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THOUGHT LEADERS INVITED REVIEW

The descriptive psychopathology of melancholia in Roubinovitch and Toulouse's 1897 monograph "La Mélancolie"

Kenneth S. Kendler[1], and Virginia Justis[1]

Our modern syndrome of major depression developed over the 19th century and assumed its largely current form in Europe during the last decades of that century. A defining monograph in that historical development in German-speaking Europe was published by Krafft-Ebing in 1874. In this article, we provide a detailed commentary (and an English translation) of key sections of a monograph—"La Mélancolie" (The Melancholy) published by Roubinovitch and Toulouse in 1897—that plays a parallel role in the Francophone world. We emphasize six features of this important document. First, is it thoroughness, covering, with often vivid descriptions, the symptoms, signs, subtypes, course of illness, and outcome of melancholia. Second, this work describes the key features of the evolution of the concept of melancholia over the prior century. Third, we also see in this monograph important references to the leading explanatory psychophysiological model for melancholia developed in the middle third of the 19th century—melancholia as psychalgia or "mental pain." Fourth, the authors are committed to attempting to understand, in psychological terms, key features of the melancholic syndrome and in particular the development of delusions. Fifth, they give great emphasis to a symptom/sign pair in their diagnosis and description of melancholia: psychological suffering accompanied with resignation and "psychophysical decrease." Sixth, these authors attend to the lived experienced of their melancholic patients, considering some key themes, such as derealization, now emphasized in phenomenological studies of depression. Seventh, they have an insightful view of the evolution of psychiatric diagnoses that applies to the modern day—that disease identification in psychiatry lags behind that most parts of medicine as our diagnostic categories are still "only provisional symptomatic groupings which will one day be replaced by more exact conceptions of the nature of the relationships which unite the facts."

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The modern syndrome of major depression/melancholia developed over the course of the 19th century and assumed its largely modern form in Europe during the last quarter of the 19th century (1–4). A key 69-page monograph that helped contribute to the solidification of this syndrome in German-speaking Europe was published by Richard von Krafft-Ebing (1840–1902) (5, 6) in 1874.

Here, we examine a lengthier French monograph published 13 years later by Jacques Roubinovitch (1862–1950) and Édouard Toulouse (1865–1947) (hereafter R&T) entitled simply "La Mélancolie" (The Melancholy) (7) (Figure 1). The book, 420 pages long with 8 chapters and 22 detailed case histories, has received little attention in the Anglophonic literature and, in our view, played a role in the Francophone world broadly comparable to that of Krafft-Ebing's work in the German literature. That is, both present detailed summaries of the depressive syndrome that document its evolution into its broadly current form, although from relatively distinct national psychiatric traditions. Given space limitations, our commentary focuses on the descriptive psychopathology sections of this monograph largely contained in chapters 2 through 4 (pp. 24–234). We present, as online Supplementary Material, an English translation of chapters 1 through 4 and the first part of chapter 5 (pp. 1–271). (Chapters 1 and parts of 5 are included in the translation so readers can review, respectively, the authors' history of melancholia and their views of the etiology of melancholia). We sometimes add italics to our quotations from R&T for emphasis. Quotes that are of interest, but less essential to our narrative, are placed in Table 1. We turn now to brief biographies of the authors.

Biographies of Roubinovitch and Toulouse and Their Collaboration

Jacques Roubinovitch (1862–1950) born in Odessa, Ukraine to a French mother and a Ukrainian-Jewish father, was a gifted psychiatrist and researcher who spent his time working on the improvements of the conditions in psychiatric assistance; however, he was also concerned with the relationship between organic syndromes and psychiatric illnesses (8). He received his doctorate in Paris in 1890, one year after becoming a French citizen. In 1891, he completed his thesis: Hystérie mâle dégénérescence. Roubinovitch, prior to receiving his doctorate, interned at the Asiles de la Seine. In 1894, he was named as Head of the clinic of mental illness at the Faculté de Médicine de Paris. Following this position, he became the head doctor at Bicêtre in 1899.

Throughout his career, he published many works with his contemporaries, such as Édouard Toulouse and their work on melancholia, Gilbert Ballet and their work on urine toxicity in the mentally ill, and E. Phulpin and their work on dementia praecox, among many others. Roubinovitch is also responsible for the French adaptation of Atlas und Grundriss der Psychiatrie by Wilhelm Weygandt in 1904.

Also in 1904, Roubinovitch contributed to the overhauling of the 1893 law on the insane in his role in the Legislative Studies Commission. Later in his career, he focused on the issue of childhood delinquency and worked with the Child Rescue Organization and provided childhood psychiatry consultation at the Henri-Rousselle Hospital.

In 1921, Roubinovitch and his colleague, Toulouse, founded the French League of Mental Hygiene to increase awareness about causes surrounding mental health. Today, this organization still exists under the name Ligue Française pour la Santé Mentale (French League for Mental Health).

