous influence of the classificatory work of Emil Kraepelin was what finally buried (although not entirely, which we will discuss later) the old idea of unitary psychosis.24 However, it was also Kraepelin who in 1920 wrote: "No experienced diagnostician can deny that the cases in which it is impossible to make a clear decision are lamentably frequent."24 It was words like these which brought Angst to affirm, perhaps somewhat boldly, that "it is very likely that Kraepelin would have changed his concept of this dichotomy had he lived longer."25

Given these cases of difficult distinction, Eugen Bleuler spoke of "mixed psychoses" while Kurt Schneider used the term "cases in the middle."26 Kretschmer even affirmed that "close to half of all psychotic patients suffer from mixed psychoses."27 Schule showed the existence of cases that begin as manic-depressive, and end as schizophrenic, as well as the other way around.

In 1928, the Spanish psychiatrist Sanchís Banús highlighted the conceptual difficulties in separating dementia praecox from manic-depressive psychosis. Five years later, the American psychiatrist Jakob Kasanin (1933) coined the term "schizoaffective psychosis" to refer to these cases of mixed symptoms, in what Alarcón called the first American contribution to psychiatric nosography.28

Without a doubt, in the Spanish-speaking world it was Barolomé Llópis who most distinguished himself in defending the paradigm of unitary psychosis. He did so from the disadvantaged position he occupied due to his political convictions in Spain during the 1940s. Based on his observations on the mental pathology of patients with pellagra, he developed his theory on the "axial syndrome common to all psychoses. His book continues to be, more than half a century later, an extraordinary example of psychopathological science, and so has been revived for new generations in a new release. Here we might recall Kuhn TS (1962), who has shown us the destiny of paradigms in the sciences, while Lanteri-Laura indicates that something always survives from the replaced paradigm.

Flor-Henry, in 1969, studying schizophreniform and affective cases in patients with epilepsy, found himself unable to differentiate clinically between the schizophrenic and manic-depressive cases, while also finding something very interesting: a greater incidence of epileptic foci in the dominant hemisphere in the first group, and in the non-dominant hemisphere in the second. This was confirmed by many authors, as Trimble points out.29

The paradigm of unitary psychosis, as we can see, re-emerges in the 21st century, and for many reasons. "Thus we return to the possibility (never fully abandoned) that the brain mechanisms underlying the occurrence of psychotic symptoms are shared, and that the value of the symptomatology must be established based on the function of the patient, not the condition," as Baca affirms.30

We find authors such as Menninger, Ellenberger and Pruister, who hypothesized that neuroses and psychoses are different stages of dyscontrol.31 On the other side of the world, in the Soviet Union, Gannushkin PB, one of the leading figures of the so-called Moscow School of Psychiatry, in a classic monograph from 1931, affirmed that there was a continuum between neuroses, psychopathic personalities and psychoses.32

Hueso Holgado states: "These proposals are important in understanding how psychotic episodes can occur in people whose normal functioning is neurotic, or that of a personality disorder, as I believe there is a continuum between the psychotic and neurotic."33 Also Peralta et al.34 described psychoses as continual processes in a schizoaffective spectrum. Or, is it possible to admit that a patient suffers from schizophrenia and bipolar disorder as comorbid entities?

For Villagrán, authors like Bonhoefer, Hoche, Kretschmer, Conrad, Ey, Menninger, Rennert, Janzarik, can be considered unitarists in one way or another. To this list we can add Ber-
rios, Timothy Crow and Robin Murray. The master of Bonneval, Henri Ey, proposed that all mental disorders result from changes in the longitudinal axis (diachronic) or transversal axis (synchronic) of the structures of consciousness.\textsuperscript{39} Likewise, Timothy Crow as well as Murray and Dutra\textsuperscript{40} affirm on multiple occasions that there is a continuum in psychoses, proposing that “we accept that the neo-Kraepelinian vision that schizophrenia and bipolar disorder are totally distinct entities is not supported by available scientific evidence.” To this we must add that spoken by Renato Alarcón: “It is, in reality, impressive that the dichotomy that underlies the apparent clinical separation between schizophrenia and bipolar disorder has survived almost a century.” Similarly, Murray and Dutra go so far as to affirm that the history of psychiatry can be seen as the story of efforts made to overcome the notion of unitary psychosis. Other authors agree that the results of research conducted are inconsistent with the classification of psychoses, and in some cases, as with Craddock and Owen,\textsuperscript{35} they offer that current classifications inhibit both research and clinical practice. This statement coincides surprisingly with the words of Heinrich Neumann, written in 1854, more than a century and a half ago: “We cannot believe in the true progress of psychiatry before making the decision to throw away all classifications.”

