To Study The Relationship Of Classification Of Depressive Disorders With The Hahnemannian Concept Of Mental Illness

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Abstract: Background: Hahnemann (1996) has classified mental illnesses in a rather different way. He understood the mental illness not very different in kind from the physical illness. He classified the illnesses on the principles of cause and effect and the dynamic shift of the illness from the body to mind or vice versa. Aim & Object: To classify patients suffering form Depressive Disorder as per DSM IV criteria. To determine the relationship of this classification with that enunciated in the 215,216, 221 and 225 aphorisms of Organon of Medicine. To evolve the totality of patients on the basis of the above evolved Hahnemannian classification of Depressive Disorders. To project a therapeutic plan based on the finding in 1, 2 and 3 above. Material And Methods: Detailed interview focusing mainly upon symptomatology for arriving at a comprehensive clinical diagnosis according to DSM IV. Studying the evolutionary pattern of the selected cases to understand them according to the Hahnemannian classification. Correlating the therapeutic outcome with the principles used and thus discovering any correlation between the two approaches. Result and Conclusion: The conclusions range from the conceptual clarity of the applicability of the two systems of classification together to the specific understanding of the requirement of appropriate remedy in the appropriate potency and repetition based upon a collective understanding of the predisposing and maintaining causes and the susceptibility. The importance of understanding of the susceptibility came out as the most important aspect in the combination of the two systems of classification. [Joshi H Natl J Integr Res Med, 2022; 13(6): 10-17, Published on Dated: 15/11/2022]

Key Words: Depressive Disorder, Mental Illness, Homoeopathic Treatment

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Introduction: Clinical Depression is increasingly becoming one of the most common mental illnesses in the developing world (DSM IV, 1991) Disturbances in functioning due to this not only hampers the quality of life of those affected but also that of the community in general.

Depression presents in a variety of forms ranging from very mild, short lasting to a very severe depression that may lead to suicide. Classification is extremely important and will help in the understanding of the phenomena and guide in developing specific therapeutic measures to deal with the specific conditions.

As a Homoeopath, understanding the nature of these illnesses helps us to plan our therapeutic measures and gauge the need for the use of different forces – medicinal and non-medicinal.

Different types of the illness, viz. Dysthymia and Major Depressive Disorder have a very different clinical course and hence a different prognosis. They differ in intensity and duration. Thus the episodic nature of Major Depressive Disorder with a complete recovery and the prolonged period of "low" feeling in Dysthymia are clearly distinguished. The case where the depression has evolved from an existing medical illness has a very different homoeopathic understanding as compared to the cases where the depression has somatised in to a certain bodily illness.

For the Modern Psychiatrist these intricacies will not have any meaning as in the evolution of the depression or its effect on the body. Also the modern system has a segregation of the therapeutic services to be provided to the patients suffering from depression.

The Psychiatrists treat depression with the pharmacological chemicals while the Psychologists and the Counsellors provide only with the psychological counselling (Morgan 1993). While in the homoeopathic practice the homoeopath is expected to be doing all these together at the same time. This leaves us with a huge demand to be well versed with the knowledge of both the system; Modern Psychiatry and principles of Homoeopathy.

Material & Methods: Sources Of Data: Patients coming to the Psychiatric department of the Dr M. L. D. Trust's Rural Homoeopathic Hospital, Palghar. Patients visiting all the other clinical centers of the institute.

Method Of Study: (Including Sampling Procedure If Any): Detailed interview focusing mainly upon symptomatology for arriving at a comprehensive clinical diagnosis according to DSM IV.

Classification of the symptoms into Conation, Cognition and Affect, thereby diagnosing the case on the Multi-axial system. (DSM IV; Kaplan,), Detailed interview focusing on diagnosing the patient as a person (the mind and physical generals), Studying the evolutionary pattern of the selected cases to understand them according to the Hahnemannian classification, Constructing a totality of the patients by incorporating the principles of both the approaches and assessing the susceptibility.

(Kapse, 2003), Projecting a treatment plan based on the Totality erected, Correlating the therapeutic outcome with the principles used and thus discovering any correlation between the two approaches.