During the occupation of France in World War II, Roubinvitch was arrested by the Germans and interned at the Rothschild Hospital, where it is said that he provided comfort to the patients. He died in 1950 in Paris.

Édouard Toulouse (1865–1947) born in Marseille, France was a French psychiatrist, journalist, and eugenicist. In his early life, Toulouse worked

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Table 1. Additional quotations

#	Quotation
1	What sometimes adds to this suffering is that patients remember with remarkable clarity their entire previous emotional life, they then remember that previously, even when they were grieving, they were sensitive to what was happening around them. They could have joyful feelings, sympathize with the pain of others, console others, love; in a word, their affectivity was normal. Whereas, once ill, they became deaf to all the calls [41] coming from the outside world; nothing touches them anymore, nothing moves them. And from this comparison between their previous psychological state and their current state, they conclude that *they have become unworthy beings, monsters having lost all human feeling* (7). p. 40–41.
2	Memory, that is to say the faculty of recalling mental images, is generally weakened in melancholic people … Patients seem to be searching for words, probably because the verbal motor images are too faded to allow easy speech… Motor images are also weak… the melancholic … cannot clearly conceive and consequently execute his desires.… It is impossible for him to engage in the slightest work … As a result of the reduction in his psychomotor functions, the patient loses all confidence in his strength. He no longer formulates desires because it is impossible for him to imagine their realization. Often the patient expresses this reduction in his voluntary power by saying: "I would like to, but I cannot. » This weakening of motor images ultimately affects the processes of volition.… No idea is accompanied by energy great enough to determine the individual in one direction rather than the other.… Indecision is therefore a characteristic feature of the mental state of melancholic people… The slowing down of psychological functions can, in certain cases, go as far as complete cessation. It is then a question of melancholia with stupor (7) p. 61–67
3	… delusional ideas of melancholia can sometimes become systematized … Sometimes it is the ideas of ruin that predominate. The patient is convinced that he has lost everything, his money, his position, his situation in the world, and that he will never be able to get them back; he sometimes refuses food on the pretext that he cannot pay for it. Sometimes we observe ideas of humility. The subject declares that he is nothing, that he is miserable, that he does not deserve the care given to him and he does not understand how anyone is interested in him. From there to ideas of guilt, there is only one step; and this step is very often taken. The subject is then a serious criminal. He is the cause of all the evil that happens on earth. If people around him suffer, it is his fault. A patient in a hospital ward … accused herself of contributing to the end of her roommates; it was her breath that carried death around her. Sometimes this delusion of self-accusation takes on a particular intensity. And we hear patients declaring themselves guilty of misdeeds they never committed.…Hypochondriac ideas are often associated with melancholic delusions… The patients believe they have an obstructed digestive tract, they complain of not being able to urinate, of having their anus turned upside down, they are very concerned functions of this or that organ, and find in these fears about the physical state of their viscera, a new element of delusion (7). pp. 110, 113
4	The means that melancholic people use to commit suicide are numerous. They have varied according to the historical period, and still today they vary depending on whether the subjects are free to move or closely monitored… Each sex has its means. Women hang themselves more willingly, while men prefer sharp weapons and, for example, cut their throats—a delicate maneuver that frequently fails. For hanging, which is often just a simple strangulation, everything is good. Outside a tree, and on a window latch, a nail, the rungs of a ladder, an exposed lead pipe, everything that projects and can hold a tie is used by melancholic people. The link is often a simple rope, a handkerchief, a garter, a scarf…Submersion is mainly used … by women. Poisoning … with laudanum, chemical matches, are common …morphine, arsenic. Some people have tried to die by becoming deeply intoxicated with rum, absinthe or any other alcoholic beverage. More often alcohol is absorbed as providing the stimulation necessary for suicide to occur.… Others throw themselves from a high place, from a window for example (7) p. 138, p. 140–142
5	A lady Do… remembers that she once had a miscarriage. This memory haunts her. Her dreams are filled with painful visions of children having their throats slit. Her anxiety increases, and one fine day she tells herself that she must have had an abortion, that this miscarriage is a very bad thing. She is therefore a criminal; it must be cut into pieces, etc. (7) p. 177.
6	The melancholic hypochondriac, having reached the period of state, becomes an unbearable tyrant for those around him. He demands the presence of his relatives or guardians day and night. … His doctor is naturally one of his first victims. Every day he tires him out for hours by describing to him in detail everything he has experienced since the day before, the new symptoms he has discovered, the medications he has taken; he speaks to him in great detail about his sputum, his urine, his excrement (7). pp. 191–2

as a journalist and a drama critic. He then moved into the sphere of psychiatry, where he focused on melancholia (9). His interest in medicine came about in the late 19th century when he began to study it in Marseille. Toulouse was of the belief that art played a large role in psychology, and used literature to study the mind.

In 1891, he wrote his doctoral thesis: Étude clinique de la mélancolie sénile chez la femme. Toulouse interned at many psychiatric hospitals around Paris at this time, gaining helpful experience and insight.

