

Jack R. Foucher et al.'s Wernicke-Kleist-Leonhard phenotypes of endogenous psychoses: a review of their validity

Carlos R. Hojaij's comment

Current psychiatric research in search of glory: instead of looking at a Van Gogh painting from a distance to understand what he has painted, the current research concentrates on one or two small strokes of different colors spread out across a large area; it is unable to consider the whole picture; a significant waste of time leading to inconclusive conclusions.

C.R. Hojaij

"Publication of psychiatric books, with didactic characteristics is not a preference to those specialists, maybe forgetting the numerous contributions offered to their cultural formation by the many national and international manuals and textbooks editions where are harmonic and methodologically condensed the totality of knowledge of this attractive area of medicine."

Heitor Carrilho (1943)

"Clinical psychiatry is in its worst moment. Particularly psychiatric diagnoses are so impoverished that completely different states -in terms of clinical picture as well as course- may receive the same designation. This marasmus has two causes well connected. From one side, the modern hyper-pragmatism favouring numbers devaluating the clinical pictures and trying to create a new 'Aufklärung' with the cold statistic masks. On the other hand, an insipid style full of euphemisms, not allowing a description of reality. (...) Consequently, the young student walks blindness in his clinical work. Facing this situation, we need to indicate the lost route, illuminate the track conducting to the sources. Let's describe the syndrome in full reality; and listen to the classic lectures. From the last year's coldness may return the spring colours."

J. C. Goldar (1996)

"Only the integration of empirically based classification systems in future research and treatment strategies will be essentially stimulative and may help to overcome the impending impasse of psychiatry research regarding etiology, genetics, prognosis, and differential treatment. Dogmatic and ideological reservations about classification of endogenous psychoses by Kleist and Leonhard should be dropped so that serious scientific discussion can begin."

Helmut Beckmann (2000)

In science, any kind of 'validity' is temporary, for it is dependent on a theory. In psychiatry, what is more valid is the reliability criteria, for it is based on a description of reality.

C. R. Hojaj

I welcome the inclusion of this article to INHN, together with its Appendices.

The names Wernicke, Kleist and Leonhard first came to my attention in 1965, in my third medical school year, during the one-year course of psychopathology given by Prof Paulo Fraletti. These names were part of historical aspects of psychiatry along with how they contributed to the development of our specialty. I think it is important to say that until the beginning of the 1960s medicine in Brazil had its foundation in French and German schools. I had the privilege of complementing my formation by reading several French books belonging to my father (also a doctor) and, when already inclined to psychiatry, looked into Spanish, French and Portuguese translations of German psychiatry books. Years later, in 1973, when a member of the department of Psychiatry and Medical Psychology at the Faculty of Medical Sciences, Santa Casa (São Paulo), I introduced a course for residents concerning the main aspects of Leonhard endogenous psychoses. My major source for the course was the textbook of psychiatry, *Manual de Psiquiatria*, prepared by J. Solé-Sagarra and Karl Leonhard in 1953, with a prologue by Karl Kleist.

In 1991, during the World Congress of Biological Psychiatry held in Firenze, Italy, I met a man from Würzburg who became a very good friend, Helmut Beckmann. Since that time, on several occasions I attended conferences where Helmut was presenting his work on schizophrenia and making reference to Wernicke-Kleist-Leonhard. Helmut organized several conferences in Latin America during the '90s and early 2000s. Many of them were in Argentina where he met interested and competent colleagues interested in adopting his concepts. During my time in the World Federation of Societies of Biological Psychiatry (WFSBP), organizing several educational meetings in Central and South America, a space was always open to Helmut; he always delivered his own

research and promoted the old Wernicke-Kleist-Leonhard psychiatric school. Surely due our friendship, he included my name in this society.

In 1997 Helmut wrote the foreword to *Diez Comunicaciones, Introducción a las localizaciones cerebrales en Neuropsiquiatria* ("Ten Communications. Introduction to Neuropsychiatry's brain localizations") edited by Prof. Diego Luis Outes, Dr. Luis Florian and Dr. Jose Victor Tabasso (1997). Juan Carlos Goldar, a famous Argentine psychiatrist with a solid German background, also participated in the publication.