In the field of psychology, the unitary theory has also had its distinguished followers, such as Hans Eysenck, of the Maudsley Hospital, and Gordon Claridge, from Oxford.\textsuperscript{36} However, Emil Kraepelin had a very interesting thought which deserves to be studied carefully. In their extensive study on this author, Berrios and Hauser\textsuperscript{37} say that in his “Research Programme” from 1897, Kraepelin already proposed a plan for the classification of psychoses, which he developed from 1896 to 1898. Very soon he incorporates the problem of the evolution in the classification of psychoses, announcing that he had found a new way to study mental disease, describing early predictors of the clinical course. The Kantian category of time enters the door to psychiatry through the work of Kraepelin. Diagnosis was a way to understand the connections between the clinical case and the underlying anatomical impairment. With his procedure, he wanted to link etiology, pathology and symptomatology. For Berrios and Hauser, contemporary psychiatry lives in a “Kraepelinian world”. The authors translate to English an extensive paragraph from his work, which reads as follows: “¿... to what extent and with what clinical methods can we understand with the greatest clarity the manifestations of madness? The symptoms and signs that correspond to the base conditions are extraordinarily varied, which implies that the conditions preceding the process must have been complex. Even when external agents are clearly involved (for example, an injury to the head or intoxication)... there is a group of forces working in the mechanism: the nervous system of the affected individual, the deficit inherited from past generations, and their own personal history... these prior conditions are especially important in considering the manifestations of the disorder that are not derived from external injuries, but from the circumstances of the individual in question... it seems absurd to propose that syphilis causes patients to believe they are the proud owners of cars... and not that the general desires of people are reflected in these delusions... if these observations approach the truth, we will have to seek the key to understanding the clinical case primarily in the characteristics of the individual patients... because their expectations play a defining role.”

The work of Berrios and Hauser, and the writings of Kraepelin, not only illustrate the depth of their thinking, but also give important epistemological clues for the clinical practice that they propose in their time. On the one hand, they want to integrate the personal history of the patient in the interpretation of the psychopathological phenomenon. This anthropological approach should not surprise us, coming from an author who was one of the first to conduct trans-cultural psychiatric studies. On the other hand, Kraepelin does not seem to feel satisfied with the psychopathological exploration techniques, as they do not allow him to articulate with the underlying condition. We believe that the study of the representations, with the most recent findings provided by neurophenomenology and the neurosciences, together with systems theory and in consideration of chaos, represents a good chance at transcending the epistemological obstacles that hinder Kraepelinian research, as well as articulating the issue of the “underlying impairment” with clinical practice in treating disease and its pathoplastic expression.\textsuperscript{49} We will touch on this in the next section.

**THE REPRESENTATIONS APPROACH**

Reading a text from Michael Trimble,\textsuperscript{41} we come across this phrase from Lombroso: morbus totius substantiae, which could be translated as the total essence of the disease or as the disease is the essence of all. We mention this because when speaking of unitary psychosis, we are grasping for nothing less than the total essence of mental illness, which in Latin, Greek, German, Spanish and French can be written as: “totum essentiam mentis morbitur”, “οσύλο θ’ ουσία τ’ θ’ γι’ υκλής ας qgebêiaç”, “die gesamte Substanz der Geisteskrankheit”, “la esencia total de la enfermedad mental” and “le produit total de la maladie mentale”, respectively. Now, among the clinical entities of psychiatry, which of them contain the greatest amount of the substance we are after? We believe there would be a consensus that schizophrenia and bipolar disorder best answer this question. Unitary and dichotomous classifications contain within their structure the greatest expression of the whole of mental illness. Following this inevitable circumlocution, we can add that for the ancient Greeks, the human body is apominesis tou hólou, that is, a copy of everything, imitation of the universe, which is very much in keeping with the
theoretical postulates of complexity and its hologrammatic principle, which affirms that "not only is the part in everything, but also everything is in the part." That being said, let us study "the parts" that contain the greatest amount of the whole that makes up the psychoses, which, in our opinion, together with autism and fear of death, are hallucinations and delirium.42,43

