Temperament, personality and the vulnerability to mood disorders. The case of the melancholic type of personality

A. Ambrosini[1], G. Stanghellini[2], A. Raballo[3]

[1] Department of Psychological, Humanistic and Territorial Sciences, University "G. d'Annunzio", Chieti, Italy;
[2] "D. Portales" University of Santiago, Chile; [3] Department of Mental Health, Reggio Emilia, Italy

Summary

The concept of Typus Melancholicus (TM) was shaped by Tellenbach to describe the premorbid and intermorbid personality vulnerable to endogenous depression. The first part of this paper aims the description of the premorbid features of TM personality-orderliness, conscientiousness, hyper/hetereonomia and intolerance of ambiguity.

After, we present the life world of the TM, i.e. a qualitative descriptions of the lived experiences about the body, self, time, space, and others.

Also, we describe the basic principles of Tellenbach's theory – the method, the concept of endon, rhythmic and situation sensu Tellenbach as a special way of the person of living the relationship with the world per se in an endless reciprocal exchange.

Starting from a clinical case, we show the theoretical evolutions of TM concept and underline the typical way which links the premorbid condition to melancholia.

Finally, we ask if the TM concept can be still considered a valid construct in today's society, helpful in understanding and explaining identity crisis leading to depressive decompositions.

Key words

Major depression • Melancholic type • Personality • Pheno-phenotype • Post partum depression • Psychopathology

The features of the typus melancholicus

The concept of typus melancholicus (TM) was shaped by the German psychiatrist Hubertus Tellenbach (1914–1994) [1] to characterise the premorbid and intermorbid personality structure liable to endogenous depression. Based on the catamnestic recollection of 119 melancholic inpatients hospitalized at the University Hospital of Heidelberg, Tellenbach identified a fundamental set of distinctive features (i.e. orderliness, conscientiousness, hyper/hetereonomia and intolerance of ambiguity) that inform the premorbid personality of the TM, i.e. a certain way of being in the world that revolves around the possibility of developing major depression (melancholia). The work of Tellenbach is essential to clarify the relationship between premorbid personality (broadly understood as an anthropological pre-condition for the development of psychopathological crisis in the spectrum of endogenous depression), existential critical events and developmental pathways towards clinically-relevant psychopathological phenomena. According to the author, indeed, the selective combination of the premorbid characteristics of the TM confers a stable and recognisable imprint through which the vulnerability to major affective disorders is expressed already at the level of a specific personality structure.

By "personality structure", it is here intended a relatively homogeneous set of thoughts, emotions, customs, values and behaviours which, as a whole, constitute the anthropological core of individual subjective being and axiological orientation in the social world. Tellenbach emphasised that TM is a personality structure giving rise to a stable mode of relating to the world and oneself in a way that entails a potential for the development of affective episodes. According to Tellenbach, TM is defined by a set of concomitant, stable characteristics that organise the vulnerability to major depression and transpire across premorbid, intermorbid and morbid phases. Crucially, such characteristic imprint is situated at the ethical-ontological level of value-formation. In fact, values are attitudes that regulate the significant actions of the person, and are organised into concepts that do not arise from rational activity, but rather within the sphere of immediate situative feelings emanating from the type of relationship that the person has with him/herself, with others and with the world. Values are essential in putting the meaning of existence *per se* into order. Thus, values are organised according to the ontological constitution and pre-struc-

Correspondence
A. Ambrosini, Department of Psychological, Humanistic and Territorial Sciences, University "G. d'Annunzio", Chieti, Italy • E-mail: alessandra.ambrosini@tiscali.it

ture a world-view that establishes what is relevant and meaningful. In the case of TM, such a world-view already entails a germ of potential decompensation [2].

Although in the literature the concept of premorbid personality vulnerable to depression is used with several meanings (e.g. as an attenuated expression of an affective disorder, as a personological variable with pathoplastic effect on the development of depressive symptoms or as a result of recurrent depressive episodes), in the case of TM the notion of premorbid is to be intended in a specific pathogenetic sense, i.e. TM personality is a *predisposing* factor to the development of an episode of major depression [3].

According to Tellenbach's phenomenological analysis the core features of the TM are concern with orderliness and conscientiousness (Tables I, II).

Along these lines, originally combining the intuitions of his mentor Tellenbach and Mead's social theory, Alfred Kraus identified two further of the anthropological structure of the TM: hyper/heteronomy and intolerance of ambiguity. According to Mead's social theory, self and identity are an import of the social process. Mead [4] postulated that such identity is dialectically constituted by two poles, the "Me" (i.e. the self as social object) and the "I" (i.e. the self as subject). Whereas the "me" is the organised set of attitudes of others which an individual assumes, the "I" is the individual, subjective response to such accumulated understanding of how one is being perceived by others ("the generalised other"). Inspired by Mead's emphasis on how the mind and the self arise out of social interaction and experience, Kraus focused on the typical way of being social of the TM, extrapolating specific TM features of the dialectic between role identity and self-identity. Briefly, *role identity* is that which each person has to assume on the basis of their own social function; *self-identity* is the self-determination of the personality, that is beyond simple and straightforward identification with the role. The distancing from the role is a necessary operation to preserve one's authenticity as a person over and above that of the mere agent of an impersonal role. This means that a person may maintain a sense of autobiographic continuity recognising him or herself in spite of the transformation of role-identities and not being vexed by self-alienation and estrangement [5]. Such a vital dialectic between role- and self-identity is reduced and suppressed in the TM, which tends to collapse and crystallise self-identity in the simulacrum of the role. Indeed, the TM is unable of going beyond the socially established rules, reinterpreting his relation with himself, the other and the world in a flexible and an autonomous fashion.

Therefore, prominent features of the TM are hyper/heteronomy and intolerance of ambiguity (Tables III, IV).

Besides germanophone psychopathology, Japanese tradition also identified specific features of the TM. Shimoda [6]

TABLE I.
TM's features.

