

**Monopolar Affective Psychoses:
Pure Melancholia and
Pure Depressions according to the
Wernicke-Kleist-Leonhard-School**

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Classification of the Endogenous Psychoses

| | favourable prognosis | | | unfavourable prognosis | |
|------------------|---|---------------------------------|---------------------------|--------------------------------|------------------------------|
| Kraepelin | manic–depressive insanity | | | dementia praecox | |
| Bleuler | manic–depressive illness group of schizophrenias | | | | |
| DSM–IV ICD 10 | affective disorders | | schizoaffective disorders | | schizophrenia |
| Leonhard | monopolar affective psychoses | manic– depressive disease | cycloid psychoses | unsystematic schizophrenias | systematic schizophrenias |

Classification of the Endogenous Psychoses in Leonhard's Differentiated Psychopathology

monopolar affective psychoses
manic-depressive disease

cycloid psychoses
anxiety-happiness psychosis
confusion psychosis
motility psychosis



**favourable
prognosis**

unsystematic schizophrenias
affect-laden paraphrenia
cataphasia
periodic catatonia



**unfavourable
prognosis**

systematic schizophrenias
systematic paraphrenias
hebephrenias
systematic catatonias

Basic Conceptual Differences between ICD 10/DSM IV and Leonhard's Classification

DSM IV / ICD 10

Diagnosis is made by the identification of a

minimum number of symptoms from a given symptom-catalogue which have to exist over a **given period of time.**

Leonhard's classification

Diagnosis is made by the evidence of

characteristic symptom constellations (specific symptoms form **characteristic syndromes**), which run a **typical course** (**prognosis**).

descriptive psychopathology

|

symptom connections

(„Symptomverbindungen“)

cardinal symptoms / core disturbances
facultative symptoms

|

clinical entities

(„Krankheitsgruppierungen“)

|

nosology of mental diseases

differentiated aetiology

Depressive Episode according to ICD 10

absence of etiological assignment (reactive or endogenous)
minimum number of symptoms with duration of ≥ 2 weeks

symptoms (the individual „usually“ suffers from):

depressed mood
loss of interest or enjoyment
reduced energy leading to increased fatiguability and
diminished activity; marked tiredness after only slight effort

} 2 out of 3

other common symptoms:

reduced concentration and attention
reduced self-esteem and self-confidence
ideas of guilt and unworthiness
bleak and pessimistic views of the future
ideas or acts of self-harm or suicide
disturbed sleep
diminished appetite

} ≥ 2 out of 7

somatic syndrome („melancholic“, „vital“, „endogenomorph“):
(„recorded by those who so wish, but can also be ignored“)

loss of interest or pleasure in activities
lack of emotional reactivity to normally pleasurable events
depression worse in the morning
psychomotor retardation or agitation
marked loss of appetite, weight loss, marked loss of libido

} 4 out of 8

International Classification System (ICD, DSM)

recurrent depressive disorder

unipolar course
“switch” to bipolarity in 10–50%
of cases

manic episode (only ICD)

unipolar course

bipolar affective disorder

bipolar course

Differentiated Classification acc. to K. Leonhard

Manic–depressive Illness

bipolar course
unipolar course
mixed states / partial states

pure phasic psychoses
(pure mania, melancholia
pure depressions/euphorias)

strictly monopolar syndromes
without mixed or partial states
strictly monopolar course

Manic-depressive illness

bipolar phasic psychoses; potentially unipolar course
symptoms vary not only between the poles, but in each phase
different pictures are noticeable => polymorphic form

- essential feature is the manic or melancholic basic syndrome, with distinct modifications of the core syndrome:
incompleteness or absence of essential single (cardinal) symptoms (absence of thought or psychomotor inhibition) or partial states of pure mania or melancholia
- more rarely: mixed states, in which in place of the missing symptom a symptom of the opposite pole appears (i.e. depression with flight of ideas)
- broad range of symptoms partially mimicking pure forms or even cycloid psychoses
obtrusive depressive ideas, stuporous states, change of symptoms during the episode
- unstable, labile depression (brightened during conversation auffhellbar)
unstable elevated mood (transition to testiness)