Inclusion Criteria: Study will include all the cases fulfilling the general criteria for Depressive Disorder as laid in the DSM IV. Cases diagnosed as Major Depressive Disorder, Dysthymia or Depressive Disorder not otherwise specified as per the DSM IV.

Exclusion Criteria: Cases having features of Mania, Hypomania or any other psychiatric disorder.

Results: Out of the thirty cases studied, 16 cases were of males (53.28% of all the cases) and 14 of females (46.72% of all the cases).

Table 1: The Age Wise Distribution Of The Patients That Were Studied Was As Follows

Age-Group (Yrs.)	Total Number
15 – 25	3
26 – 35	10
36 – 45	6
46 – 55	5
56 - 65	4
66 - 75	2
Total	30

Out of the 30 cases studied, there were a total of: 22 cases Major Depressive Disorder. (73.26% of all the cases).

6 cases were diagnosed to have Dysthymia. (19.98% of all the cases). 2 cases had Depression due to General Medical Condition. (6.66% of all cases).

Among the 22 cases of Major Depressive Disorder, there were: 1 Case of less than 6 months duration = 3.33% (of all the cases). 12 Cases of MDD chronic type= 39.96% (--"--). 9 Cases of MDD recurrent type= 29.97% (--"--).

Out of the twenty two MDD cases, the Recent Onset case was classified in to the Type II of Hahnemannian classification.

Out of the 12 MDD chronic, cases there were: 5 Cases that were classified in to Type III of Hahnemannian classification. (16.65% of all cases).

6 Cases that were classified in to Type IV of Hahnemannian classification. (19.98% of all cases).

1 Case was classified in to the Type I of Hahnemannian classification. (3.33% of all cases)
Out of the nine cases diagnosed as MDD recurrent, there were: 5 Cases that were classified in to Type III of Hahnemannian classification. (16.65% of all cases).

3 Cases that were classified in to Type IV of Hahnemannian classification. (9.99% of all cases).

1 Case was classified into Type II of Hahnemannian classification (3.33% of all cases)
Of the six cases of Dysthymia: 4 Cases were classified as Type IV of Hahnemannian classification. (13.32% of all cases). 2 Cases were classified as Type III of Hahnemannian classification. (6.66% of all cases).

The classification as per the Hahnemannian classification, we can see that there were: 2 Cases belonging to the Type I Hahnemannian classification. (6.66%). 2 Cases belonging to the Type II Hahnemannian classification. (6.66%).

12 Cases belonging to the Type III Hahnemannian classification. (39.96%). 14 Cases belonging to the Type IV Hahnemannian classification. (46.62%).

While diagnosing the phase of the illness we see that out of all 30 cases: 18 Cases are in the functional phase. (59.94%). 6 Cases are in the structural-reversible phase. (19.98%). 6 are in the structural-irreversible phase. (19.98%).

Both the Type I cases (Case nos. 10 and 18) were structurally irreversible stage due to the nature of General Medical Condition. Of the 3 cases coming under Type II, all were in the functional stage of the disease evolution. Of the 12 cases that were classified as belonging to the Type III class: 11 Cases were found to be in the functional phase. (91.66%) 1 Case was found to be in the structurally irreversible phase. (8.33%). No cases are in the structurally reversible phase.

Out of the 14 cases that were classified to belonging to the Type IV class of Hahnemannian classification: 5 Cases are in the functional phase. (35.71%). 6 Cases are in the structurally reversible phase. (46.15%). 3 Cases are in the structurally irreversible phase. (23.07%).

While studying the treatment of the cases taken up it was seen that out of 30 cases: 19 Cases required only the constitutional remedy. (63.27% chances of the constitutional remedy being indicated.) 9 Cases required Constitutional and had to be supported by the Intercurrent (anti-miasmatic) remedies. (29.97% chances that the constitutional remedy may need help of the intercurrent to relieve the patient.)

