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Study of delusional depression: Drive, dynamics, therapy

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ABSTRACT

Background: The diagnosis of delusional depression is difficult on the basis of the classification systems and the therapeutic possibilities are still insufficiently researched. The suicidal risk of the disorder is particularly high. Psychiatrists are therefore often blind and paralyzed in diagnosis and treatment of the disease in clinical practice.

Methods: The present study therefore chooses a clinical-psychopathological approach. On the basis of selected historical, scientific and clinical data, an attempt is made to develop the delusional depression from an underlying disorder of the drive. A clinical case illustrates the individual steps of the investigation process.

Results: Melancholy is a separate entity in the group of depression, characterized mainly by inhibition which culminates in depressive delusions. Inhibition can be detected in all symptoms and in particular creates fear. Fear arising from inhibition, transforms individual worries about illness, poverty, and guilt into delusional beliefs. The treatment of fear with benzodiazepines therefore is of particular importance in delusional depression.

Limitations: Clinical-psychopathological studies are scientifically weak because they are based on heuristic-selected findings.

Conclusions: On the other hand, these investigations can once again clear the mind for the nature of delusional depression and the problems associated with diagnosis and therapy. Further studies on diagnostics and on the importance of benzodiazepines in treatment should follow.

1. Problems of diagnostics and therapy

Since the beginning of the 19th century, the psychiatric classification systems have concentrated mainly on the aetiology of mental disorders. Karl Jaspers and Kurt Schneider therefore based their nosological system on the distinction between psychotic/endogenous versus neurotic/reactive conditions and developed the dyadic system of psychiatry (Bürgy, 2008a). They defined psychoses as somatic diseases with a mental expression, which primarily require biological treatment, while they saw neuroses as being the results of undesirable developments in life history and where the focus is on psychotherapy. This view was transferred to depressive disorders. Endogenous, cyclothymic, melancholic and vital depressions were subsumed under the classification of psychoses and differentiated from reactive, neurotic and personality-related depression. While DSM-II (APA, 1968) still followed the distinction between endogenous and neurotic depression, DSM-III (APA, 1980) for the first time made an attempt, to dispense with aetiological hypotheses in order to improve the reliability of the classifications. Akiskal and McKinney described depressive syndromes in terms of their uniform psycho-biological stages in 1975 and thus created the preconditions for the dimensional classification of depressive conditions in terms of their severity (Akiskal & McKinney, 1975). With the introduction of DSM-III in 1980, endogenous depression was now seen as being a subtype of depressive disorder with melancholic or psychotic features. The introduction of the concept of disorders had led to the abandonment of the term "psychosis" as a description of a process. Psychosis was replaced by the adjective “psychotic.” The term psychotic now refers to the appearance of symptoms such as hallucinations, delusions, ego disturbances, disorganised thinking and behaviour. In 1991, ICD-10 (Dilling et al., 1991) additionally classified symptoms, which are described elsewhere as "melancholic, vital, biological and endogenomorphic," as being a somatic syndrome in the case of mild and medium depression. The definition of severe depressive disorder does not include this distinction, but it is described as being either with or without psychotic features. The occurrence of psychotic features is associated, both in DSM-IV (APA, 1998) as well as in ICD-10, with the severity of depression. This association is abandoned in DSM-V with regard to bipolar disorder (Rothschild, 2013). There remain numerous indications that psychotic depression, as compared with non-psychotic depression, is distinguished by the particular severity and the frequency of the phases, as well as by increased suicide rates (Coryell et al., 1996; Gaudiano, Young, Chelminski, & Zimmermann, 2008;

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Johnson, Horwath, & Weissmann, 1991). Melancholic depression is the precondition for the emergence of psychotic depression. This is evidenced by the great overlap of symptoms between melancholic and psychotic depression and by the more severe depressive symptoms in psychotic depression. The recently evaluated "Psychotic Depression Assessment Scale" therefore combines the melancholic items of the Hamilton Depression Rating Scale with the Brief Psychiatric Rating Scale (Ostergaard et al., 2014a; 2014b; 2015). Gordon Parker and his team have been calling since the 1990s for the distinction between melancholic and non-melancholic depression to be restored. They argue that the psychotic symptoms should be understood as a worsening or culmination of the melancholic syndrome (Parker et al., 1995; Parker, 2000; Swartz & Shorter, 2007). In their opinion, melancholia is a particular psychopathological and biological entity requiring a classification as a separate affective disorder and one which should be more clearly delimited from major depression (Parker et al., 2010). In DSM-IV and DSM-V (APA, 2013), precondition for the diagnosis of the melancholic type of depression is the fulfilment of the criteria for major depressive disorder. The two main symptoms of major depression, "depressive mood with sadness and emptiness" or "loss of interest or joy", are given special diagnostic weight. However, it is a problem to define these major depressive symptoms as entry criteria for the melancholic type, if they differ so strongly in quality from the melancholic type. DSM-IV and DSM-V go on to characterize melancholic features by "the lack of reactivity to usually pleasurable stimuli" and by "the distinct quality of the depressed mood." DSM-IV describes this particular quality of depressive mood as significantly different from "normal grief over the loss of a loved person". DSM-V tries to describe the melancholic mood not only by differentiating it from normal affect, but in its peculiarity as "deep discouragement, despair and/or moroseness or the so-called feeling of unfeelingness". Because discouragement and moroseness are emotions of normal psychology, they could not describe the melancholic state. Desperation is indeed significant for melancholia. It is, however, a complex affect, which is closely linked to the cognitive structure of doubt and is insufficient defined (Bürgy, 2007). It is only the "feeling of unfeelingness" which characterises the sensation of emptiness and the absence of affects and which thus points to a central aspect of the melancholic alteration.