In traditional psychology, the concept of representation accepts a certain polysemic. It is thus that the apprehension of an immediately present object can be understood, as occurs in perception, but also the reproduction in the awareness of a past perception; likewise, the representation can be made to anticipate a future event, which brings it toward imagination.44 In some cases, there is a poietic representation, through which reality is resemantized with novel subjective additions and, in intense contrast with that reality, there is the mineralized representation that characterizes hallucinations. For Wittgenstein, the best representation must share a structural or logical form similar to reality, bringing it closer to the isomorphic conceptions whose best empirical expressions are found in mathematics and chemistry. Ricoeur distinguishes between image and memory, for which he proposes an appropriate eidetic analysis.45 It is based on Husserl and his terms Vorstellung, Bild and Phantasie. Here, Vorstellung is equivalent to representation, Bild corresponds to the presentifications that describe something indirectly, like sculptures and paintings; while when speaking of Phantasie one thinks of the angels and demons of legend, thereby tying the concept to fiction and beliefs. In any case, past events tend to become present as something already perceived or lived by the subject, or to the contrary, it is not recognized as one’s own. If hallucinations and delirium must be admitted as representations, then we must immediately point out a deficient piece of data regarding the majority of cognitive representations: they fail to adhere to what Kant refers to as triple subjective synthesis, consisting of traversing, joining and recognizing, which guarantees the cohesion and appropriation of what is perceived.46

Representing is not understanding, but it is a prior and important step toward understanding reality. In the process of understanding, the represented is assimilated and enriched by consciousness, until it becomes part of the Ego. For Plato, ideas and things are not the same. Ideas belong to the reign of Being, while things have been created by a demiurge to the image and likeness of ideas. These kinds of considerations have given rise to a debate on the relationships between the concepts of eidolén, eikón and phantasia, that is, between the world of ideas and concepts, icons and the imagination, or fantasy. Although some debate whether representations were a subject of discussion in the world of the ancient Greeks, Foucault’s research seems to show that they were. In effect, when he examines the spiritual exercises recommended by the stoic emperor Marcus Aurelius, in his Meditations, he finds a recommendation "that the object that we represent and capture in its objective reality, pass through description and definition, to the thread of suspicion, of the possible accusation, of the moral reproaches, of the intellectual relationships that dissipate illusions, etc."47

To capture the objective contents of the representation, it will then be necessary to have a moment of both eidetic and onomastic meditation. In our words, we would say that the exercise recommended by Marcus Aurelius requires a lucid and self-critical awareness, not to be fooled by the first perceptive instant, and to examine the object until transforming the perception into an apperception, where the guarantee of having arrived at the truth is achieved when reflection drives and forms part of the Reason that presides over and organizes the world. To represent, then, is a mental activity that requires the integrity of the processes that make consciousness possible, which ought to be studied through the light of contemporary neuroscience.