2 Cases required the Phase remedy. (6.66%). No cases were managed by the anti-miasmatic medicines alone. Out of the 19 cases that required constitutional remedy: 2 cases received only the 30c potency in the course of treatment. Out of these only one case showed a cure. (50% chance of the 30c potency working curative.)

1 Case improved when shifted from the 30c to 200c potency. (Cannot comment on this as there is only one such case.) 8 Cases were treated by the 200c potency alone. It was seen that 3 cases showed significant amelioration when the doses were repeated frequently. (37.5% chances of the 200 potency providing relief). 4 cases did not show a significant relief in the symptoms and the state of the mind. (50% chances of the potency not being useful.). 1 case required infrequent doses and showed significant relief. (12.5% chance of infrequent repetition of the 200c potency working good.)

In 3 cases the potency was raised from 200c to 1M almost all of them showed a favourable result. In about 5 cases the constitutional was released in the 1 M potency and all of them showed a complete amelioration. (100% result seen).

(It shows that the Constitutional medicine in the higher potency-1 M works significantly better than the lower potencies-30c and 200.)

Out of the 9 cases that required the introduction of the intercurrent medicine with the Constitutional medicines: 30c potency was used in 1 case with complete amelioration.

200c potency was used in 2 cases but with no relief. In 4 cases the potency was raised from 200c to 1M. In these 3 cases showed moderate to good result while 1 case did not respond well. (75% chances of amelioration.)

2 cases received 1M potency where only 1 responded favourably. (50%). 2 cases required the Phasic remedy that was indicated at the time of prescription. Out of these one showed a good result while the other failed. A study of the posology cannot be done in these cases.

Discussion: The basis on which the Hahnemannian classification was done was found to be of practical use. Its application helps to identify the predominant causative factors in the case. Knowing the nature of the Predisposing cause helps us to identify the fundamental miasm in the case.

Knowing the Disposition helps in identifying the vulnerabilities, and propensities of an individual which helps in forming the totality of symptoms.

This also helps in the planning of the treatment of the individual as in assessing the need for medicinal and the psychotherapeutic measures.

Thus highlighting the implication of Hahnemannian classification in the formulation of the therapeutic plan for the patient.

The precipitating cause is the most important cause as far as homoeopathic prescribing is concerned. If present it is the most important symptom in the totality. The maintaining causes can also be identified as the one that maintains the mental state (illness) and is also responsible

for the progress of the illness to the physical plane. The application of this helps us in planning and programming of the case with respect to the posology and repetition of the remedy.

The study of the progress of the illness from the body to the mind as in Type I mental illness or from the mind to the body as in the Type III helps us to assess the susceptibility, the phase of the illness. This has a prime importance in deciding the therapeutic measures required in the course of the treatment.

Major implication is on the choice of the remedy – phasic, constitutional or anti-miasmatic – its posology and repetition.

Identifying the correlations between the DSM and the Hahnemannian classification we see that: The Axis 1 diagnosis gives the nature of the illness, its course whether acute as in MDD, recent onset (that can be classified as Type II of the Hahnemannian classification as seen in the case nos. 2, 21, 27) or chronic protracted course seen in the MDD, chronic or Dysthymia (that can be classified in to either Type III or IV of the Hahnemannian classification as seen in most of the cases) or a recurrent episodic pattern seen in the MDD recurrent (which may be classified in to Type III and IV of the Hahnemannian classification). Depending upon the intensity and pace of the illness the treatment can be appropriately planned.

The Axis 2 dealing with the personality disorders and prominent ego- defence mechanisms used by the patient gives an understanding of the patient's personality similar to that derived in the Disposition in the Hahnemannian classification.

The only difference may that the disposition identified may not always be classified as a disorder yet have a bearing on the psychopathology. Here we see the additional benefit of the Hahnemannian classification over the DSM for homoeopathic management of depressive disorders.

The Axis 3 becomes helpful for identifying the co-existing physical illness if it is the causative element for the depression as in Depression due to General Medical Condition (this correlates with Hahnemannian Type I mental illness or Type IV if it is a result of the mental illness – psychosomatic).

This helps in understanding the phase of the illness and understanding the susceptibility of the case along with the dominant miasm.