Orderliness
An accentuated seeking for order and harmony in the field of interpersonal relationships. It is manifested, above all, in the domestic and work setting and its function is to maintain the surrounding setting free of possible conflicts that may entail feeling of guilt. TM embodies the prototype of the very high demands by means of the subject's way of being, so that with the other, the TM tries to anticipate and pre-empt any possibility of remaining in debt. E.g.: *"When someone helps me, I feel guilty. If anyone helps me, I need to forget about it afterwards. I cannot think about having to thank them"*.

TABLE II.
TM's features.

Conscientiousness
This is an elevated demand above the mean of one's own possibilities, fuelled by the need to prevent feelings and attributions of guilt. Melancholic persons aim at fulfilling many obligations, always in a consistent, reliable and effective way. The need to cling to one's own controllable and predictable order assures the state of wellbeing and defends it from potential threats from the surrounding world, from the undefined and uncontrollable. Conscientiousness is inspired by a fundamental need to avert any potential feeling of guilt or accusatory attributions. Hence, the TM is constantly seeking acceptance from the other and his behaviour is not based on one's personal criterion, but rather on the perceived social expectation. This is the way in which the subject attempts to keep the conscience scrupulously clean and to protect against any feeling of guilt. It is fundamental to not be blamed by the other. Hence, each interpersonal gesture is a tribute that should be given to existence, a need that protects it from each possibility of loss. The idea that the TM has about his/her order does not foresee exceptions, as they are not open to flexible adaptation in accordance with the circumstances. Given that sooner or later, the unforeseen will outbreak in the *scenario* of existence, the TM radical refractoriness to being subject to the unforeseen in his/her existential field, generates an important exposure to vulnerability. In fact, despite the effort in preserving a controlled and ordered existential eco-system, the desired harmony is never a permanent and guaranteed achievement, especially given that the constriction between such rigid limits prevents the TM from developing the necessary transcendence to reach a higher balance. It is as if the TM had acquired once for all, an impersonal order at the cost of sacrificing the margin of subjective freedom that is required to manage the relationship with the world. E.g.: *"What would be right to do in such a situation?"*.

TABLE III.
TM's features.

Hyper/heteronomy
TM continuously attempts to gain external confirmations of their own identity through the *modus operandi*. The *hypernomia* consists in an excessively rigid adaptation of the standard practice, where the excessive aspect is given by the indiscriminate and stereotyped application of the rule, not linked to the context. The other facet of this incapacity of monitoring the situation in an independent and personal way is made up by the *heteronomy*, an exaggerated reception of the external standard practice by which each action is guided by an impersonal motivation, referring to the socially established criteria.

TABLE IV.
TM's features.

Intolerance to ambiguity
Allows the TM to attune only to those social situations that confirm the pre-established image they have of themselves and of others. This reduces the capacity of TM to maintain true interpersonal relationships as well as the possibility of accommodating situations that presuppose recognition of emotive complexity and ambivalence. Because of the complete attentional absorption in ideal, prototypical role-relations, TMs are not capable of harmonically perceiving the full-scale and the shades of their own and others' individuality *(idioagnosia)*. In this sense, their intersubjectivity is mutilated and sclerotised, being partly blinded to the rich emotional complexities of the interpersonal world. In fact, relating with the other only through their role, the TM does not intercept and relate to the individual needs, desires and feelings of the other, but rather to his/her expected ones as directly derivable from the social identity. On a surface level, the TM is extremely keen on interpersonal relations, anticipating the needs of the others and working intensely to satisfy them, their apparent altruistic availability is not primarily directed at the person in the flesh, but rather is aimed at maintaining social balance. What they have is – de facto – an "impersonal" empathy, based on the effort of synchronising with the other as a social actor, which moves following the predetermined rules and guidelines.

in particular conferred critical importance to "immobilithymia" (i.e. the tendency to cling to a certain mood and therefore to certain ways of being and doing). This characteristic, according to Shimoda, would be typical of those structures with the tendency to the development of manic-depressive conditions, representing a functional strategy to prevent manic or depressive decompensation. Shimoda characterises these persons as diligent, honest, scrupulous and efficient.

The life world of TM

Phenomenological investigations of abnormal human subjectivity suggest a shift of attention from mere symptoms (i.e., state-like indexes for nosographical diagnosis) to a broader range of phenomena that are trait-like features of a given life-world. The phenomenological exploration of patients' life-worlds is the gathering of qualitative descriptions of the lived experiences about the individuals. As lived experiences are always situated within the grounds of body, self, time, space and others, we adopt these basic dimensions of lived experience to organise the data. The result will be a rich and detailed collection of patients' self-descriptions related to each dimension, for example, temporal continuity/discontinuity, space flat/filled with saliences, bodily coherence/fragmentation, self-world demarcation/permeability, self-other attunement/disattunement and so on. In this way, using first-person accounts, we detect the critical points where the constitution of experience and action is vulnerable and open to derailments [7].
In the Table V we summarise the life world of TM.

Phenomenological method and the centrality of temporality

Tellenbach stated that the analysis of his patients was based on an "empirical-phenomenological" method. This method is "empirical" because it is based on the patient's self-description of their experiences and behaviours, and "phenomenological" because these phenomena are investigated as manifestations of the way of relating with the world and oneself. His intention was to understand the "*what*" that characterises the premorbid personality and "*how*", that is, the pathway that leads the TM to endogenous depression. The study of Tellenbach focused on the investigation of the essential properties that belong to the endogenous substrate and how these are added up, forming a stable and recognisable structure.
Tellenbach's theory is indeed framed by an overarching, global view of man in continuous and essential relationship with the world with specific attention to the "*essential forms* of the human condition" (or, more specifically, to the "essential forms of being melancholic"). This comprehensive view of human existence refers to the concept of *endon* as a way of connection between the psychic and somatic and between the person and the world. The endogenous is comparable to the *nature (physis)* of the Greeks and indicates the basic imprint prior to the formation of the personality, i.e. its structure. The endogenous is not considered only in relationship with the somatic or psychic sphere, but also includes a concept of person in his/her relationship with the world. Central in this theory is the role of *temporality* since all this is directly

TABLE V.
TM's life world.