It is during this time of his life that he encountered Jacques Roubinovitch, and many other colleagues with whom he collaborated to produce a wide array of research into the mind. During his lifetime, Toulouse published over 20 works. Research and journalism remained important to Toulouse, evidenced by his prolific writing.

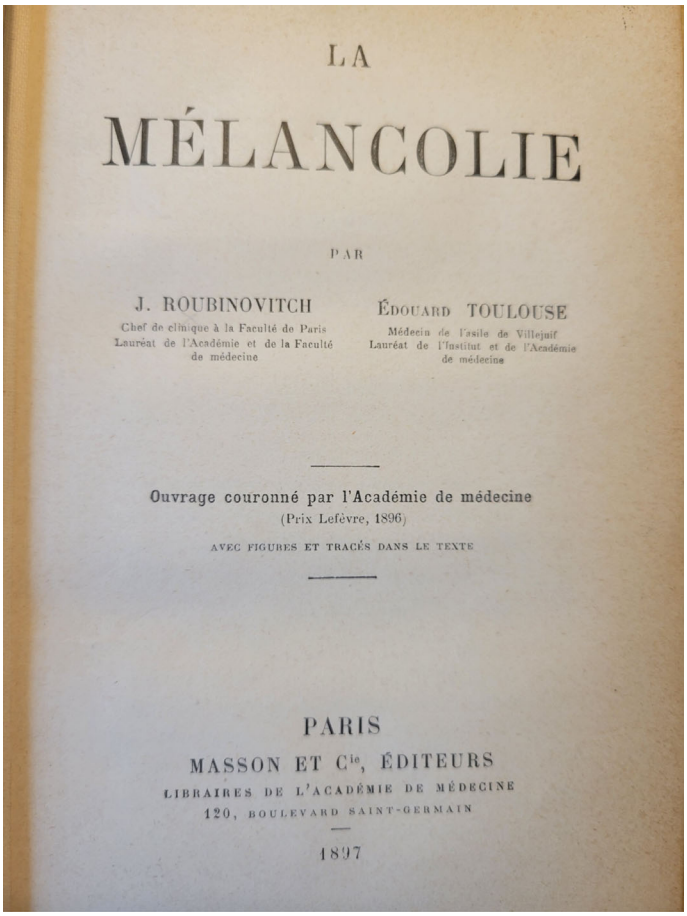
In 1898, he became director of l'Asile Villejuif in a Parisian suburb. While there, he collaborated with other psychiatrists like Henri Piéron and the psychologist Théodule Ribot.

In 1901, Toulouse opened an experimental laboratory to study the convergence of social relations and encounters and psychiatric research. Toulouse was at this point interested in the study of genius, and worked with Émile Zola to understand the link between genius and madness.

Toulouse was also a eugenicist, with a firm belief that motherhood should be reserved only for women in perfect health. He wanted to use his scientific knowledge to make society more reasonable and just (10).

In 1912, Toulouse revisited his love of the arts and established a literary journal, Demain. From 1922 to 1936, Toulouse directed le Centre de prophylaxie mentale du département de Seine. Currently, there is a psychiatric hospital named after him, Le Centre Hospitalier Édouard Toulouse, located in Marseille, France.

Both Toulouse and Roubinovitch worked at Sainte-Anne asylum under the service of Alix Joffroy, whose observations were used in La Mélancolie (7). They chose to write together to share observations to be useful to other practitioners as well as to explore different theories. After the publication of La Mélancolie, Toulouse and Roubinovitch continued to interact. As mentioned above, the two were integral in the forming of the French League for Mental Hygiene in 1920. Roubinovitch's psychiatry consultation career at Henri-Rousselle was also an important location for


LA

MÉLANCOLIE

PAR

J. ROUBINOVITCH
Chef de clinique à la Faculté de Paris
Lauréat de l'Académie et de la Faculté de médecine

ÉDOUARD TOULOUSE
Médecin de l'asile de Villejuif
Lauréat de l'Institut et de l'Académie de médecine

Ouvrage couronné par l'Académie de médecine
(Prix Lefèvre, 1896)
AVEC FIGURES ET TRACÉS DANS LE TEXTE

PARIS
MASSON ET Cie, ÉDITEURS
LIBRAIRES DE L'ACADÉMIE DE MÉDECINE
120, BOULEVARD SAINT-GERMAIN

1897

Figure 1. Roubinovitch and Toulouse's 1897 monograph "La Mélancolie".

Toulouse—it is where he set up the first free outpatient psychiatry service. Starting in 1932, the two also collaborated, as part of the 27 psychologists, psychiatrists, and anthropologists, in the Society of biotypology (10) for the goal of gathering research across many disciplines to have a more complete idea of the "individual." The same year, Toulouse introduced the Society of criminal prophylaxis, and he asked Roubinovitch to contribute his knowledge on delinquent youths.