For their part, Crick and Koch48 propose aspects of great relevance in understanding the so-called Neural Correlates of Consciousness. On the one hand, they are concerned with very quick reaction times, of an order that goes from milliseconds to a handful of seconds, in which there is only the possibility of already-developed behaviors, which the frontal area of the cortex seems, in large measure, to control, where some inputs from the sensory zones activate stereotypical and unconscious responses, which for their speed do not require significant conscious elaborations. This indicates that a large part of the frontal activity runs and is dedicated to unconscious processes. On the other hand, they propose that the main function of the sensory cortex consists of constructing and utilizing detectors for specific traits or qualities, like those that are activated for orientation, movement, and facial recognition. In this way, we could affirm that most of the sensory and motor activities are already made and available throughout the cerebral cortex, by way of global prior representations.49 For Libet, nearly one half second must pass in order for a situation to be registered in the unconscious, so that we are unaware of certain behaviors, as the unconscious brain has carried them out.50 It is not necessary, for example, for an animal to explore between a wide variety of behavioral possibilities in order to know that there is a predator and that it is at risk. Instead, immediately the unconscious neural registries are consulted, leading to fight or flight behaviors. It is not only a matter of emotional or flight responses that are innate or learned, but also of neuronal groups of niches where unconscious behaviors are stored, which are very necessary for the preservation of the species and the perfection thereof among individuals. Crick and Koch speak even of an unconscious homunculus and of "zombie modes" that can be seen as cortical and structured unconscious reflections, such as rapid and stereotypical responses. It is accurate to use the word zombie, a word of Haitian origin, which is used to refer both a person who is supposedly dead, but that has been revived by witchcraft,
as well as to designate an automated behavior in a subject with a certain level of alteration in consciousness, which at the same time appears void of voluntary initiative and vivid reflections in behavior. The zombie metaphor makes sense, because if, effectively, all behavior were not illuminated with the living light of consciousness, it would seem to be a kind of neuromotor robot. Consciousness is achieved much more slowly and with broader and less stereotypical sensory input, often configured in images, and it takes longer to decide between thoughts and appropriate responses that require complex processes. This process of conscious qualification of the different sensory nuances and its progressive complexity is a progressive trait, which, within phylogenetic evolution, leads up to the *homo sapiens sapiens*. Phylogenesis is characterized by increasing complexity, subjectivity and individuality. In fact, in the so-called half-conscious, driven by thalamocortical activation, when a task is performed that requires effort and attention, we find spontaneously co-activated neural structures that are coordinated in space and time, of the kind called prior global representations by Chaneux, in such way that we can affirm that most sensory and motor activities are already made and available throughout the cerebral cortex. It must be admitted that there are visual, auditory, tactile, olfactory, motor, linguistic, mathematical, and aesthetic representations of different levels of complexity, which are constantly adjusted in the personal organization of the subject. Some are psychomotor and/or cognitive habits whose automation and availability save the subject some effort, allowing him energy for other realizations, while others require an autopoeitic completion that implies contrasting prior representations to process novel behavioral emergencies, which involve several levels of initial chaos, as well as new possibilities for organization of life and of the person. As such, we accept with other authors that perception, hallucination, and delirium, as well as other cognitive and neuromotor activities, are representations, and that, as such, they cannot be considered as conceptually opposed categories, while they can be differentiated. But we also recognize that all representations imply the joint activation of complex cortical connections related to thought, language, and imagination, and at a vertical and deeper level, of the regions that regulate and harbor needs, drives, and desires. Research by Kandel on memory and its neurobiological basis, refers to processes relating to ontogenesis. However, research on the human genome shows that there is a vast genetic heritage shared between the *homo sapiens sapiens* and other living beings. The effect on behavior of certain genotypic and phenotypic attributes is understood, as well as their relationships with neuroplasticity and the environment, but we still know very little about the effect that the common heredity of our species can have on the symbolic products of the individual. The way we see it, Sarro’s approach to the issue of delirium, which he considered to be expressive mythologems of the universal fears and desires of the human race, which feed both delirium and myth, means they can also be considered to be archetypal representations whose neurobiological basis is only beginning to be understood. 31,52,53 Téllez-Carrasco says that the "archetypal" voice comes originally from Saint Augustine, who uses it in his work De Div Quest, and is an explanatory periphery of the Platonic eidos. Jung later used it in his famed theory of the collective unconscious. For Téllez-Carrasco, "archetypes would be symbols that shine through the same forms to reveal the vitality in time and in space, and I suggest naming them with the neologism tinofantias." 55

The hallucinatory phenomenon had been considered, since Esquirol, as a "perception without an object." The definition had not been substantially modified until recently Alonso-Fernández questioned Esquirol’s idea in affirming that "the hallucination is anything but a perception without an object, because it is not a perception and it does have an object (...). Contrary to the activity of sensoperception, which comes from the outside to the inside, in its capacity as the centripetal mental function par excellence, the hallucination is produced by objectivizing a mental image, providing it with sensoriality, and then projecting it outward, in brief, an objectifying projection, in a distinctly centrifugal way." 56 In addition, today it is accepted that there are hallucinatory phenomena in healthy subjects, which are related to certain personality traits, including imagination.57 Likewise, one aspect of the hallucinatory phenomenon has been brushed aside, that which was indicated by Falret JP, in La Salpêtrière, from 1864, where he states: "hallucinations of the insane refer only to one sense, to an object or an identical series of objects. To the contrary, in dreams, fantastical perception of absent things cannot be predicted, they occur at random, with no discontinuity, and in the field of all the senses... hallucination, this perception without an object, or, if you prefer, this rumination of sensations..." 58

That is to say, dreams present a subjective richness that is absent in the hallucinatory phenomenon, which constitutes a distinctive and fundamental piece of information in the semiology of both states. The phenomenology of hallucinations is best described as the rumination of sensations, as Falret so correctly calls it. We can conclude with Amaral, that hallucinations would be representations equipped with all the characteristics of normal perception, including the power of convincing us of the existence of the represented object, 59 although it must be stressed that the most significant differences would be subjective richness, the greater level of complexity of conscious phenomena, and the sensation of the ego in control, all which characterize the representations of lucid consciousness.

From England, Hughlings Jackson began to propose a Darwinian reading of the phenomenon of delirium: “the disease only causes the physical condition for the negative element of the mental condition; the positive element, that is, delirium, obviously an elaborate delirium, as absurd as
it may be, means activity of the healthy available nervous system, it means evolution moving toward what remains intact of the highest cerebral centers. Later, in the times of the great clinical structures, the neo-Jacksonian theory proposed by Henri Ey only considered psychotic or delirious hallucinations to be true hallucinations, which constitute a free and positive aspect, a product of a global destructuring of the activities of the neo-cortex, which has as a negative trait the loss of the ability to distinguish between reality and the interior fantasy that makes hallucination possible. In this way, for Ey it is not a matter of simple cortical irritation, nor of the projection of a repressed affection in the unconscious, but one of a very complex alteration that severely impacts the subject and restricts his/her freedom.