Self/Identity	TM structure does not entail disorders of the pre-reflexive self as is the case with schizophrenia. It implies a different kind of depersonalisation involving the process through which we form the representation of our identity, that is, the narrative self. The narrative self is the concept one constructs of oneself. One's own narrative identity arises from the interplay between I-am's and I-can's. I-can's are what one is not, one's own possibilities. TM persons insist on a finite and un-chosen perspective of stable characteristics that they consider their own, and with which they over-identify and experiences other possibilities merely as a source of alienation or nullification [8-10]. This intolerance to other possibilities and the avoidance of the dialectic between I-am's and I-can's immanent in the constitution of one's narrative self leads to an identification with partial, external and reified identities, such as role-identity, i.e. external/socially appreciated representations of identity [11 12]. They internalise role-identities and through this internalisation they acquire a stable, although inflexible, self-identity [13]. Their identity is based on a reified, sclerotic self-representation. It implies an over-simplified categorisation of oneself and others, who appear in the light of their social roles, rather than in that of their ego-identity [3 11].
Time	The TM strives not to lag behind himself – that is behind his duties and obligation deriving from the social role he has taken up. His entire life can be interpreted as an effort to pay his debts before he contracts them. In order to avoid the danger of remaining behind regarding the subject's own expectations and the emergency of the duty, the time of TM is characterised by a constant need to anticipate the requests of others and timely comply with the duties related to their social roles.
Space	To preserve inner harmony, each thing should occupy a dictated place within a pre-established order. Taking refuge within the limits of one's order is a way or assigning oneself a place, a defined and limited space within which the melancholic person feels able to exercise her own "autonomy".
Other	Its mere existence cannot give satisfaction to anyone. Thus, being loved is an acquired right. TM persons can hardly enjoy the pure and simple fact of being with the other. Their intersubjectivity does not foresee the implicit pleasure of being-together-with another. Occupying a place in the physical or relational space is a right to be conquered and earned with effort and determination in a rigid regime of meritocracy. In fact, spontaneous free exchanges without any obligation of return are not contemplated, the sense of "justice" is reduced to a circle of *do ut des* (I give and you give back) in which the TM is already in a position of disadvantage, one step behind.

related to the rhythmic processes of life, that is, to the normal tendency of man to adjust and synchronise one's own biorhythm (sleep, awakeness, etc.) with the world. This emphasis on temporality is the central feature of all phenomenological theory of the pathogenesis of depression. In normal situations, the *rhythmic* is understood as a fundamental form of the flow of life, which is expressed in some of the characteristics of human behaviour. Tellenbach understands this to be an endo-cosmo-genetic periodicity. This periodicity – yearly, monthly, circadian rhythm cycles – are considered fundamental organisers of the life of a person. Rhythm is not a passive reaction to the environmental influence; on the contrary, it is the indicator of a natural tendency to the synchronisation of the person with the world. Both the slowness and speed of a rhythm contribute to the harmony of movement and are a result of a capacity of control and an inner measure. Both would represent normality and would be the characteristics of movement. In disease, measure and rhythm seem to be absent. Rapidness – understood as swift rhythm – may be replaced by agitation and slowness by delay. Agreement between subjective and objective rhythm defines a state of harmony. Melancholy may be considered an endogenous condition as it breaks such harmonic state. Melancholy is linked to transformation of the movement of life and more specifically inhibition of passing of inner time and loss of ground regarding the flow of the world. This transformation is translated into a modification of the rhythm in all its manifestations: mood, impulses and motivations.

The TM strives not to lag behind himself – that is behind his duties and obligation deriving from the social role he has taken up. His entire life can be interpreted as an effort to pay his debts *before* he contracts them. In the pre-melancholic situation this order goes into pieces. The key-feature of the pre-melancholic situation is despair. To Tellenbach, despair is the emotion characterising the pre-melancholic situation, that is, the prodrome of melancholic breakdown (see below). Tellenbach emphasises the intimate relation between the concept of "despair" (*Verzweiflung*) and the notion of "doubt" (*Zweifel*) as disintegration of something simple and definitive into something ambiguous. He writes:

[T]he crucial emphasis, as also in the concept of *doubt* [*Zweifel*], shifts to the "two", to the doubling. This doubling [zweiheitliche] is also contained in *dubietas* and *dubium*. What we call despair [*Verzweiflung*] is remaining captured in doubt. From the doubling of despair re-

sults all *average* meanings of human states characterized by being shattered [*Zerrissenheit*]. To be precise, despair is *not* just hopelessness and desperation, not an ultimate or an arrival at an endpoint, but rather the movement backward and forward, an alternation, so that a definite decision [*endgültige Entscheidung*] is no longer possible [1] (p. 165 [149]; translation modified).

As a consequence of the ambiguity, the person experiences ambivalent feelings in the sense of being simultaneously moved towards two opposite directions. The person is aware of this contradiction, but is not able to resolve it. The core of despair is therefore indecision, and its contrary mental state is not hope, but decision. In despair, this opposition comes to an extreme which results in a *profound alteration of temporality*: "[w]hat previously came about in the mode of *succession*, now appears only in the necessity of *simultaneity*" [1] (p. 167 [151]). The same happens with lived space. Whereas we usually organise our actions in the mode of succession, in despair movements remain stuck in the indecisiveness of juxtaposition, that is, a kind of paralysis of action and thinking, but not a static one, rather a frensied, restless, disconcerting paralysis.