One year before, 1996, Outes and Tabasso published a psychiatry textbook containing the first non-German complete translation of Carl Wernicke's papers, complemented with the Leonhard Endogenous Psychoses.

Leonhard's endogenous classification, translated into Spanish in 1999, was prepared by the Argentineans Outes, Tabasco and Florian, in collaboration with Beckmann. (Outes, Tabasco, Florian. (1999).

During my more than 50 years of practice, I have seen numerous patients who could fit in some of the 35 phenotypes described by Leonhard. I must stress how important are the clinical descriptions, which I would include in the non-systematic Kurt Schneider (1975) classification. I also was able to consider, for instance, that some of the so-called epileptic psychoses could be seen as cycloid psychoses and vice-versa.

Beckmann, assisted by Ernst Franzek, took the ideas and research of Wernicke, Kleist and Leonhard to Latin America, (mainly Argentina) sowing the seeds for the school's development in the region. In fact, some of the co-authors of this review publication may be considered fruits of Beckmann's efforts, like Cetkovich and Morra.

While it was difficult to apply Leonhard's classification to everyday clinical practice, this was not the primary reason for its lack of acceptance. Rather, the culprit was the splintering of traditional university research into several individual publications from different parts the world, which allowed for the proliferation of inconsistencies in methodology and interpretation, as the authors usually lacked a common perspective and experience.

I agree that resistance to Leonhard and his followers did exist, even among German psychiatrists, but my observation is not limited to this school. Even Karl Jaspers - in my opinion a kind of Hippocrates for psychiatry has been for few decades ignored in his own country.

A north-American "culture" became a prevalent force in which physicians were seduced to provide simple, superficial research and practice, aimed at easy financial profit and international acceptance. I understand this is also another example of the WKL tradition's decline, a generalized trend of the modern society.

Now I will make some limited comments concerning a few aspects of the article and the two appendices.

I understand it is a misunderstanding to say, “the ICD-DSM” paradigm has been a major advance in clinical psychiatry” and it holds “usefulness for biological psychiatry.” (Foucher et al). The DSM (which highly influenced the ICD) became a systematic instrument for reducing the psychiatry born in Europe (mainly France and Germany) to a ridiculous list of symptoms selected by all sorts of people, from professors of psychiatry to the family of psychiatric patients, and advisors from the big pharma, intent on composing what they call a “diagnostic manual.” The DSM practically ignored the essential scientific catamnestic studies developed over several years, even decades, by remarkable departments of psychiatry. The formidable archives of clinical history elaborated under an organized method allowed constitution of psychopathology and elaboration of a psychiatric nosology. Nosography came second, because more important is a description and identification of the disease, and not its classification. The richness of Wernicke-Kleist-Leonhard school is the detailed observation and description of numerous patients over years, grouping and separating by similarities and differences in hereditary, evolution and treatment.

Independently of adhering or not to the Leonhard classification of endogenous psychoses, comparing it with DSM only causes damage. The former is like the big Argentinean grilled steak adored by Beckmann and the latter a lettuce salad without dressing.

The idea that there is a distinction between clinical psychiatry and biological psychiatry is equivocal. There is only one psychiatry. The term “biological psychiatry” should be strictly applied to a specific period in history when the emphasis was on calling for the return of psychiatry to biological aspects, as much as to the philosophical and social elements of the human expression. It is important to remember that Jaspers, in the last edition of his monumental *General Psychopathology*, finished in 1942, only published in 1946 (as a consequence of WW-II), with contributions by Kurt Schneider, wrote: “There is a need to develop a ‘biological’ psychiatry. ‘Biological here means considering the whole of life, not just one of its manifestations, somatic or psychological” (Jaspers 1963). In an editorial published in *The World Journal of Biological Psychiatry*, I commented on how the predominance of neuroscience under an exclusive objective and materialistic perspective was reducing psychiatry to a simplistic medical intervention, leaving behind its fundamental humanistic aspects. The main issue for this “going off track” was the disregard for psychopathology. Biological psychiatry must incorporate the current knowledge of biology and conceive man in his whole dimension, where the psychic and the spiritual are consistent, real parts. I concluded that we should be rephrasing our specialty to psychiatric biology, or simply say psychiatry (Hojaij 2017a).