The topic of delirium has been subject to many different reflections. We know that the term was coined by Chiarugi in 1795, defining it as a disturbance in the ability to judge or as a feverless fantasy with no alteration in consciousness. A formal description of delirium is later developed by Jaspers, in 1913, who in addition to indicating the impossible content of delirium, insists on its character of absolute evidence and its incorrigibility by way of logical argument or experience. Other authors have insisted on the primary or derived character of the delirious experience, from which comes the description of the delirious occurrence or feeling, delirious cognition, and delirious perception. The problem of the genesis and understanding of delirium is also debated, referring to the possibility of understanding delirium based on a specific experience that changes radically throughout the life of the subject, or if to the contrary, it is a matter of a primary experience, not derived from any other, which would allow us to speak of primary and secondary delirium. Another debate on the problem of delirium consists of understanding it as a separate entity, with clearly defined compartments within mental activity, or if, to the contrary, these boundaries are blurred with passions, fantasies and beliefs. Clérambault insisted on the automatic character of the delirious phenomenon. In obsessive disorders, the patient is besieged by intrusive thoughts which are perceived as having come from outside the desire and intention of the Ego, but in so-called psychic hallucinations, there is a true xenopathic emancipation, by which thoughts become structured as a whole in delirium, until being broken down in the final stages of schizophrenic disorder. Amaral performs an interesting exercise in establishing the debate between delirious perception and apperception. But the perspectives of Castilla del Pino and of Dörr Zegers must also be highlighted, who used very different methodological means to arrive at similar conclusions on the function of delirium. The former proposes that delirium would have an orthopedic function for a starving and ill-structured Ego, while the latter, wanting to see beyond the disease, considers that delirium can be another human possibility through which a person transforms an unbearable existence into a different less painful reality.

In our case, we are interested in studying the phenomenon by which delirium comes to install itself at the center of the life of the patient, as a mineralized representation of the world of himself, until structuring most of his behavior and his life, which we propose be called anankastic representations, clarifying that this concerns a separate approach that in no way seeks to diminish or discount different possible approaches to this phenomenon. Diachronic study of the topic shows that said anankastic representation comes from a series of prior phenomena, such as Griesinger’s pre-delirium, the primary experience of Moreau de Tours, or Conrad’s trema, until the delirium constitutes a unitary world in the conscious mind. To understand the phenomenon, it seems to us that Llops’ idea is fundamental, regarding the fact that nature does not have different laws for producing similar phenomena, in such way that the delirium and the hallucinations that are observed in different clinical entities, must obey one pathogenetic mechanism, and so, “thought disorders and perception disorders are not, in reality, qualitatively different, but just means of expressing the different levels of intensity of a disorder.”

Thanks to brain research techniques like fMRI and SPECT imaging, electronic microscopes, histochemistry, etc., the neurobiological basis of hallucinations is better understood. A decrease in the activity of the left dorsolateral prefrontal cortex, together with the activation of some areas of the sensory cortex, seem to be the most notable traits of this process. In any case, what must be stressed is that what is activated in the hallucinatory phenomenon is a sensory network carrying a threatening signal to the patient, which is only possible because it has left his/her control. Everything points to this being a matter of representations that are presentified before a conscious mind that does not recognize them as its own, because they have evaded the coinciding detection mechanism for afferent and re-entrant signals that support conscious perception, according to the findings of neuroscientists. This is a critical finding for this debate, and so neurophysiology must take on the issue of representations, the storing of information, engrams, and the recognition of the constitutive memories of the individual.

Processes of simulation and supervision intervene in the many states of consciousness that allow global access to the past, present and future. The subject is not only receiving stimuli from their environment, to which they respond
from their brain with the innate patterns encoded in their genome, but they are also an agent that makes new realities and behaviors. They are a poietic and autopoietic factor. And for that reason they have dignity. In the dialogue regarding genetic traits, environment and the constitution of the epigenetic, consciousness and neuroplasticity are fundamental.\textsuperscript{67} In order for everything to work harmoniously, a balance of activity is needed between the sensory and primary motor cortex and the association areas scattered throughout the cerebral cortex which, it would seem, are organized from the prefrontal cortex. The constructs contained in prior representations must be reviewed at every chance and undergo some circumstantial adjustment or profound transformation, as the case may be. This is a process of metacognition through which the mind examines its own contents, in a similar way to that recommended by Marcus Aurelius in his exercises from the 2nd century. When a pathological situation alters this process, the constructs can become raw material for hallucinations and delirium. The autopoiesis is interrupted and the mental dynamic is trapped by anankastic representations. Crick’s zombies, the prior representations of Changeux, or Téllez’s timofanías, now independent from the Ego, imposed automatically on a conscious mind that cannot differentiate them from reality, thus constitute a symptomatic expression of what we have called mental illness, unánik.\textsuperscript{68}