The concept of "situation"

The concept of "situation", and especially "pathogenic situation", has been for decades a focus of psychopathological research. Indeed, the pathogenic situation expresses the intimate relationship between a type of event and a type of personological vulnerability, that is, between the psychological structure of the person and the quality of the event. An event is traumatic if it hits the person in his/her weak point. In this case, the event concept assumes the meaning of personal experience (*Erlebnis*), that is, the very individual way that person lives a particular event. The event turns into a traumatic experience when it acts like a key in its lock (trauma-key-lock). Phenomenological psychopathology makes a distinction between two prototypes: the pathological reactions to the event and the development of personality. Jaspers [14] emphasises the importance that a specific event assumes for a person as a lived experience in relation to the emotional upheaval that it generates in determining pathological reactions. This pathological condition "does not occur because of a single experience, but for the sum of the various effects". In pathological reactions, on the one hand there is a link between the experience and personality, and on the other a link between traumatic experiences and the psychopathological contents (such as emotions, thoughts, etc.). The notion of "personality development" [14] emphasises the personological ground on which an event falls. One of the best known examples of such development of personality is provided by Ernst Kretschemer [15] in his seminal study on "sensitive delusion of reference". This particular persecutory delusion appears to be the prototype of the psychological intelligibility of psychotic manifestations [16]. Kretschmer pointed out the importance of a particular personality (i.e. the sensitive type) structure in the unleashing of a progressive psychopathology under the triggering pressure of a particular type of interhuman event, which has a selective, specific potential to upset that kind of personality.

According to Tellenbach, man is *linked/engaged* in a relationship of special interdependence with the context *per se*. Therefore, a *situation* cannot be either reduced to a way in which a person is passively hit by an event, or to a constellation of events simply induced by the person. The situation transcends the dyad individual-surrounding environment and rather cuts-across the constant modeling of the self-world relation. The notion of *situation* captures both the *active role* (in the sense that the person actively concurs in creating the situation) and the *passive role* (in the sense that there is not an explicit intention or desire to create the situation in itself by the person or that they could not do it in another way). The event and the person are reciprocally reflected in the situation. The TM tends to be located within the typical self-world relationships and being engulfed in characteristic pre-melancholic situations [1]. In other words, the pathogenic situation *mirrors* the person's vulnerability and the person can see vulnerability *reflected* in one's own pathogenic situation.

The concept of *situation* illuminates a hidden aspect of the relationship between the event and the person in the sense that each person may theoretically find any type of event. However, each person tends to co-create the kind of situations that characterise them. The way of being of a person, with his/her anthropological structure, way of understanding life and expressing relationships with the other, the hierarchy of priorities and values, leads to having relationships that are typical for this person. In the case of TMs, this moves from their structure of values characterised by the concern for orderliness and conscientiousness. TMs have high interpersonal sensitivity and do not judge their own behaviour on the basis of personal criteria, but rather on the basis of social standards. Since the main latent existential aim of TMs is social desirability, they intensively strive to comply with the expectations and needs of the others, even before these have been expressed. This double ethical path leads TMs to recursively approach situations characterised by the constellation of *includence* and *remanence* [17 18].

The pre-melancholic phase: includence, remanence and despair

The pre-melancholic situation seems to be the crucial connecting point to understand the link between the

TM personality structure and melancholy. In this phase, there is a critical matching between the existential situation and a certain personality structure, which generates the pathogenic situation. The pre-melancholic situation is characterised by a constant increase of the fixed tasks that overburdens the capacity of TM to preserve predetermined order. In such conditions, the TM is not capable of establishing a hierarchy of priorities, and is unable to discriminate what can be momentarily left aside or postponed. Two key moments characterise the pre-melancholic phase: the situative constellations of *includence* and *remanence*, and, finally, *despair* (i.e. a radical transformation of the self-world relation).

The constellation of *includence* indicates a self-contradiction that sees the TM, at the same time, in the extreme attempt to maintain order and in the need to overcome it, exceeding his own limits. This is the moment in which the undesired is manifested and imposed in the existence, so that the typical meticulous and orderly form of being of the TM is destabilised [1]. In the words of Tellenbach's patient: "*I am very orderly, I need a lot of time, I've always been that way, this is terribly painful for me*". The anxiety related with a possible change in the order of things is clear.

The other constellation is that of *remanence*. This is characterised by the danger of remaining behind regarding the subject's own expectations and the emergency of the duty. The TM is conditioned by the paradoxical tendency of cancelling possible debts in advance. When they are up against the unexpected and chance and unforeseen breaks the schemes, this may precipitate the melancholic episode. Tellenbach described his patient as follows: She had "never shown herself to be guilty of anything" but "*I feel guilty because I haven't been able to carry out my work*".

The two constellations are always manifested in the pre-melancholic situation, but they are not clear until the melancholic phase has begun. The bridge that joins the pre-melancholic phase to the melancholic one is called *despair*. The concept of "despair" cannot be translated, either as hopelessness or helplessness [18]. This concept does not indicate, in fact, either loss of hope or feeling deprived of establishing the possibility of being helped. Rather, with the term despair, "coming and going" towards possibilities for which none are reachable is indicated. In this way, in despair, a cognitive dissonance [19] is manifested and specifically, the lack of capacity to establish priorities. That which previously had an order (one after the other) is now found in the need of the contemporaneity, which becomes inaccessible to the evolution of existence. Tellenbach described the experience of his patient as follows: "*This situation had been partially arduous, on the one hand she had the constant impulse to work as much as possible and as accurately as possible but on the other, the inhibition hindered the way*". Herein, the concept of *despair* should not be understood as a condition without hope, but a situation in which you cannot take any decision. The person who becomes despaired is in suspension in the face of still un-actualised possibilities, having the intention of contemporarily *being* in two places[1]. This is the moment in which melancholy is initiated. Pre-melancholic despair seems to be the pathway through which the TM becomes stagnated, even on a somatic level: the TM person undergoes psychomotor block because of the incapacity to reach a compromise with themselves and with the world.

The evolution of TM concept

Starting with the major contribution of Tellenbach, a series of investigations further explored the TM construct both in the theoretical and empirical directions [1-3 8 11 12 20-65].