The Axis 4 correlates with the maintaining factors which keep up the illness. This could be an intra-psychic or factor relating to the environment that needs to be dealt with appropriately. This will also have an implication on the management plan as in what all things the patient has to modify about himself and how much of the immediate environment needs to be modified as Hahnemann has mentioned in the 4th aphorism.

The Axis 5 is used an indicator and ca be used as a prognostic evaluator.

Identifying the importance of the cause, its nature along with the clinical diagnosis as pre the DSM Multiaxial system: Here we see that in cases of MDD recent onset, mostly we find a definite cause. This along with the sudden onset makes it to be classified as Type II of the Hahnemannian classification as we see in the case nos. 2, 21 and 27.

The MDD, chronic gets classified mostly as Type IV or Type III depending on the presence or absence of somatization i.e. if a psychosomatic illness has been resulted the case is classified as Type IV.

The MDD, recurrent predominantly is classified as Type III. These cases generally do not show evidence of any somatic illness occurring due to the depression. They may have somatic symptoms but in these cases there is no "physical illness" distinct from the depression, they are just somatic symptoms, hence classified as Type III.

They can progress in to the Type IV illness if the maintaining factors persist over a period of time.

Dysthymia case mostly gets classified in Type IV than Type III. The maintaining factors in cases of Dysthymia (similar to cases of MDD, chronic) are generally active for a longer time and hence its long protracted course gets somatized more than that in the MDD recurrent type. Hence the cases of Dysthymia are more often classified as Type IV than in Type III.

Depression due to General Medical Condition is always Type I. as it is very clear that the depression in cases where there is a severe

medical illness as seen in case nos. 10 and 18, the depressed mood arises as a result of the medical condition, IHD being by far more commonly seen.

Hence it is seen that Depression as a group when classified as per the Hahnemannian classification falls more often in the Type IV and Type III followed by Type II and Type I in order of decreasing frequency.

Studying the phase of the illness in cases of Depression according to the Hahnemannian classification we see that: The cases of Type I class as in case 10 and 18, show changes at the physical structural level that are irreversible in nature.

Most of the Type II cases show functional changes i.e. they do not have structural involvement of any tissue at the physical level. The functional changes are seen only at the mental level and the physiological level as seen in the case nos. 2 and 21.

Most of the Type III cases show functional changes. As in the Type II the cases do not have structural involvement of any tissue at the physical level. The functional changes are seen only at the mental level and the physiological level. (Case nos. 1, 4, 5, 7, 9, 13, 14, 15, 17, 22, 26, 30 demonstrate these changes.)

The Type IV cases show all the three types of changes. As the cases show somatization of the mental illness, they show all the three types of changes i.e. functional (case nos. 6, 8, 11, 27, 28), structural reversible (case nos. 12, 16, 19, 20, 23, 24, 25) and structural irreversible (case no. 29).

Hence the most common among them are the structural reversible changes, functional changes then the structural irreversible changes, in the decreasing order.

Studying the variation of susceptibility and sensitivity based on the symptomatology and phase diagnosis, in the cases of Depression according to the Hahnemannian classification we see that: The cases of Type I class (case nos. 10, 18) show a low susceptibility at the tissue level (the organ involved, Axis 3) due to the structural irreversible phase and less characteristic symptoms, but the sensitivity at the level of the mind and nerves is high. From the understanding of the phase of the cases of Type II, the assessment of the susceptibility and sensitivity is in the higher zone. Similarly in the assessment of the cases of Type III (Case nos. 1, 4, 5, 7, 9, 13, 14, 15, 17, 22, 26, 30) the susceptibility ranges from low to high depending upon the clinical syndrome.

The study shows that the susceptibility was found to be high in cases 1, 4, 5, 7, 13, 17, 22, 26, 30 and low in cases 9, 14, and 15 demonstrating the higher prevalence of high susceptibility in Type III cases.

In the Type IV cases the cases in the functional phase (case nos. 6, 8, 11, 28) show high susceptibility except the case 27 having a low susceptibility. The structural reversible cases (case nos. 12, 16, 19, 20, 23, 24, 25) show high susceptibility more than low susceptibility. The structural irreversible case (no. 29) shows a high susceptibility because of the presence of the characteristic modalities and other characteristic symptoms.