Authors that study the relationships between chaos and health propose, contrary to prevalent thinking, that health has a high level of uncertainty, in the same way that a lack of variability and physiological and behavioral chaos leads to a mineralization of the possibilities of existence, just as occurs in most mental disorders. As such, new therapeutic strategies must not regularize the behavior of the patient on the level of his unánik, but rather increase his repertoire of lost complexity, transforming psychiatry into a true science of liberty, as Henri Ey once proposed.\textsuperscript{69}

\section*{THE BIOLOGICAL FUNDAMENTS OF THE PROPOSAL}

The Kraepelinian desire to link symptoms to the "underlying disorder" is ongoing. Today it has been suggested that the correlation between biological variables with psychological dysfunctions, as well as the existence of basic units in psychopathology in so far as common nuclei between different disorders that show different clinical manifestations, seems to be more appropriate for classification in psychiatry. However, we must not forget that the history of the patient and their cultural experiences have a fundamental pathoplastic value, as Kraepelin himself acknowledged. From the neurobiological point of view, it is well established that the there are signs of alterations in the metabolism of the neurotransmitters that are not specific to any disorder, which rather are related to psychopathological dimensions of certain specificity. In this same way, functional psychopharmacology is in line with the approach of said dysfunctions, and inevitably will lead to the use of combinations of useful drugs in different disorders.\textsuperscript{70}

While nosography still holds a place of privilege in psychiatry, it is itself a guide that can become complicated. The syndromic organization of current psychopathology has been shown to have faults. It is believed that a functional organization in this area could be more appropriately used as a reference framework for research in biological psychiatry, with proposals for a two-tiered diagnostic system. On the first tier we would find the nosological diagnosis, while the second would include a detailed description of the psychological and biological components of the dysfunction, together offering a way to deal with what has become a problem in the area of psychiatry, which has been called, rather ironically, nosologomania.\textsuperscript{71} These criteria support our proposition regarding the need to read the findings of psychopathological and clinical research from a new epistemological point of view.

New systems have been proposed for grouping the different psychiatric disorders, based on aspects such as the presence of common genetic findings, the existence of similar biomarkers, comorbidity, and response to the same family of medications. Taking into account these proposals, it is clear that schizophrenics share more dimensions with bipolar disorder than with other mood disorders.\textsuperscript{72} More recent psychopharmacological research offers evidence that drugs originally proposed for treatment of schizophrenia, such as olanzapine and quetiapine, are not prescribed for so-called drug-resistant depression.\textsuperscript{73,74} In the same way, other medications initially used for epilepsy are now indicated as mood stabilizers.\textsuperscript{75,76} Likewise, the so-called "Attenuated Psychotic Symptoms Syndrome,” which is proposed for the new DSM-V, seems to respond better to preventive treatment with SSRIs than with antipsychotics.\textsuperscript{4} This all points toward a common pathogenetic mechanism that places the separate entities of the nosotaxis in doubt.

A strong and significant overlap has been found in biomarkers such as the slow tracking eye movement, sensory openness (P40), prepulse inhibition, the reduction of P300 and a neural synchronization defect both in schizophrenia and in bipolar disorder.\textsuperscript{77,78,79,80} Although Del-Ben, Rufino Armanda, Brandão Fragata et al.\textsuperscript{81} have used instruments allowing them to hone the ability of the clinician to make differential diagnoses in the first psychotic episodes, their efficacy is clearer in episodes induced by drug abuse. It is possible that with their instruments one can better distinguish between the different etiologies in the severe stages of the disorder, but without a doubt, a very similar response has been activated in all cases. Similarly, Mauricio Kunz, Keila Maria Ceresér, Goi Pedro Domingues et al.,\textsuperscript{82} find biological data on inflammatory and immunological activity that
seems to differ between schizophrenics and those suffering from bipolar disorder, which could indicate a rather severe expansion of the underlying impairment, which regardless can exist in both cases, and so can result in false negatives.