Along these lines, Jaspers, referring to Karl Schneider says, “It is not justifiable that at the beginning of schizophrenia we should immediately suppose the existence of somatic elements; it is

false to prematurely compare functional psychic conditions experienced to the somatic ones and understand the formers just materially as morphologic or mechanics, or in the best scenarios as energetic; it is necessary to be liberated from the idea that we would find in the somatic (organic) a causality, a global one, to the psychological experience; the biological link between the somatic and the psychic process will be very different from today's conceptions" (Jaspers 1963).

It is imperative to recognize that the idea of having the same criteria applied across all medicine to psychiatry remains limited. In terms of psychoses, what remains clear is the distinction between exogenous psychosis (etiologically identified) and endogenous psychoses (not yet, or to never be identified, considering the stage of current investigations). Yet, for the exogenous psychoses (organic, acute, chronic, symptomatic, etc.) the causal naturalistic medical principle can be applied. But to consider that the endogenous psychoses have to be restricted to this principle is to deny - as clinically described by Wernicke, Kleist and Leonhard - the significant external (comprehensive elements) influence in the presentation and development of some of these psychoses. Just as an example, in describing "Mania and Melancholy" Leonhard says, "In mania... Nothing affects the mood. In other cases the affective state is not so solid, but it may easily be affected from outside" (Sole-Sagara and Leonhard 1953). I understand that manic-depressive illness will someday move to the basket of exogenous psychosis, for the influence of external and internal factors (functional dysfunction like hormonal variations, or specific pathology like diabetes) are becoming more and more evident. I doubt the same will ever happen to schizophrenia. Since Jaspers differentiation between organic psychoses and psychic process (1977) and Bleuler (1960) naming schizophrenia (mind's split) for dementia praecox and, according to my experience, I would say the schizophrenic never returns to a previous personality condition; we could say that the process is irreversible, no matter the appearance and evolution of the clinical picture.

Foucher et al. (2020) defend the naturalistic view of the biomedical paradigm: "According to the naturalistic assumption, a disease comes from a single cause of major effect. If this effect is reasonably consistent, patients should have some homogeneity of appearance, allowing them to be described using a typical set of clinical manifestations, i.e., phenotypes. This is the principle of genera, also referred to as the principle of Sydenham."

Bonhoeffer (Sagara and Leonhard 1953) opposing Kraepelin, concluded that in the brain the same etiological factor may cause different psychopathological manifestations, and there is not specific psychopathological symptomatology linked to a specific cause (Mayer-Gross, Slater, Roth 1969). The same cause can promote different clinical pictures; the same clinical picture can be caused by different pathologies. Also for the traditional General Paralysis, even initiating the investigation from the clinical picture, a direct relationship cannot be established with the cause: it can be assumed that there is a cause there, but the assumption has to be tested.

The exogenous psychoses bring psychiatry close to neurology. But neurology is concerned with the direct elements damaging brain morphology and function. If psychiatry goes to the point of being fundamentally concerned with matter and objective manifestations, all psychopathology would be disregarded because psychological concepts would be entirely dependent on cerebral functions. The environment's effects - broad sense - on brain development, its neuroplasticity and human expressions, is indisputable. On the other hand, if neurology takes over, completely, the entire man's dimension will be ignored; the patient will become an object, like a liver, or lung, etc. Let's leave the brain to the neurologists. Let's keep the psychic human dimension with the psychiatrists. For the authors, the naturalistic framework favors a "construct validity." However, the authors are prudent enough to state, "...validity per se will be only considered for periodic catatonia which has the most supported biological model."