Phasic Psychoses: Characteristics of Subjects

| total sample (n= 399) | monopolar affective psychoses (n= 66) | | manic-depressive illness (n= 158) | | cycloid psychoses (n= 175) | |
|---|---|------|---|------|----------------------------------|------|
| gender distribution (F/M in %) | 17.9 | 15.8 | 40.0 | 39.4 | 42.1 | 44.9 |
| age at onset (years) | 41.7 | 15.9 | 33.2 | 13.6 | 26.7 | 9.3 |
| age at first hospitalisation (years) | 46.2 | 16.0 | 39.1 | 14.2 | 28.7 | 9.7 |
| duration of disease (years) | 12.7 | 12.6 | 14.8 | 12.5 | 10 | 9.8 |
| total number of episodes | 5.2 | 4.4 | 9.8 | 15.8 | 5.6 | 5.6 |
| number of episodes requiring hospitalisation | 3.8 | 3.3 | 4.8 | 5.9 | 4.8 | 4.9 |

recruited at the Dept. of Psychiatry, Psychosomatics and Psychotherapy, University of
Würzburg, 1995-2004

Phasic Psychoses: Frequency of Treatment with Mood-Stabilisers

| total sample (n= 399) | lithium | carbamazepine | valproate | combination | none |
|--|---------|---------------|-----------|-------------|------|
| monopolar affective psychoses (n= 66) | 21.2 | 1.5 | 1.5 | 4.6 | 71.2 |
| manic- depressive illness (n= 158) | 30.4 | 7.6 | 5.1 | 22.7 | 34.2 |
| cycloid psychoses (n= 175) | 19.4 | 9.1 | 9.1 | 20.7 | 47.6 |

% = percentage of probands with mood-stabiliser per diagnostic group during the course of disease

Monopolar Forms of Phasic Psychoses

- stable and distinct clinical pictures in each episode
- phasic course with the same symptomatology in each episode
- course of disease is strictly monopolar without oscillation to the opposite pole
- strictly phasic with complete remission between the episodes

- subtypes: pure melancholia
pure mania



basic symptoms
completely developed

- pure depressions
pure euphorias



specific disturbances
of higher emotional systems
thought and psychomotor
activity are not
specifically disturbed

Subtypes of Monopolar Phasic Affective Psychoses

| functional system | monopolar forms | |
|---|----------------------------|--------------------------------|
| disturbances in the area of temperament | pure melancholia | pure mania |
| disturbances in the sector of specific emotional systems („Gefühlssphären“) | pure depressions | pure euphorias |
| „Triebgefühle“ endogenous feelings | agitated depression | unproductive euphoria |
| „Sinnesgefühle“ sensory feelings | hypochondriacal depression | hypochondriacal euphoria |
| „Instinktgefühle“ situative feelings | self-tortured depression | exalted euphoria |
| „assoziative Gefühle“ associative feelings | suspicious depression | confabulatory euphoria |
| „mittelbare Gefühle“ indirect feelings | apathetic depression | indifferent/apathetic euphoria |

Melancholia

3 cardinal symptoms (core syndrome)

quiet, moderately inhibited depression, with sparse depressive ideas

depressed mood:

- anergic mood, unmotivated depressive mood (<-> sadness)
- apathetic mood with a physical decline of the feelings, „vital“ depression
- apathy, more characteristic than anxiety

psychomotor inhibition:

- poverty of expressive movements
- slowing down of all movements, slow speech pattern

thought inhibition with indecision:

- long latency periods in questions requiring reflection
- thought process inhibited, working against abnormal elaboration of ideas
- ruminating of thought, brooding

accompanying symptoms:

- limited depressive ideas (feelings of insufficiency, ideas of sinfulness, self-accusations. ideas of inferiority, fear, anxiety, ideas of alienation, depressive ideas of reference)
- impoverishment of interest
- somatic symptoms – uneasiness
- danger of suicide
- no mutism or stupor!

Hypochondriacal Depression

moderately depressed mood with obsessing misperceptions which are peculiar and point directly to bodily organs (inner organs, heart, muscle, skin etc; strange burning, drilling, pressing, not equivocal to perceptions mentally healthy people are used to experience, unlike symptoms of physical illness)

cardinal symptoms:

- moderate intensity of depression with complaints on bodily misperceptions
- misperceptions (not simply pain) involving the whole body, without organic basis
- alienation phenomena and depersonalisation, patients complain that they are not longer aware of their body, no longer touched by events and lack normal emotions

characteristic symptoms:

- fears of bodily well-being
- peculiar, sometimes abstruse descriptions of bodily sensations (no delusions, not experienced as inflicted from outside)
- only slightly depressive ideas (of inferiority or reference)
- inhibition of thought and psychomotor inhibition are always absent