Different structures have been indicated, sharing common aspects, both for schizophrenia and for bipolar disorder, especially the tonsil, the hippocampus, and above all the prefrontal dorsolateral cortex, the supraorbital cortex, and the anterior cingulate cortex. In these structures, alterations have been described, such as differences in blood flow, hippocampal dysfunction that produces an impairment in declarative memory with hypoactivity of the dorsolateral prefrontal cortex and variable dysregulation of the anterior cingulate cortex, as well as the prefrontal cortex, which explains the alterations in abstract thinking, mental flexibility, and the initiation of an activity, as well as a dysfunction in the ventrolateral cortex. In both entities a decrease has been noted in the cerebral volume, with diminished gray matter, evidenced in observable changes in imaging studies such as nuclear magnetic resonance and FMR.

Epidemiological and biological evidence, both of schizophrenia and bipolar disorder, indicates more coincidence than difference. It has already been shown that there is evidence of common basic neurobiological processes for both disorders, but equally important is the evidence that indicates a common genetic susceptibility, which would explain the alterations in neurodevelopment and brain myelination, as well as those observed in brain functions such as sensory discrimination and visuospatial orientation.

Likewise, recent epidemiological studies also highlight common components, making it ever more evident that the diagnostic division between schizophrenia and bipolar disorder is unable to define different etiological and/or pathophysiological entities. Large epidemiological studies, as well as recent genetic studies, reinforce the strong connection between these disorders.

In studies conducted with bipolar subjects that had psychotic symptoms, a relationship to the genome was suggested in the 8p and 13q chromosomes, which have been implicated in prior research both on schizophrenia and bipolar disorder. In other association studies for bipolar subjects with psychotic symptoms and subtypes such as bipolar patients with psychotic symptoms incongruent with mood have shown weak positive results for several potential dysbindin genes, DAOA/G30, DISC-1 and neuregulin. This is consistent with the hypothesis that subphenotypes of bipolar psychotic patients can represent a clinical manifestation of genes overlapping between schizophrenia and mood disorders.

Specific common genes, or loci, have been implicated in both disorders. The evidence suggests an overlap in the genetic susceptibility between traditional systems of classification that dichotomize psychotic disorders into schizophrenia and bipolar disorder. The most notable findings are the genes DAOA (G72), DISC1 and NRG1. Identification of genes that make individuals susceptible to psychosis will surely have a large impact on our understanding of pathophysiology, leading to changes in classifications and clinical practice. More recently, studies have compared the risk variant to the gene ZNF804A, rs1344706, finding it able to invoke susceptibility for both disorders, where homozgyous subjects showed a reduction in the cortical gray matter in the superior temporal gyrus and in the anterior and posterior cingulate cortex.

In a large study involving some 36,000 subjects with schizophrenia and 40,500 with bipolar disorder, it was found that immediate family members (parents, siblings and offspring) of both groups had an increased risk for both conditions. If a patient suffered from schizophrenia, his/her siblings were nine times more likely to suffer bipolar disorder and four times more likely to suffer schizophrenia. Half siblings with the same mother were 3.6 times more likely to suffer schizophrenia if their half sibling had schizophrenia, and 4.5 times more likely to suffer bipolar disorder. Half siblings with the same father were 2.7 times more likely for schizophrenia and 2.4 times more likely for bipolar disorder. Adopted children with a biological father with either of the disorders had a significant risk for the other disorder. This leads to the conclusion that both shared and unshared environmental factors contribute to risk, but to a lesser extent than genetic predisposition.

In an extensive association study conducted by the International Schizophrenia Consortium, the genomes of 3,322 Europeans was compared to 3,587 control subjects, showing the extent to which common genetic variations underlie the risk of suffering schizophrenia. They found the major histocompatibility complex on chromosome 6, as well as chromosome 4 related to cognition and 11 related to perception, indicating that there is genetic evidence for a polygenic component for the risk of suffering schizophrenia, which involves thousands of common alleles of very little effect. This component also contributes to the risk of suffering bipolar disorder, but not for other non-psychiatric disorders.

All these findings lead us to consider that the relationship between schizophrenia and bipolar disorder could be described either as two pathologies that present a high level of overlap, or as a continuum that presents one common nucleus of genetic, neurochemical, and structural susceptibility. Some authors suggest that as a model of the relationship between schizophrenia and bipolar disorder, extended endophenotypes should be established, which, based on a common genotype, would share one neuroanatomy, one physiopathology and certain cognitive impairments that would present a particular clinical manifestation. Other authors have come to suggest that the current model of schizophrenia includes multiple phenotypically juxtaposed syndromes and that, as such, the unitary concept of schizophrenia may have come to an end, meaning we must configure the known facts on genomic, environmental, endo-
phenomic and phenotypic dimensions to identify groups of 
etiopathologically significant and empirically demonstrable 
entities. It can be concluded that the findings described on 
the relationship between schizophrenia and bipolar disor 
der constitute a challenge for the conception that they are 
unrelated diagnostic entities. These disorders represent a 
continuum of deficits in neurodevelopment influences both 
genetically and environmentally, more than etiologically 
separate entities.\textsuperscript{105} Major clinical syndromes, in part for the 
severity and for the predominant pattern of abnormal brain 
development, result in functional deficits, modified in turn 
by other genetic and environmental factors.\textsuperscript{106,107} 