Background

In their introductory chapter on the history of Melancholia, R&T make a few points that put their further discussion into context. With respect to their approach compared with the very broad definition of melancholy, sometimes noted in earlier in the 19th century French writings, they wrote:

> By such a definition of melancholia its circle is noticeably narrowed; because to justify such a diagnosis *it is no longer enough to simply be dejected and in a state of sadness; In addition, a whole set of symptoms with a special evolution is required* (7). p. 15

In modern terms, they argue that melancholia is a biomedical syndrome quite distinct from isolated mood states of sadness. How similar is their approach to melancholia to contemporary writings in the German and Anglophonic literatures? Their views are quite close to "how melancholia seems to be understood today by the majority of French and foreign alienists (7). p. 15." They continue

> One of us did a particular study on this question (11). We will limit ourselves to citing the German alienists who have carried out extensive research on this subject. From a clinical point of view, *they understand melancholia almost as we do* (7), pp. 16–17

R&T then discuss whether melancholy really qualifies as a "morbid entity"

> ...must we not admit that what the authors call melancholia is a heterogeneous compound of physical and psychological disorders, which no natural link unites, something comparable to the chest inflammation or the cerebral fever of the ancients? (7) p. 24

They review the long debate about the homogeneity versus heterogeneity of melancholy, noting that psychiatry differs from medicine which in their era was making great progress with the identification of many specific diseases related to specific microbial agents:

> We cannot, in mental pathology, *be as rigorous in the categorization of morbid disorders as, thanks to progress in microscopic and bacteriological analysis, it is permitted to be in general medicine* (7) pp. 25–26.

R&T continue

> But, in psychiatry, what can we use to delineate a morbid state? It is not about the microbe, nor about experimental transmission—as in infections; nor is it about the visceral lesion, which is still unknown. *So is it necessary to forbid ourselves from any study of phenomena, because they are more complex than elsewhere? No, certainly; and we are obliged to create morbid categories, as naturally or rather as less artificially as possible.* This, without hiding the fact that these are probably *only provisional symptomatic groupings* which will one day be replaced by more exact conceptions of the nature of the relationships which unite the facts (7). p. 25

Their approach is rather Kraepelinian in tone, echoing his position that psychiatry in this era needed to initially use clinical research methods—studying symptoms, signs, and course—to define syndromes and then hope validation will occur from other sources—like physiological, postmortem, or genetic studies (12).

R&T then discuss the core symptom of depression "what characterizes melancholia is sadness (7) p. 27." They reject the earlier 19th century definition of melancholia which required psychotic symptoms:

> What, then, characterizes it [melancholia] more specifically? It is not delusion, since it can be absent, the subject nonetheless remaining a lypemaniac [a synonym for melancholic introduced by Esquirol]: we then say that it is a question of melancholia without delusion. On the other hand, delusional conceptions of a sad nature are encountered in a host of illnesses without dominating the scene and making one think of lypemania. But if melancholic delusion is not necessary for the diagnosis, even more so are morbid conceptions of negation, of immortality, of hallucinations, all of which may or may not exist in the mental disorders that we are trying to characterize (7) pp. 27–28.

They then present a clear definition of their understanding of the core of the melancholic syndrome:

> There are other characteristics, these constant ones, and which are pathognomonic, especially in their association, of what we call melancholia. *It is the mental pain and the slowing down of mental functions*.... Mental pain, even more than the cessation of the mental faculties, is the attribute of the melancholic. It is the pain which creates this constant sadness even under ... the paroxysms of anxiety. And we can say that *melancholia is above all a pathologically sad emotion* (7). p. 28

They elaborate to help differentiate melancholia from the generic sadness that often accompanies other forms of psychiatric illness, especially in their history:

> This *psychological suffering must still present itself with particular characteristics, and—to put it straight away—with a certain resignation*.... The individual no longer receives from all his organs, from all his tissues, the usual sensations which accompany the state of health... This change in perceptions determines a distressing emotional tone (7) pp. 28–29

R&T here give a clinical pointer to help in the differential diagnosis of melancholia from the nonspecific sadness common in early stages of psychotic disorders: "For far from accusing others, he [the true melancholic] accuses himself to the point of usually seeking an end to his ills in suicide (7) p. 31."