Alfred Kraus is possibly the author who has most studied the characteristics of premorbid personality [9 10 22-26] and the psychopathological characteristics of melancholy in the most depth [25 26 66 67]. One of his most important contributions is the definition of the characteristics of the TM construct as opposed to the anancastic behaviour [23]. Whereas in the case of obsessive disorder there is an orientation with the individual standard that is maintained through ego-dystonic thinking that assumes symbolic and magical meanings, the TM bases his/her behaviour on the social expectations and his/her way of reaction is ego-syntonic. Other authors, such as von Zerssen and Mundt, have carried out works that are mainly empirical, attempting to outline and define the specificity of this construct more precisely and to design a test for the diagnosis of the TM personality. A converging research line was developed in Japan where the first self-applied TM test was proposed in 1984 by Kasahara [27], and followed by a series of other studies in nonclinical sample [47-53]. Moreover, several authors have explored the concept of TM with regard to personality disorders [30 36 60] and development of major depression or manic depressive disorder [20 37 40 43 58]. In recent years, the TM construct has been studied as a possible indicator of vulnerability to depressive postpartum disorders [65].

An example of the clinical importance of TM: postpartum depression

An important focus of research into postpartum pathology is the identification of risk factors for this common and often disabling disorder. Risk factors can be divided into three main categories: psychosocial, clinical and those factors related to pre-morbid personality or temperamental features [68]. Although the most frequently cited are marital conflict [69], lack of a confidant [70], difficult psychosocial conditions [70 71], negative life events during the

year preceding childbirth [72], financial and professional difficulties [73], the personality style of women vulnerable to postpartum depression has been neglected.

Recent studies on the relationship between TM and motherhood [74] highlight two key points: first the pathogenic role of masculine discourse on motherhood in TM women. Indeed, women who blindly accept the standard discourse on motherhood are obliged to exercise their procreative function in an impersonal way. In this way, motherhood ceases to be a personal experience and acquires value only to the extent to which it adheres to social and cultural stereotypes. If women surrender unconditionally to the myths of motherhood, created by men and secularised by culture, they are more likely to feel inadequate, unworthy and incapable. Every attempt made to adhere to an ideal prototype is destined to failure considering that this prototype does not account for women's responses to the birth of a child.

The traditional values that shape the social behavior of TM include *orderliness* and *conscientiousness*. They may have a pathogenic valence in so far as they bring forth a particular kind of mindset and behaviour that reflects the myths of motherhood we described above. TM mothers seem over-identified with social representations of maternal roles that reflect time-honored male expectations. Their system of values, which shapes the inner core of these women's personalities, heightens their psychopathological vulnerability.

Motherhood can assume a pathological valence for women – it is the case of TM mothers – who tend to adhere to the impersonal and masculine discourse on motherhood. This discourse – which has been popular from the times of ancient Greece up to the present, but also informs the technical jargon of psychoanalysis – presents motherhood as the apotheosis of femininity and leads mothers into assuming a role that is functional to the stability of the family and social order. This means giving up many prerogatives of women that are not compatible with motherhood.

In the case of these *hetero/hypernomic* women, who tend to abide by social norms, play the established social roles and hide their inner conflicts and tensions, myths of motherhood contribute to suppress the contradiction which is intrinsic to motherhood itself making this contradiction invisible but still painful and hence uncontrollable and potentially devastating.

Heteronomy, as well as the attitude to subscribe acritically to these myths on motherhood, forcing oneself to live motherhood in keeping with rigid and impersonal schemes that do not take into consideration women's authentic experience of motherhood, signaling a conception of motherhood as the fulfillment of female nature instead of presenting it as a period of existential crisis characterised by the dichotomy between social expectations – "*how I should be*" – and personal experience – "*how do I feel with regard to this new situation*" – may worsen this contradiction and bring the mother on the verge of psychopathological illness.

This urge to meet social expectations that are construed around the idea of motherhood-as-apotheosis of femininity, rather than the idea of motherhood-as-crisis, together with the constant growth of tasks related to motherhood, creates an emotional overload that is hard to deal with and leads to the development of depressive pathology.

The second point highlights the possibility of considering the TM personality structure as a valid model for the early diagnosis of women at risk to develop an episode of postpartum depression, even in those cases in which a clear anamnesis of major depression, as well as other types of mood disorder or symptoms before and during pregnancy, cannot be established. Indeed, motherhood is like a *quid novi* in which a previous existential equilibrium is put at risk [74-76]. TM women are compelled to adapt their own way of being to the new situation and to the changes it involves. Motherhood is a threat to the rigid existential order of TM women, and it is a danger to their *orderliness*. TM women tend to distort the meaning of birth, which is not perceived, at the same time, as a moment of task/duty as well as an opportunity/possibility of self-development and existential self-realisation. The reason for this distortion of the meaning of birth lies in the feature of TM called *intolerance of ambiguity*. The birth is conceived as an obligation characterised by necessity, tasks to fulfill – according to the rules given by *consciousness* and *hyper/heteronomy* – which are typical of TM personality. As a consequence of this, disorganised behaviour and confusion may characterise the prodromal phase of postpartum depression. The pre-melancholic situation is thus characterised by the presence of the situation of *includence*, i.e. the TM encloses herself within the boundaries of her *ordo* – and *remanence* – i.e. she remains encapsulated within these boundaries thus "remaining in self-default" [1].

TM and social change: hyper/heteronomy in the liquid society

The TM concept was shaped in the mid-1950s in a type of society with its set of values and cultural constraints that have radically changed. Among these changes, the affirmation of individualistic values like the increasing importance attributed to liberty and the decreasing importance of security, the advent of liquid society where nothing is fixed (including social bonds and work careers) and everything changes very quickly, and the triumph of instantaneousness over long-term projectuality. All these have determined radical changes in late modern identities and led to the conceptualisation of personal identity as a con-

tinuous task rather than a heritage to be preserved[78]. In this light, can the TM concept be still considered a valid construct in today's society that is helpful in understanding and explaining identity crises leading to depressive decompositions?