It remains unclear how depressive delusions can even emerge at all from an affect which in the extreme consists of emptiness and lack of feeling and how the themes of delusions are selected. The classical German literature on depression and the classification systems up to ICD-10 and DSM-IV only find a relation between delusion and severity of depression. (Blankenburg et al., 1991; Janzarik, 1988; Jaspers, 1913; Weitbrecht, 1952). The delusional contents are essentially limited to the themes of "guilt and sin", "hypochondria" and "poverty". Kurt Schneider has spoken of the primal fears of people, of fears for the soul, fears for body and fears for the basic necessities of life (Schneider, 1950).

ICD-10 also lists, in addition to delusions of guilt, hypochondriac and nihilistic delusions, persecutory delusions, acoustic hallucinations with defamatory or accusatory content, olfactory hallucinations involving the smell of putrefaction, and severe psychomotor inhibition.

A distinction is made between synthymic psychotic symptoms, which are appropriate to the depressed mood and parathymic psychotic symptoms which are not appropriate to the depressive mood. Persecutory delusions or hallucinations without affective content are considered as being parathymic. DSM-V classifies the typical themes of depressive delusions, guilt, illness, death and nihilism, as being mood-congruent psychotic symptoms. The mood-incongruent psychotic symptoms listed in DSM-V include thought insertion, thought broadcasting and experiences of being influenced from the outside. These symptoms from the schizophrenic spectrum are accepted diagnostically if their appearance is confined to the depressive episode. This is why depressive disorders with mood-incongruent psychotic symptoms have more transitions into schizophrenia (Coryell & Tsuang, 1985; Coryell, Tsuang, & McDaniel, 1982; Flennig, Bromet, Tanenberg, Ram, & Jandorf, 1996).

The diagnosis of psychotic depression remains difficult, however. Rothschild et al, found there was an incorrect initial diagnosis in approximately every fourth patient and it is to be assumed that the error rate is still actually considerably higher than this (Rothschild et al., 2008).

In addition to the uncertainties in making the diagnosis, treatment remains a problem. Remission of unipolar psychotic depression occurs in 50% of patients receiving medication within 2–3 months, in 75–81% of patients within 6–12 months and in 94% of patients within 24 months. Some patients are ill for 10 years and longer (Coryell et al., 1996). It remains unclear as to whether these patients in remission regain their premorbid functioning level (Coryell, Keller, Lavori, & Endicott, 1990; Tohen, Hennen et al., 2000, 2000b).

The recommendation for combination treatment with antidepressants and neuroleptics has only recently been included in most sets of guidelines (APA, 2010; DGPPN et al., 2015; Lam et al., 2009; Leadholm et al., 2013). There is a lack of comparative studies for the combination of various antidepressants and neuroleptics and there are very widely differing views about the use of benzodiazepines. In general, it can be stated, however, that if a diagnosis is incorrectly made and if the therapy is not conducted with care, the prospects for success are unfavourable.

In view of the problems described for diagnostics and therapy, the present study is intended to provide a deeper understanding of drive, dynamics and therapy for delusional depression. Firstly, we explore the hypothesis that melancholic-delusional depression is less an affective disorder but that it should rather be seen as being a disorder of the drive. This approach may lead to a better understanding, both of the symptoms, as well as of the patients' experiences. Secondly, we describe the levels of disease dynamics. This is intended to make clear how symptoms of melancholia and depressive delusions develop from the interplay of a disorder of drive and of the patient's personality. Thirdly we develop the essential therapeutic strategies from the dynamics of delusional depression. A clinical case study illustrates the individual steps of investigation.

1.1. Case study: on problems of diagnostics and therapy

Mr A., a 48-year-old man, was treated for 15 weeks in a private psychiatric hospital. The excerpts from the patient files supplied to us, supplemented by his descriptions of symptoms are intended to illustrate the problems of diagnostics and therapy.

The hospital documents report that Mr A's promotion and the implementation of restructuring measures in his workplace had put him under increasing pressure for the previous six months. He developed "states of restlessness, involuntarily replaying thoughts, inability in decision-making, fear of failure and finally anxiety attacks," which eventually made it impossible for him to work. Neither holidays, sick leave or outpatient psychotherapy brought any improvement in his mental health. The psychopathological findings on admission and on discharge were almost identical and showed no improvement during the course of treatment. His affect was described as "depressed mood, anhedonia, loss of interests, hopelessness and lack of perspective." He had "many fears," specified as "social fears, fear of failure, fear of change, fear of not conforming to his self-image, feelings of insufficiency and of poverty." His drive was described as "a significant reduction and inhibition, morning low, with motor restlessness and severely reduced emotional resonance." His formal thinking was described as "brooding, circling and catastrophizing, thematically constricted on loss and failure." Delusions were, however, explicitly excluded. On discharge he still suffered from "sleep disruption, problems with concentration and memory, slowing of thinking and thoughts of being tired of life." On this basis, and in accordance with ICD-10, he was diagnosed as experiencing a "severe depressive episode without