In addition to the sad mood, they reemphasize what they above called "slowing down of mental functions" in melancholia:

> Mental arrest, which starts from simple dulling and ends in complete stupor with or without delusion, is an almost equally constant phenomenon.... We are therefore armed with two criterial signs sufficient to limit the clinical field of melancholia: psychological suffering and psycho-physical decrease. The first especially, psychological suffering with resignation, is absolutely characteristic of the illness (7) pp. 31–32

Chapter III – Symptomatology

In this chapter, R&T examine the melancholic syndrome in greater detail:

> After examining the constant psychological and physical symptoms, we will study the inconstant ones, those which, like hallucinations, various delusional ideas, acts, are contingent, and may or may not be present without altering the diagnosis of melancholia (7) pp. 31–8

Symptomatology – Consistent Symptoms

They provide, at the start of this chapter, a formal definition of melancholia:

> it is a *state of sadness without sufficient reason* with a tendency to *resignation,* a state of which *psychological suffering* is the fundamental symptom. To this sign is added another no less important one: *the slowing down of psychological processes*, which in certain cases can go as far as complete cessation. (7) p. 39

It is worth taking this pithy definition apart. Is melancholia fundamentally what we would now call a mood disorder? This was not obvious for much of the 19th century. R&T are, however, here, making their position clear. However, to preserve the idea that melancholia is a mental disorder, they add an important caveat which has been present in many but not all definitions of melancholia in the 19th century (13). That is, they exclude from their definition cases where the depressed mood arises with "sufficient reason." To anticipate by several decades the position of Karl Jaspers (14, 15), depressive episodes that were psychologically understandable reactions to overt stressors would not meet R&T's definition of melancholia.

R&T provide the reader with further information to distinguish a normative depressive reaction from melancholia:

> The psychological suffering of the melancholic is a chronic painful emotion, which, in serious cases, gradually invades the entire field of consciousness. Is there a difference between this psychological suffering and that which occurs in a normal individual under the influence of a reasonable motive? ... in the normal individual with excessive grief, *the possibility of receiving pleasant perceptions still remains*, and there remains *some hope of emerging from the painful phase* he is going through. The true melancholic has completely lost the faculty of experiencing sensations which can distract from his sorrow; and he is convinced that he will never be able to get rid of his psychological suffering. He no longer sees any favorable solution; there is *a real wall between him and the outside world against which all hope is shattered* (7). pp. 29–40

So, they find that complete anhedonia and the state of hopelessness are important distinguishing features of reactive depressive states and melancholia. Furthermore, the qualitative feeling of the depression differs:

> *The intensity of this suffering makes it unlike any other*. The recovered melancholic people we interviewed always told us that the pain they experienced could not be compared to any physical pain (7) p. 40

For a poignant description of the reactivity in "normative grieving" versus the pervasive anhedonia of melancholia, see Table 1 quote 1. R&T did not consider severity of mood disturbance a necessary requirement for a diagnosis of melancholia. Milder cases of illness could also be considered as disordered:

> Certainly, there are melancholic states in which everything *is limited to mild pain*. What then allows it to be considered pathological is the absence of sufficient reasons and also the patient's belief that he no longer has the same emotional sensitivity as before. Moreover, the intensity of this psychological suffering is not always equal in the same individual. There are oscillations; and, on the same day, the melancholic can feel more distressed in the morning than in the evening ... , *this mental suffering always has the characteristics of being accompanied by a feeling of resignation, of helplessness* (7) pp. 41–3.

Note the description of classical diurnal mood variation frequent in 20th and 21st century descriptions of melancholia.

R&T then turn to providing a psychophysiological explanation of the origins of the mental pain characteristic of melancholia. Here they use the unusual term *coenesthesia* which is defined as "the blend of numerous bodily sensations that produces an implicit awareness of being alive and of being in a particular physical condition:"

> *Let us now try to show how the psychological suffering of the lypemaniac arises and develops and on what it is based.* We have already said that it was necessary to suppose at the origin of a melancholic state ... *The thousand sensations, which continually come from all the organs, are no longer the same. The coenesthetic sense ... is ... altered*. The patient no longer recognizes his usual sensations; *he no longer feels like he is living as before*..... We can in this way explain how simple alterations of coenesthesia can cause somewhat serious discomfort. In addition, sensory sensitivities (vision, hearing, etc.) undergo similar alterations in their functioning. It is then *that patients say that they feel transformed and that they no longer see the outside world in the same way*.... The patient isolates himself, since all external impressions arouse and maintain his suffering. These modifications in internal and external perceptions do not occur with impunity; and the patient is surprised and suffers from this alteration of his sensations. *The melancholic always has his thoughts concentrated on unpleasant mental representations* (7) pp. 43–44

We need to unpack this important paragraph. R&T focus on a proposed psychophysiological theory for melancholia. Fundamental to this theory is the proposed changes that occur in the bodily physical sensations and internal and external perceptions and subsequent representations that are typically associated with a sense of well-being. These are all dramatically changed in melancholia, causing a cascading set of changes that produce physical discomfort, psychological distress, and depression. These developments are also responsible for the sense of derealization that often accompanies the disorder—the ill individual feeling a substantial change in their lived experienced. Their physical and social world has shifted as have the mental representations that populate their inner life. We outline below how these descriptions echo a key earlier theory in 19th century psychiatry of melancholia and a form of psychalgia. (16)

From symptoms, R&T then move to describe the main "physical" features of melancholia:

> What then are the signs of sadness, to which we usually compare melancholia?... What is characteristic is first of all *an action paralyzing the muscles. The movements are difficult and painful, hence a feeling of discouragement*. The *voice is weak, the gestures are slow, the gait is unsteady; the features of the face sag.... The pulse and breathing slow down* .... (7) pp. 52, 54

They then explore the psychological origins of depressive delusions—assuming the individual unconsciously seeks explanations for their psychological and associated somatic mood state in their prior actions.