In an unpublished general population study in which 500 university students underwent a protocol for the validation of a self-report TM questionnaire, the dimension "hyper-heteronomy" did not feature among the characteristics of students who could be typified as TM. Of 500 interviewees, 49 (about 10%) were positive for the TM profile. Yet, among these, hyper-heteronomy was absent in 90% and difficult to diagnose in the remaining 10%.

Hyper-heteronomy consists in the rigid adaptation to stereotypical social norms, an unconditional adherence to established socially-shared roles. It is not surprising that in our flexible society (so different from the post World War II rigid German society in which the TM concept was established) hyper-heteronomy may have become non-characteristic in TMs, that is, in people who share all the other features of socially adapted individuals, and chiefly conscientiousness and orderliness. The question is *which* of societal values are (or are not) interiorised.

In a previous paper [65], we found that hyper-heteronomy is a key feature in TM women who developed a melancholic depression in the postpartum. Our interpretation is that the development of postpartum depression may be a consequence of these women's adherence to old-fashioned, if not atavistic, myths of motherhood, including the centrality of the maternal function in defining a woman's identity leading to an idealisation of motherhood. We argued that in hyper-heteromic mothers, who tend to abide by social norms, play the established social roles and hide their inner conflicts and tensions, myths of motherhood contribute to suppress the contradiction which is intrinsic to motherhood itself making this contradiction invisible but still painful, and hence uncontrollable and potentially devastating. The conception of motherhood as the fulfillment of female nature, rather than a period of existential crisis characterised by the dichotomy between social expectations – "how I should be" – and personal experience – "how do I feel with regard to this new situation" – is at the heart of this contradiction.

These two examples may suggest that the adherence to old-fashioned values that are in conflict with the mainstream mind-frame, rather than the presence of hyper-heteronomy, may be the crucial risk factor for the development of major depression.

In fact, social norms have changed and heteronomy may have remained the *form* of a given personality structure whose *content* has changed with the transformation of societal standards. Conformism is no more than compliance to the values of modern sociality, but adherence to the liquid instantaneity of the contemporary late-modern mediatic-social world. The historical prototype of the TM template on the European social codes of the previous century is plausibly rather changed in several apparent social features. The relative eclipsing of the no longer functional faithfulness to cultural standards of the past (in which adherence to tradition and dedication to it were to be considered functional to the task envisaged within the roles imposed by society) has unveiled the TM of the third millennium as a neurotic-like, conflictual structure which seeks a continuous adaptation between the need for order and an "atmosphere" characterised by social instability and disorder.

Next to this "neuroticised" heteronomic structure, there grows other forms of heteronomy that are totally syntonic to the *Zeitgeist*. It is the case of what can be called the "I can" value structure and its psychopathological decomposition that can be named "manager depression". Whereas for the TM the moral imperative can be summed up with the "I must" formula, that circumscribed a limited set of goals to be achieved by restricting one's sense of freedom, "I can" personalities are characterised by an interminable escalation of goals to be achieved that goes together with an exalted sense of freedom. This anthropological structure is endlessly projected towards new objectives and unable to be satisfied with goals once they are achieved. "I can" is the modal verb that reflects late modern *Leistungsgesellschaft* or the society of performance [79]. In this type of culture, the must is being performing and personal identity is conceived as a task to be achieved via being the manager of one's own life. Of course, "I can" personalities are totally egosyntonic with respect to the value of performance. Depressive forms stemming from this anthropological make-up are radically different from melancholic depressions and characterised by exhaustion, burn-out and insolvency and are accompanied by a feeling of shame. This is just another example of the metamorphosis of depression and its mirroring of the transformations of society.

Conflict of interest

None.

References

1 Tellenbach H. *Melancholy*. Pittsburgh: Duquesne University Press 1980.

2 Stanghellini G. *Antropologia della vulnerabilità*, Milano: Feltrinelli Editore Milano 1997.

3 Stanghellini G, Mundt C. *Personality and endogenous/major depression: an empirical approach to typus melancholicus. Theoretical Issues*. Psychopathology 1997;30:119-29.

4 Mead GH (1934). *Mind, Self, and Society*. Chicago: University of Chicago Press 1934. Trad.it. *Mente, sé e società*. Firenze: Editrice Universitaria 1965.

5 Kraus A. *Dynamique de rôle des maniaque-dépressifs*. Psychologie Medicale 1987;19:401-5.

6 Shimoda M. *On manic-depressive illness* (in Japanese). Yonago-Igakushi 1950;2/1:62f.

7 Stanghellini G, Rossi R. *Pheno-phenotypes: a holistic approach to the psychopathology of schizophrenia*. Current Opinion 2014;27:236-41.

8 Kraus A. *Sozialverhalten und psychosen manisch-depressiver*. Enke: Stuttgart 1977.

9 Kraus A. *Modes d'existence des hystériques et des mélancolique*. In: Fédida P, Schotte J, editors. *Psychiatrie et existence*. Grenoble: Millon 1991a.

10 Kraus A. *Role performance, identity structure and psychosis in melancholic and manic-depressive patients*. In: Mundt CH, editor. *Interpersonal factors in the origin and course of affective disorders*. London: Gaskell 1996, pp.31-47.

11 Stanghellini, G, Bertelli M. *Assessing the social behaviour of unipolar depressives: the criteria for typus melancholicus*. Psychopathology 2006;39:179-96.

12 Mundt C, Goldstein MJ, Halweg K, et al. *Interpersonal factors in the origin and course of affective disorders*. London: Gaskell 1996.

13 Mundt C, Backenstrass M, Kronmueller KT, et al. *Personality and endogenous/major depression: an empirical approach to typus melancholicus. Validation of typus melancholicus core properties by personality inventory scales*. *Psychopathology* 1997;30:130-9.

14 Jaspers K. *Psicopatologia generale*. Roma: Il Pensiero Scientifico 1964.

15 Kretschemer E. *Der sensitive beziehungsswahn. Ein beitrag zur paranoidefrage und zur psychiatrischen charakterlehre*. Berlin: Springer 1919.