Current classifications are based on symptoms and ign 
ore etiology. It is said that these classifications have a high 
level of reliability, an uncertain validity, and a variable util 
ity. Biological criteria must be established for the current 
diagnostic entities. The biological variables and the endo 
phenotypes established could validate the diagnostic enti 
ties following quantitative and qualitative methods. There 
is no doubt that contemporary neurosciences are close to 
bringing clinical practice to identify the "underlying impair 
ment," as Kraepelin desired. But psychiatry does not read 
symptoms as they do in neurology, a more topographical 
and synchronic discipline, where the relationships are clear 
ly established between injury, symptom and sign. Access to 
the experiential world of the patient requires, in addition 
to an understanding of his/her body, a diachronic exercise 
that reveals the meanings and their value in the subjectivity 
of the patient. In summation, it is a matter of a hermeneu 
 tic with a higher level of complexity.

**FINAL REFLECTIONS**

Affirming the existence of a "unitary psychosis" would be a 
controversial act given the clinical and neurobiological data 
we have reviewed. However, the proposal of Llopis regard 
ning the *axial syndrome common to all psychoses* (in plural, and so 
multiple), seems to us an idea that sheds a lot of light on the 
phenomenon, and one that is not theoretically exhausted. In 
the same way, it seems difficult to construct clinical structures 
as separate entities by virtue of recent research. At best, the 
solution would be to do more nosology and less nosotaxis. 

The historical approaches toward unitary psychosis 
indicated by Berrios have in common their basis on a natu 
ralist focus on the phenomenon, inherent to the positivism 
so present in the sciences, even today. From this perspec 
tive, everything points to an enormous symptomaticatology, 
biological and even therapeutic overlap between schizo 
phrenia and bipolar disorder. However, another episte 
miological possibility is opened by way of systems theory, 
chaos theory, and complex thought. This is how we want 
to suggest the possibility of a new reading of psychopatho 
logical phenomena, as a tension between the stochastic and 
the anankastic, which underlies many biological and social 
 happenings. Both in health and in disease, many processes 
coexist, which are inherently linked to life. Apostosis must 
occur, while neuroplasticity and neurogenesis must occur at 
the same time. Using complex thought, it is easier to under 
stand and accept the dynamics of programmed regularities 
and emerging chaos.

Although from a mechanical and determinist point of 
view, there are strong reasons to think that human be 
havior is overdetermined by cerebral biological conditions, 
we cannot deny the processes which lead to the forming of 
self-consciousness and that occur in the connection between 
the sociodependent internal circuits and the so-called "exo 
brain," represented in the myriad symbols that circulate in 
our culture and that allow us to "conceive" objects, unlike 
signs and signals, which only announce them. This is rel 
evant, because Bartra believes that there is found the seed 
of our own free will, which he believes to have a miniscule 
representation in the entirety of our behavior.\textsuperscript{108} So, it bears 
mention the importance of the hermeneutic effort in inter 
preting this symbolic world, and its value for the under 
estanding of the psychotic existence. Although the so-called 
"free will" has a quantitatively miniscule share of overall 
behavior, its specific weight in the organization of subjectivity 
is enormous and fundamental. In some way we could see it as the apex of the processes of autopoiesis that lead to the expression of subjectivity, arrested by the anankastic impositions of the psychotic process.

We believe that in the psychotic structure of world, men 
tal life is anchored to some anachronic place of the *physis*, 
from which it is anankastically regulated and subjected to a 
progressive sclerosis that suspends the autopoietic systems. It 
is a process where the many expressions of the entropic (en 
ergy seeking to organize itself) end up absorbed by a mineral 
izing structure, leaving very little for the fresh and chaotically 
unexpected of healthy behavior. It is evident that in mental 
illness there is a loss of complexity. As such, nineteenth cen 
tury positivism must be transcended if the search for mental 
health seeks to arrive at a restitution of subjectivity with all its 
richness. An understanding of these phenomena will result in 
new therapeutic practices, both psychosocial and biological, 
and psychiatry will come closer to the concept of the science 
of liberty, as Henri Ey once proposed.

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