> Among the consequences of this mental suffering, we must note the feeling of *helplessness* which invades the patient. When psychological pain is at its maximum, sensory perceptions and ideas lose all pleasant or unpleasant meaning for the melancholic, and the individual falls into a true emotional anesthesia.... But before arriving there, *the melancholic questions himself, and, in this perpetual need for explanations which is specific to the human mind, even when sick, he finds, in the path of passive resignation indicated above, reasons to his sufferings*; this is *the origin of the delusional ideas* ... In this the patient *reasons logically*. As he is in a somatic state analogous to that which accompanies remorse, these come naturally to his mind. To justify them, he accuses himself of imaginary misdeeds; he says he is a great culprit, having committed serious mistakes. (7) p. 58

To recapitulate their point here, R&T argue that the melancholia individual, from a somatic and psychological perspective, feel they are in a state of remorse. How could this be, they wonder. Surely, it then follows,

Figure 2. A melancholic patient p. 71 of volume.

I must have done things for which I should be remorseful—I must have been a bad person ...

They then turn to examine what they call the "mental decline" associated with melancholia:

> In the melancholic, we observe a *general slowing down of psychological processes*, which is probably related to the *somatic conditions of sadness*. We have seen that sad emotions could be psychologically characterized by difficult associations of ideas; the two phenomena, *sadness and mental slowness*, would therefore be linked. Clinically we know that in all painful emotions there is a certain cerebral torpor: the head seems empty, according to the expression of patients.... What is certain is that *all mental processes are slowed down and weakened in the melancholic: perceptions, memory, ideation, attention, judgment, even imagination, [and] especially will*. (7) p. 60

To see a description of these features in more detail, see quote 2 in Table 1.

R&T then review the signs of melancholia, illustrating the facial expression and posture by a poignant photograph (Figure 2). They write:

> *The physiognomy of melancholic people expresses their psychological suffering and their lack of energy*. The eyebrows are contracted, vertical folds are formed immediately above the root of the nose; *the forehead presents horizontal wrinkles as a result of prolonged contraction of the frontalis muscle; the angles of the mouth are lowered, the mouth itself is tight;* the face, aged, seems longer than normal (7) pp. 72–3

They continue:

> This reduction in motor skills is seen on the patient's sagging features; it also manifests itself in his immobility. The muscles are often trembling, which indicates that the contraction is hesitant .. the voice is furthermore dull, monotonous, indistinct (7) p. 73

Sleep problems are prominent features of the disorder:

> Among the physical symptoms that appear at the very beginning of melancholia, *sleep disorders should be noted. These are persistent insomnia* ... often accompanied by sudden awakenings. In other cases, the individual notices that, even after sleeping, he wakes up in the morning as tired as the night before; *sleep then ceases to be restorative*. (7) p. 75

They follow with a 17-page description, complete with figures, of physiological measures of the changes in respiratory and cardiac function as well as body temperature and urine volume and composition in melancholic pts (pp. 78–95). They conclude this section by noting the frequency of amenorrhea and weight loss:

> Menstrual functions are often stopped, especially in the stuporous.... more or less rapid malnutrition is the consequence of all these functional disorders... [and] consequences of this reduction in nutrition is a lesser resistance to infectious diseases and in particular to tuberculosis. (7) p. 96

Symptomatology – Variable Symptoms

R&T turn to examining "...the symptoms of melancholia which do not have the constancy of those we have just reviewed (7) p. 98," beginning with auditory hallucinations. When present, the content is almost always derogatory:

> Almost always the voices say *unpleasant things*. These are crude insults, where the same filthy words are constantly found. These are threats, sinister warnings, which only increase the depression or anxiety of patients. (7) p. 101.

Interestingly, the hallucinations can blend into thought withdrawal and thought echo—among the classic so-called Schneiderian symptoms which were actually commonly described in the 19th century psychiatric literature (17).

> ... the patient says that his thoughts are being stolen from him, that he cannot think of anything without a voice immediately repeating in his ear what he is thinking. In other cases, they overhear dialogues between the subject and imaginary people (7) p. 102.

They then describe the typical melancholic delusions, noting the resigned acceptance of these beliefs rather than the active defiance typically seen in cases with primary psychotic disorders:

> Delusion is a frequent element of melancholia, but not constant. There are clinical forms where patients do not manifest any delusional conception. But there are others—very numerous and varied—where melancholic ideas are clearly delusional... The melancholic delusion *is of a distressing nature*; and whatever form, whatever color it takes on, it is *always a sort of nightmare*. Such a patient says he is abandoned by everyone; another believes that all his relatives are dead; he hears utterances of terrible threats against him; this one is convinced that the scaffold will be erected to guillotine him... Far from recriminating, as the persecuted constantly do, and trying to take revenge on the people to whom they attribute the evils with which they are overwhelmed, *they submit, resigned*. (7) pp. 108–9

For a poignant description of the common delusional themes of melancholic patients, see Table 1, quote 3.