It has been classified as structural irreversible due to the presence of structural changes of the rectocele, cystocele and prolapse of uterus.Hence most of the Type IV cases demonstrate a high susceptibility and few show low susceptibility. Over all study demonstrates the high prevalence of High Susceptibility in the cases of depression and ALL the cases have High Sensitivity.

Studying the pattern of totality available and the remedial force required in the cases according to the Hahnemannian classification, we find that: In the 2 cases of Type I, Constitutional totality was found in case no. 10 which required Constitutional remedy and case no. 18 had a Sector presentation requiring a Sector remedy followed by a Phasic totality of the mind requiring a Phase remedy.

The response of the phase remedy in the overall pathology of the patient (psychopathology and the physical pathology) suggested that it could have been the Constitutional remedy of that patient in retrospective analysis.

In the Type II cases, all the cases had a Constitutional totality and therefore required a Constitutional remedy. In the Type III cases, only case no. 17 shows a phase totality and received a phase remedy. The other 11 cases have a Constitutional totality and hence received a

constitutional remedy. Due to the miasmatic load (fundamental and dominant) cases 4, 14, 22 and 30 required an ant- miasmatic as an intercurrent to enhance the action of the constitutional.

Hence in Type III cases mostly only constitutional remedy is indicated some may require an intercurrent while rarely a phase remedy is indicated.

In the Type IV cases, out of the 13 cases all the cases exhibited a constitutional totality and hence required the constitutional remedy. Out of these, 10 cases (11, 13, 16, 19, 20, 24, 25, 28 and 29) did well only on the constitutional where as 4 cases (3, 6, 8, 23 and 27) required an anti-miasmatic as an intercurrent remedy in the course of treatment.

Hence it can now be state that the type of totality evolving in the cases of depression in general is mostly constitutional and require constitutional medicine most of the time.
Studying the posology and the repetition of the constitutional remedy in the cases of depression we find that: In the Type 1 cases as the susceptibility is low most of the times as seen in the cases 10 and 18 they require a lower potency preferably 30c in frequent repetitions. To start with it can be given weekly and later may be daily doses.

As the susceptibility improves with the correct remedy the potency should be raised to the 200 when the rate of improvement slows down or evidence of more functional disturbances are seen. The rate of requirement of intercurrent remedy is higher in Type I cases.

In the Type II cases the susceptibility and sensitivity both are high with functional disturbance in the body. This calls for the higher potency starting from 200 but preferably 1M. If the course is prolonged it means that there are maintaining factors that are at play in the case hence the recovery will be limited and not as expected from the apparent functional, high susceptibility simple case as seen in case no. 21 where the maintaining factors have led to a poor result of the treatment.

Here intervention to remove or modify the maintaining factors or isolating the patient from them is required. In the Type III cases it observed that the constitutional remedy I the 1M potency work best in infrequent doses when the susceptibility is high and there are little or no maintaining factors. It can be see in some cases that the constitutional remedy in the 1M potency effected a change in the dispositional sensitivity and helped develop better adaptation to the situation without any psychotherapy.

Some patients require psychotherapy or counselling to help develop the coping mechanisms to deal with stress. Cases with low susceptibility or where the maintaining factors are active require the constitutional remedy in either 200c or 1M potency with frequent repetition e.g. Case on. 15 required the 30c initially but later got improved by the 200c in frequent doses, Case no. 9 exhibits a low susceptibility and required frequent repetition of the 200c potency before stepping it up to 1M after which there was a significant relief.

Case no. 14 required an intercurrent remedy as the maintaining factors were too strong. Cases with significant predisposition or family history of depression may also require the intercurrent anti-miasmatic remedy.

In the Type IV cases when the susceptibility is high a significantly better result is obtained by using the high (1M) potency even if there be predisposing factors along with Structural reversible change (Case no. 16). Cases with high susceptibility started with the 200c potency need much frequent repetitions (Case no. 11) and also at times an intercurrent, eventually the satisfactory change is seen when the potency is raised to 1M.