If the naturalistic framework would be really sustainable to justify validity for Leonhard's endogenous psychosis classification, why is this not happening, considering so many decades of investigation made by conscious and responsible psychiatrists?

I offer three observations: 1) the naturalistic framework is not enough for psychiatry, as has been pointed out by Jaspers and many others; 2) there is a psychological and existential dimension that goes far beyond the structural brain; and 3) the brain has a meta-physic activity that should be implicated in normal and abnormal consciousness expressions (Edelman and Tononi 2001a,b; Hojaij 2017b).

Another point that disturbs the validity expectations for the endogenous psychoses refer to the last aspect of the "diagnostic medical paradigm": therapeutic. In reality, up to now we do not have a drug that could be called an anti-depressant and, even less, a drug that could be fully effective in schizophrenia. For both illnesses, the clinical resolution is partial, temporary or none. Unfortunately the therapeutic criterion does not entirely correspond to the classical medical diagnostic paradigm. How could someone nowadays expect a precise psychiatric diagnosis considering that the human brain contains 100 billion neurons, each one containing 5,000 thousand synapses, and each person having during life different, unique experiences?

The outstanding contribution of Leonhard's school is not in "validity," but in reliability; the extensive descriptions are there, vivid, registered in clinical files and objective through numerous videos. If one insists, in this case, reliability proves validity.

Thus, I understand it is a return to a long condemned reductionism to say, "The field of endogenous psychoses is the one which the hypothesis of 'brain diseases' is the most likely in psychiatry." Apropos, "...science has always tried to eliminate the subjective from its descriptions of the world. But what if subjectivity itself is its subject?" (Edelman and Tononi 2001a). If we maintain

the simplistic tendency to split body and mind, it would be difficult to understand how, from a concrete body, we can have a psychological phenomenon. I would be in favor for the Leonhard school to incorporate the modern consciousness studies from a psychiatric perspective. Something called “consciousness” does exist. Such a statement is valid because we do experience a continuous process that permits us to be aware of ourselves, the world and the meaning of things and events, and because we do experience a continuity of ourselves giving the picture of our history. The meaning of “conscious” is different from “consciousness.” While sleeping we are not conscious, but our consciousness remains active through dreams, giving continuity to our personal history. If we consult modern cosmology, becoming aware that an incommensurable cosmos arose from a simple dot in space (Delsemme 1988; Gribbin 2000, that a whole human being arose from stardust, maybe we can admit that even in psychiatry energy matters, i.e. energy can be a real process emanated from matter, relatively taking its own conduction and direction until matter again perishes or the energy vanishes. We can speculate that being emanated from the brain, energy organizes itself relatively independent from the brain, constituting a meta-structural process. Consciousness could be understood as that meta-structural energetic process (Hojajj 2017c). In this sense, the 35 Leonhard phenotypes may progress to infinity.

As to nomenclature, the authors have a concern that if the terms used in the Wernicke-Kleist-Leonhard school are not “modernized” and “standardized” they could have a negative impact in their acceptance. The language of these three big authors is completely integrated in psychiatric language. The fact that the Wernicke-Kleist-Leonhard school has not been widely accepted may be due to other factors. For sure, one is the totalitarian DSM dominance, also in European psychiatry. During my years in the WFSBP I would observe in many colleagues a resistance to bring up the ideas and works of the traditional French and German professors and schools of psychiatry, not to say that in many cases there was also a total rejection. Another reason for this resistance is the complexity of Leonhard’s classification of endogenous psychoses, requiring too much concentration and time to absorb its concepts. Nowadays, “time is money”; superficiality is the indication to quickly finish the work; the need for social and professional ascension is intense due to ambition and competition; why not to follow the flow of inconsequence? I think the authors should maintain - as they did write - the tradition. Tradition is the foundation for further development and this is what can be observed in the Leonhard school. “Orthodoxy” would be to keep the initial Wernicke and Kleist conceptions and not progressing.

Using a “modern language” at the beginning of the article, in order to promote Wernicke-Kleist-Leonhard school’s acceptance, the authors gave me the impression of carrying out semantic acrobatics, very distant from the comprehensive and understandable language of Wernicke, Kleist, Leonhard and Beckmann.