In addition to these more typical delusional themes, R&T note "... other delusional ideas which are rarer and which are elements simply associated with distinctly melancholic conceptions. p. 116" These included delusions of damnation, persecution and more rarely grandeur. That later most typically occur in

> ...patients who are rather persecuted. When true melancholic people are ambitious, it is always in their own way. They are great culprits, accusing themselves of all the crimes and all the evils of creation; and if they are a power, it is only an evil, infernal power (7). p. 119

They then turn to consider suicidal ideation:

> ...the idea of suicide, which, by the acts it pushes one to commit, is of capital importance. The pathogenesis of these suicidal ideas is very varied. *Despair, remorse, and above all the desire to be rid of psychological suffering are the most common apparent psychological causes of suicide*. Sometimes it is hallucinations which maintain or suddenly provoke these morbid ideas. Other

> times it is anxiety, this paroxysmal mental pain, which suddenly gives rise to the idea of suicide, just as it provokes rapture. But in general, thoughts of suicide have a slow progress and onset.... It should be noted that thoughts of suicide generally have the monotony and steadiness of all the conceptions of [Melancholics]. Patients constantly ruminate on them and design more or less complicated execution plans (7). pp. 114–5.

R&T then turn to "...*acts* which are observed more or less frequently during melancholia. p. 127," the first of which is muteness. They write:

> Mutism is encountered in all forms of melancholia; but *it is much more frequent in the form which is accompanied by stupor*. This is where it is most durable; and it is not rare to observe stuporous people who go months without speaking. ... The causes of melancholic muteness are quite numerous. Sometimes *it is excess suffering* which seems to produce it; the subject is then prostrate, in one of those great silent pains, such as one experiences after terrible emotions. Other times, it is the hallucinations that bind the subject's language. (7) pp. 127–8, 132

Other notable acts in these patients include the refusal of food, self-mutilation, and suicide attempts and deaths. About the latter, they write:

> Suicides are very common during melancholia. They are found in all clinical forms; delusional melancholics and anxious people should *especially be monitored* ... Obviously acts of suicide are the expression of thoughts of suicide; and when these manifest themselves, attempts at execution are to be feared. But it happens that *patients, who do not seem at all to be prey to thoughts of suicide, kill themselves in an unexpected way*. The causes of suicide are quite varied. Sometimes—most often—it is *mental suffering*, which, having become unbearable, panics the patient and pushes him to murder himself... In other cases, it is a particular delusion that causes the impulsions to suicide. A melancholic person wants, by killing himself, to escape the dishonor into which his faults and crimes have plunged him; his death will also be an expiation. He cannot survive the loss of his fortune or his parents. Another rushes into death following a hallucination that commands him to do so. (7) pp. 137–8

R&T review common methods of suicide, which for historic interest, we include in Table 1, quote 4.

Chapter IV – Clinical Varieties of Melancholia

R&T begin this chapter by articulating a distinction between what they call *melancholia-psychosis* and *symptomatic melancholia*. To avoid confusion, we will use the more familiar term of *primary melancholia* for their first subtype, which they define as follows:

> Those where we find no visceral lesions, of the brain or another organ, no nutritional disorder capable of explaining more or less well the appearance of psychological disorders. These melancholies occupy, in mental pathology, a place symmetrical to that held, in neurology, by neuroses. Both appear rather functional or–what is more precise—cannot be linked to any specific lesion (7) p. 145.

Symptomatic melancholia, by contrast, includes cases "where an immediate etiology is very apparent. These include, for example, melancholic states occurring during alcoholism, infections, circumscribed brain lesions (7). p. 146." R&T comment only briefly and this subform of melancholia and we will not consider it further here.

But before describing their four key subtypes of primary melancholia—*stuporous, anxious, delusional, and hypochondriacal*—R&T briefly review what they call simple melancholia, which they note is the form of illness "most often observed outside asylums (7) p. 151." Here is there summary of this syndrome, mirroring descriptions given earlier in the book.

> it is characterized by the reduction of biological energy. Sadness is a most striking objective aspect... This triple difficulty of feeling, thinking, and acting, which asserts itself as the affection evolves, passivity, the absence of any spontaneity, of any psychological activity manifests itself more and more. There may, at times, be a total shutdown of all ideation processes. Not only the patient's actions, but his words, all his movements become slower and slower, more and more difficult... self-consciousness is not deeply affected; it is only invaded by conceptions and images of a sad nature (7) pp. 149–50.

They add that "the patient retains the ability to control and associate his ideas. He generally combines them in the direction that his mental pain gives them (7) p. 150 ..." but delusions do not typically emerge. Furthermore, they note that this form simple melancholia can remit or evolve into more severe forms of illness.