16 Ballerini A, Rossi Monti M. *La vergogna e il delirio*. Torino: Bollati Boringhieri 1990.

17 Stanghellini G, Rossi Monti M. *Psicologia del patologico*. Milano: Raffaello Cortina Editore 2009.

18 Stanghellini G. *Psicopatologia del senso comune*. Milano: Raffaello Cortina Editore 2008.

19 Festinger A. *Theory of cognitive dissonance*. Stanford, CA: Standford University 1957.

20 Stanghellini G, Bertelli M, Raballo A. *Typus melancholicus: structur and the characteristics of the major unipolar depressive episode*. J Affect Disord 2006;93:159-67.

21 Stanghellini G, Raballo A. *Exploring the margins of the bipolar spectrum: temperamental features of the typus melancholicus*. J Affect Disord 2007;100:13-21.

22 Kraus A. *Identity and psychosis of the manic-depressive*. In: De Koning AJJ, Fenner FA, editors. *Phenomenology and psychiatry*. London Academic Press 1982, pp. 201-216.

23 Kraus A. *Dinamique de rôle des maniaque-dépressifs*. Psychologie Medicale 1987;19:401-5.

24 Kraus A. *Methodological problem whit the classification of personality disorders: the significant of existential type*. J Pers Disord 1991;5:82-92.

25 Kraus A. *Phenomenological and criteriological diagnosis. Different or complementary?* In: Sandler JZ, Wiggins OP, Schwartz MA, editors. *Philosophical perspective on Psychiatric diagnostic classication*. Baltimor: Hopkins University 1994, pp.148-160.

26 Kraus A. *Le motif du mensonge et la depersonalization dans la mélancholie*. L'Evolution Psychiatrique 1994;54:649-57.

27 Kasahara Y. *Depressed patients in the general practice* (in Japanese). J Psychosom Med 1984;24:6-14.

28 Von Zerssen D, Pfister H, Koeller DM. *The Munich Personality Test (MPT): a short questionnaire for selfrating and relatives' rating personality traits: formal properties and clinical potential*. Eur Arch Psychiatr Neurosci 1988;238:73-93.

29 Von Zerssen D. *Melancholic and manic types of personality as premorbid structures in affective disorders*. In: Mundt C, Goldstein MJ, Halweg K, et al. editors. *Interpersonal factors in the origin and course of affective disorders*. London: Gaskell 1996.

30 Von Zerssen D. *Development of an integrated model of personality, personalitydisorders and severe axis I disorders, with special reference to major affective disorders*. J Affect Disord 2002;68:143-58.

31 Schäfer ML. *Typus melancholicus as a personality characteristic of migraine patients*. Eur Arch Psychiatry Clin Neurosci 1994;243:328-39.

32 Schäfer ML, Lautenbacher S, Postberg-Flesch C. *New investigations on the melancholic type personality structure in migraine patients*. Nervenarzt 200;71:573-9.

33 Meszaros K, Fischer-Danzinger D. *Extended suicide attempt: psychopathology, personality and risk factors*. Psychopathology 2000;33:5-10.

34 Schwartz MA, Wiggins OP. *Philosophical anthropology and psychiatry: typus melancholicus as a human disposition*. Seishin Shinkeigaku Zasshi 2003;105:522-32.

35 Fukunishi I, Hattori M, Hattori H, et al. *Japanese type A behavior patterns is associated with "typus melancholicus". A study from the socialcultural viewpoint*. Int J Soc Psychiatry 1992;38:251-6.

36 Sato T, Sakado K, Sato S. *Differences between two questionnaires for the assessment of typus melancholicus, von zerssen's f-list and kasahara's scale: the validity and the relationship to DSM-III-R personality disorders*. Jpn J Psychiatry Neurol 1992;46:603-8.

37 Sato T, Sakado K, Sato S. *Typusmelancholicus measured by a questionnaire in unipolar depressive patients: age and sex-distribution, and relationship to clinical characteristics of depression*. Jpn J Psychiatry Neurol 1993;47:1-11.

38 Sato T, Sakado K, Nishioka K, et al. *Relationship between the melancholic type of personality (Typusmelancholicus) and DSM-III-R personality disorders in patients with major depression*. Psychiatry Clin Neurosci 1995;49:13-8.

39 Heerlein A, Santander J, Richter P. *Premorbid personality aspects in mood and schizophrenic disorders*. Compr Psychiatry 1996;37:430-4.

40 Nakanishi T, Isobe F, Ogawa Y. *Chronic depression of mo-*

nopolar type: with special reference to the premorbid personality. Jpn J Psychiatr Neurol 1993;47:495-504.

41 Mundt Ch, Schroeder A, Backenstrass M. *Altruism versus self-centredness in the personality of depressive in the 1950s and 1990s*. J Affect Disord 2009;113:157-64.

42 Hecht H, Van Calker D, Spraul G, et al. *Premorbid personality in patients with uni- and bipolar affective disorders and control: assessment by the Biographical Personality Interview (BPI)*. Eur Arch Psychiatry Clin Neurosci 1997;247:23-30.

43 Hecht H, Van Calker D, Berger M, et al. *Personality in patients with affective disorders and their relatives*. J Affect Disord 1998;51:33-43.

44 Ueki H, Holzapfel C, Washino K, et al. *Reliability and validity of Kasahara's scale of melancholic type of personality (typusmelancholicus) in a german sample population*. Psychiatry Clin Neurosci 2001;55:31-5.

45 Ueki H, Holzapfel C, Washino K, et al. *Concordance between self and observer-ratings on Kasahara's Inventory for the melancholic type personality*. Psychiatry Clin Neurosci 2002;56:569-74.

46 Ueki H, Holzapfel C, Sakado K, et al. *Dimension of typusmelancholicus on kasahara's inventory for the melancholic type personality*. Psychopathology 2004;37:53-8.