I think it is a step back "copying the neurological naming of the course for chronic diseases such as multiple sclerosis." Psychiatry has its own terminology. Why ignore psychopathology? New names that do not offer a new discovery may become just neologisms. A new word for an old event needs to be like a light illuminating an unknown aspect. A good example: the term schizophrenia coined by Bleuler (1960), replaced Kraepelin's dementia praecox. How would it be possible to take to the neurologic language observation of the schizophrenic delusion? Eugène Minkowski (1952) says: "The persecutory delusion represents loss of freedom and security, a reduction of vital possibility." We should always keep in mind: the psychiatrist treats a sick human being, not just a disease.

What may deserve further clarification is the elimination of the traditional terms "systematic" and "non-systematic" schizophrenias, to be replaced by "system" and "non system" schizophrenias. The original Leonhard description refers to symptomatology with an inference to pathologic dysfunctions in "areas of high development for thoughts and volition" (systematic schizophrenia). He was cautious enough to admit that "as the more distinguished level of human psychic is extremely complex and there are an inter-relationship of different functional nucleus, this explains the appearance of different clinical pictures for the systematic schizophrenia, something similar found in neurologic systems that are constructed by different functional nucleus" (Sole-Sagara and Leonhard 1953).

There is a semantic difference between "system" and "systematic." "System" refers to an ensemble of two or more things composing a consistent picture. "Systematic" refers to a structured process, persisting along its development. In a system one may have fractures or dissolution along the way.

Coming back to the authors proposition, there is not a "system schizophrenia." I understand schizophrenia's complexity touching "the more distinguished level of human psychic," a psychic related to a yet poorly explored ultra-complex brain that did not disclose all the "parts and its ensemble" in order we could identify a system for this peculiar illness. Even if one day schizophrenia appears linked to a neuro-functional/pathological system (multiple nucleus and other organs or systems), this system will be acting in the brain, at the organic level, but the psychopathology will remain at a supra-material level and characterized by a systematic schizophrenia. Not being skeptical but understanding the brain as the piece of matter most complex already found in the cosmos, I doubt one day a psychic disease such as schizophrenia will be inserted in a system, similar to the gastrointestinal, or cardio-pulmonary, because the psychic or consciousness cannot be localized, it is an expression of a whole. More than a fingerprint, or a genetic design, the identity of a person is in its own unique brain. It seems that the authors, promoting these new terms, push even more the

dislocation of the endogenous psychoses to the neurological field. Final consequence: schizophrenia and other endogenous psychoses will disappear from the psychiatric textbooks. Yet to be considered is whether patients will clinically comply with this proposition.

Considering “psychic” (*psykhikos*) outdated because it may resemble “spiritual” is just prejudice. “Spirit” has a meaning of something “disembodied, as an immaterial soul or a non-material intelligent power” (Oxford Companion to Philosophy, 1995). “Spirit” in this sense has nothing to do with psychiatry itself. In a different manner, the word “spiritual” was used by the Greeks to indicate the whole humanistic manifestation of man. It is not possible to deny the interiority of human life, essentially subjective, non-material (maybe conceivable in terms of energy), a product of consciousness, which Aristotle used to call “meta-physics,” a word created by Boecio in 525 BC (Aristotle 1977) . In relation to schizophrenia, Kurt Schneider (1975) uses the term “metagenesis” to mean an anomaly or psychic disturbance without a somatic or psychic cause; he calls it an anthropological mystery. Conrad (1963) talks about schizophrenia as a “spirit disease.” Wyrsh (1957) gives essential importance to the schizophrenic's person. We should not be afraid of the abstract.

Finally, after congratulating the authors for the commendable task of reviving the great psychiatry, I could ask, if the word psychic should be banished from our medical specialty, are they implying the terms psychiatry, psychiatrists, psychopathologists, psychology, psychologists, etc., should also be banned? Too much reforms cause catastrophe.

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