(Case no. 3): Cases with low susceptibility but in the functional phase show better response to the constitutional in 200c to 1M along with the intercurrent as and when indicated (Case no.19).

When only the 200c potency was used there was not much improvement (Case nos. 27 and 28).

Case no. 14 gives an example of the 30c potency indicated when the maintaining factor was predominant.

Cases with structural reversible changes exhibiting a low susceptibility require an intercurrent remedy along with the constitutional remedy in the 200c with frequent repetition, where the maintaining factors are active in the

environment show a partial relief (Case nos. 25). When the potency was raised to 1M showed a significant response (case no. 12).

The structural irreversible cases where the maintaining factors are active and the susceptibility is high respond better to 200c in frequent repetitions with complete recovery when the maintaining factor was dealt with.

Whereas when the susceptibility is low in a structurally irreversible case the intercurrent is required along with the constitutional remedy in the 200c potency and stepping up the potency after appropriate assessment of the improvement in the susceptibility, to 1M.

Conclusions: Form the undertaken study, "To Study the Relationship of Classification of Depressive Disorders with the Hahnemannian Concept of Mental Illness", we can make the following conclusions: Hahnemannian classification is applicable to the current understanding of the Depressive Disorders and also Mental illnesses in general.

It has a definite clinical application in the practice of homoeopathy but it is not seen to be practiced very often. The DSM classification has much more application to the practice of homoeopathy than just giving the clinical diagnosis, which apparently some homoeopaths today do not give the due importance.

The integration of both the systems of classification can give more than definite guidelines for the treatment of individuals suffering from Depressive Disorder of any kind.

Knowledge of DSM's Axis 1 helps to understand the symptomatology, its severity and course of the illness. Thus helps in prognostication and planning of the treatment. Knowledge of DSM's Axis 2 correlates with the homoeopathic understanding of the Disposition and helps individualize the patient not only at the symptomatic level but also at the level of the psychodynamics and the ego- defence mechanisms.

A conglomeration of the characteristic symptoms along with the personality of the patient gives the constitutional totality, which is most frequently available in the patients with Depressive Disorders. From the above points hence we may infer that the constitutional remedy is the most commonly indicated remedy in the patients of Depressive Disorder.

Knowledge of DSM's Axis 3 gives an insight into the associated medical illness present along with depression. An extension of this can be made according to the Hahnemannian classification to segregate the somato-psychic (Type I) from the psycho-somatic (Type IV).

This extension helps in the assessment of the susceptibility and sensitivity taking in to consideration both body and mind. The assessment of the susceptibility has a direct implication on the planning and programming of the potency and repetition.

A comprehensive understanding of the variation of susceptibility in the four types of mental illness gives us the most likely indicated potency and repetition of the constitutional remedy. It also suggests the indications of the use of intercurrent anti-miasmatic remedy or a raise in the potency.

Generally it is seen that most of the cases show a high susceptibility and hence require a higher potency of the constitutional remedy with repetitions planned according to the maintaining factors and the disposition of the patient.

If the susceptibility is low then the case requires frequent repetition and at appropriate time the potency needs to be raised as per the susceptibility to get a better result at the dispositional level, or requires an intercurrent remedy if there is presence of tissue changes of irreversible nature.

Sensitivity is almost always found to be high. Knowledge of DSM's Axis IV helps in identifying the maintaining factors in the circumstance.

Hahnemann has also stated the importance of identification and removal of these factors in the management of the Depressive Disorder.

The plan of the treatment thus will not only include the remedial measures but non-remedial measures also like psychotherapy or in some cases even rehabilitation. Thus we see the applicability and the correlation of the Hahnemannian classification and DSM classification in the management of Depressive Disorders.

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Conflict of interest: None
Funding: None
Cite this Article as: Joshi H. To Study The Relationship Of Classification Of Depressive Disorders With The Hahnemannian Concept Of Mental Illness. Natl J Integr Res Med 2023; Vol.13(6): 10-17