Agitated (Harried) Depression

tortured–depressive state with fearful agitation lacking anxious ideation, severe and constant restlessness, sometimes with iterative and uniform complaints of feeling uneasy („Jammerdepression“), depression of vital character

cardinal symptoms:

- anxiety with inner pains and extreme affect of inappetence
- agitation without ideation, tormented restlessness, which affects the whole personality

characteristic symptoms:

- constant complaining generally increases if it is attempted to calm down
- uniform ideas of anxiety, hypochondriacal ideas,
- uniform behaviour of begging, moaning, running around, wringing of hands
- dysphoria without object
- agitated and tenacious demand of immediate discharge
- antipsychotic treatment moderates severe agitation

Self-Tortured Depression

severe, torturing ideations with agitated depressive mood
patients are calm if the ideas are not verbalised; as soon as they begin to talk about their ideas of sin and inferiority the tortured-depressive affect increases

cardinal symptoms:

- depressive ideation of exorbitant self-humiliation, self-denigration, and anxiety directed at the patient himself and at his family
- extreme, grotesque self-accusation (most despicable person there has ever been, awaiting rightfully terrible punishment)

characteristic symptoms:

- punishment and suffering will affect also their families
- if contradicted, patients insist and even more intensely repeat the correctness of their pathological ideas

accessoric symptoms:

- transitory ideas of reference, worthlessness
- rarely hallucinations (reproachful phonemes)

Suspicious Depression

cardinal symptoms:

- moderate, but continuous anxious and depressed mood without agitation
- ideas of self-reference, which are deduced from activities of their surroundings
- ideas of reference display always a depressive foundation
 - ideas of worthlessness and inferiority
 - alleged serious misconduct
 - presumed criticisms coming from the environment reflecting their own inferiority due to misconduct arising from their own fault
 - misinterpretation of events in the environment arising from depressive mood

accessoric symptoms:

- occasionally auditory hallucinations which correspond to the ideas of reference
- inhibition of thought and psychomotor inhibition are always absent
- lack of severe anxiety (<-> anxiety psychosis)
- lack of an irritated reference syndrome (<-> affect-laden paraphrenia)

Depressive Ideation vs “Delusions” in Affective Psychoses

main pathological ideas:

guilt – pauperism – illness

punishment for alleged serious misconduct or wrongdoing

ideas of inferiority and ideas of guilt in a moral sense

uncovered primal fears (“aufgedeckte Urängste”, Schneider)

detached ideas of culpability (“freisteigende

Verschuldungsgedanken der reinen Ich-Schuld”, Weitbrecht)

K. Leonhard: specific forms of depressive ideas derived from

**higher levels of human experience (self-tortured depression,
suspicious depression)**

note: depressive foundation of ideas always preserved

(not connected to irritability or hostility)

sustained capability to retract one’s psychotic ideas rationally

Apathetic Depression

**harrowing state of impoverishment of feelings and will power
alienation depression (Kleist)**

cardinal symptoms

- depressed mood with impoverishment
- subjectively cooling of emotional life
- subjective kind of listlessness („Teilnahmslosigkeit“)
- absence of feelings makes up the content of the repeated complaints

characteristic symptoms

- insistent complaints on alienation and depersonalisation
- self-reproach
- compulsive brooding
- complaints on lack of sympathy in joy and sorrow, lack of feeling and lack of will
- self accusation due to non-participation

accessoric symptoms:

- occasionally ideas of reference
- inhibition of thought and psychomotor inhibition are always absent

Medical Treatment of Depressive Syndromes

in general: there exist no type-specific treatments

acute treatment

- along to the psychopathological syndrome individual treatment with antidepressant and/or anxiolytic and/or antipsychotic drugs and/or ECT
- treatment over a sufficiently long time (prolonged onset of action) and sufficiently high dosage (plasma level)
prolonged onset of action appears in ~25% of patients with assumed treatment resistant depression
- tricyclic and tetracyclic antidepressant drugs are still recommended as first line treatment in the so-called endogenous depressions (as well as organic affective disorders)

maintenance treatment

- treatment with mood stabilisers in bipolar disorders (manic-depressive illness, cycloid psychoses) recommended; lithium prophylaxis is still first choice followed by anti-convulsants or maintained antidepressant medication
- monopolar depressions are a heterogeneous group of diseases with reduced number of episodes (but longer duration of episodes) compared to manic-depressive illness; --> individual treatment of the patient