47 Ueki H, Holzapfel C, Sakado K, et al. *Prevalence of typus melancholicus in healthy germans*. Psychopathology 2006;39:113-9.

48 Furukawa T, Nakanishi M, Hamanaka T. *Typus Melancholicus is not a premorbid personality trait of unipolar (endogenous) depression*. Psychiat Clin Neuros 1997;51:197-202.

49 Furukawa T, Yamada A, Tabuse H, et al. *Typus melancholicus in light of the five-factor model of personality*. Eur Arch Psychiatry Clin Neurosci 1998;248:64-9.

50 Lauer CJ, Von Zerssen D, Schreiber W, et al. *The premorbid psychometric profile is steble over time in subjects at high familial risk for affective disorders*. J Affect Disord 1998;51:45-53.

51 Kimura S, Sato T, Takahashi T, et al. *Typus melancholicus and the temperament and character inventory personality dimensions in patients with major depression*. Psychiatr Clinical Neurosci 2000;54:181-9.

52 Kronmuller K-T, Backenstrass M, Kocherscheidt K. *Dimensions of the tipus Melancholicus personality type*. Eur Arch Psychiatry Clin Neurosci 2005;255:341-9.

53 Sakai Y, Akiyama T, Kawamura Y, et al. *Temperament and melancholic type: path analysis of a prospective study of depressive mood change in a nonclinical population*. Psychopathology 2009;42:249-56.

54 Akiyama T, Tsuda H, Matsumoto S, et al. *Cyclothymia and typus Melancholicus: empirical study on personality character of mood disorder*. Seishin Shinkeigaku Zasshi 2003;105:533-43.

55 Meyer TD. *The Hypomanic Personality Scale, the big five and their relationship to depression and mania*. Pers Indiv Differ 2002;32:649-60.

56 Blechert J, Meyer TD. *Are measures of hypomanic personality, impulsive nonconformity and rigidity predictors of bipolar symptoms?* Br J Clin Psychol 2005;44:15-27.

57 Ogawa T, Koide H. *Cultural variations in premorbid personality of endogenous depression: a transcultural study*. Jpn J Psychiatry Neurol 1992;46:831-9.

58 Abe T. *Increased incidence of depression and its sociocultural background in Japan*. Seishin Shinkeigaku Zasshi 2003;105:36-42.

59 Tsuda H, Hori A. *"Shuuchaku" in various types of manic-depressive patients*. Seishin Shinkeigaku Zasshi 2003;105:544-51.

60 Tsuda H. *Depression and personality*. Seishin Shinkeigaku Zasshi 2005;107:1268-85.

61 Sakamoto K. *Premorbide personality*. Nihon Rinsho 2005;65:1591-8.

62 Rubino IA, Zanasi M, Robone C, et al. *Personality differences between depressed melancholic and non-melancholic inpatients*. Aust N Z J Psychiatry 2009;43:145-8.

63 Yamada Y, Hirosawa M. *Does Typus Melancholicus determine characteristics of athlete burnout symptom and its process among Japanese university athletes?* J Hum Ergol 2009;38:67-79.

64 Ambrosini A, Stanghellini G, Langer A. *El typus melancholicus de Tellenbach en la actualidad: una revisión sobre la personalidad premórbida vulnerable a la melancolía*. Actas Españolas de Psiquiatría 2011;39:302-11.

65 Ambrosini A. *Postpartum depression and melancholic type of personality: a pilot study*. Italian Journal of Psychopathology 2013;19:3-13.

66 Kraus A. *How can the phenomenological-anthropological approach contribute to diagnosis and classification in psychiatry?* In: Fulford KWM, Morris K, Sadler J, et al. editors. *Nature and narrative. An introduction to the new philosophy of psychiatry*. New York: Oxford University Press 2003.

67 Kraus A. *Melancholic depersonalisation*. Comprendre 2008;16-17-18; 243-8.

68 Bloch M, Schmidt PJ, Danaceau M, et al. *The role of gonadal steroid in postpartum depression*. Am J Psychiat 2000;157:924-30.

69 Gotlib IH, Whiffen VE, Wallace PM, et al. *Prospective investigation of postpartum depression: factors involved in onset and recovery*. J Abnorm Psychol 1991;100:122-32.

70 Romans SE, Walton VA, McNoe B, et al. *Otago women's health survey 30-month follow-up. I: onset patterns of non-psychotic disorder. II: remission patterns of non-psychotic psychiatric disorder*. Br J Psychiatry 1993;163:733-46.

71 Campbell SB, Cohn JF. *Prevalence and correlates of postpartum depression in first- time mothers*. J Abnorm Psychol 1991;100:594-9.

72 Paykel ES, Emms EM, Fletcher J, et al. *Life events and social support in puerperal depression*. Br J Psychiatry 1980;136:339-46.

73 O'Hara MW, Neunaber DJ, Zekoski EM. *A prospective study of postpartum depression: prevalence, course, and predictive factors*. J Abnorm Psychol 1984;93:158-71.

74 Stanghellini G, Ambrosini A. *Depressione postpartum e typus Melancholicus. Uno studio pilota*. Giornale Italiano di Psicopatologia 2011;17:22-30.

75 Pazzagli A, Benvenuti P, Rossi Monti M. *Maternità come crisi*. Roma: Il Pensiero Scientifico Editore 1981.

76 Stern DN, Bruschweiler-Stern N, Freeland A. *Birth of a mother: how the motherhood experience changes you forever*. New York: Perseus Books 1999.

77 Bondas T, Eriksson K. *Women's lived experiences of pregnancy: a tapestry of joy and suffering*. Qual Health Res 2001;11:824-40.

78 Muscelli C, Stanghellini G. *Istantaneità: cultura e psicopatologia della temporalità contemporanea*. Milano: Franco Angeli Editore 2012.

79 Byung-Chul H. *Agonie des eros*. Berlin: Matthes & Seitz Berlin 2012.