Stuporous Melancholia

R&T begin by describing the typical presentation and course of this subtype:

> For three, four months, the individual is moderately depressed; then the slowing down of psychological processes reaches its maximum intensity, and the patient *falls into a sort of torpor which forces him to complete immobility for days and even weeks*. In this period, he looks like a real statue. *The face loses all expression, the look is vague*; sometimes with a half-open mouth lets the saliva flow, mucus comes out of the nose without the patient trying to blow their nose. The extremities are cold, cyanotic, the arms hang along the body like the sleeves of a jacket, clothes are messy; often the patient urinates and lets out his excrement without moving (7) p. 152–3

It is in such cases, they note, that one of key features of melancholia, the slowing of mental and physiological processes, is most pronounced. They also note important changes in cognitive content:

> From a psychological point of view, the feeling of helplessness is pushed to its extreme limit in the stuporous. And as, on the other hand, the emotional and affective disorder is also at its maximum, it is around these two pivots, *complete helplessness and infinite sadness*, that the psychological state of the melancholic evolves with stupor (7). p. 154

Interestingly, they report the recollections of formally stuporous melancholic subjects:

> *They lived in a world apart, like in a dream. External impressions had virtually no influence on them. They only had a very limited number of ideas, and it was especially difficult for them to produce new ones*. These ideas absorbed them, held them like true obsessions (7). p. 158.

R&T question the clinical coherence of Kahlbaum's formulation of catatonia published in 1874 (18, 19) and note some similarities but important differences between that syndrome and their view of stuporous melancholia. Cataleptic states, a key phase of Kahlbaum's syndrome, can occur, albeit rarely, in melancholia, but are also seen, according to R&T, in a wide-range of other psychiatric syndromes.

Anxious Melancholia

Often,

> ... the onset of this variety is manifested by a change in the character of the individual who becomes sad, irritable, and quite abnormally sensitive. Attributing the cause of his bad mood to his own faults ...he examines the details of his previous life, the more he finds evidence of his guilt or unworthiness. *As the affection develops, the patient becomes agitated in the circle of a small number of painful ideas, usually self-accusing* (7). p. 176

Self-derogatory delusions often emerge and become the focus on the mental life.

> It manifests itself through *the incessant repetition of the same complaints, the same accusations.* Every day, for months, the patient approaches you, explaining with great volubility the two or three misdeeds he blames himself for, the punishment he deserves, the punishment he fears (7). p. 177

For a brief case history, see Table 1, quote 5. R&T then describe the clinical picture of these cases:

> ... he is constantly in motion. He roams his room in all directions and, when he is free, he wanders off aimlessly, simply to satisfy this imperative need to change places, to move continually.... In moments of great anxiety, the patient pulls his fingers, tears his hair, scratches his forehead, cheeks, neck, chest, tears his clothes... During these melancholic paroxysms, he is capable of committing the most dangerous acts: ransacking the furniture, setting fires, tearing out his eyes, ears, genitals (7) ... p. 178

R&T note that young, inexperienced alienists who will sometimes consider these cases to be suffering from mania.

Delusional Melancholia

"Here the disorder," write R&T, "is deeper and the very content of the ideas is more or less altered. In a word, ... a new element is introduced: the delusional conception (7) p. 187." Returning to their interest in the causes of depressive delusions, they write

> How is it born? Most often, it is the consequence of a greater intensity of psychological disorders ... *It represents the patient's attempt to explain everything painful he experiences* ... Clinically, when this state reaches the highest stage of its development, ... the melancholic tells himself he is ruined and reduced to begging. He believes he is unworthy of living and incapable. He accuses himself, declaring guilt towards God and men. He feels damned, believing everyone despises him and subjects him to countless insults. Added to this is the fear of punishment, hell, torture, and also ideas of negation, immortality, etc. (7). pp. 187–8

They emphasize the role of psychalgia or mental pain:

> .... all impressions from the outside world arrive in the patient's consciousness profoundly altered; this psychological dysesthesia .... gives all impressions a dark, painful color. This is the source of all the ideas relating to the imaginary dangers which threaten the melancholic and to the equally imaginary persecutions of which he is [often] the victim (7). p. 188

Profound anhedonia also plays a role in the delusional formation, as the patient:

> ... becomes incapable of manifesting a feeling of friendship, an aesthetic impression, a religious idea. *As he is perfectly aware of this change occurring in him, he comes to the conclusion that he is no longer a human being, that he is a beast, that God has abandoned him, that he is damned*, etc. (7) p. 189.

At one extreme end of this clinical continuum, Cotard's syndrome emerges: "When psychological anesthesia is at its maximum intensity, the patient imagines that everything around him has disappeared and that he himself is dead (7). pp. 189–190." R&T give an extended discussion of Cotard's syndrome on pp. 196–208. They present a striking image of a delusionally depressed patient in Figure 3.

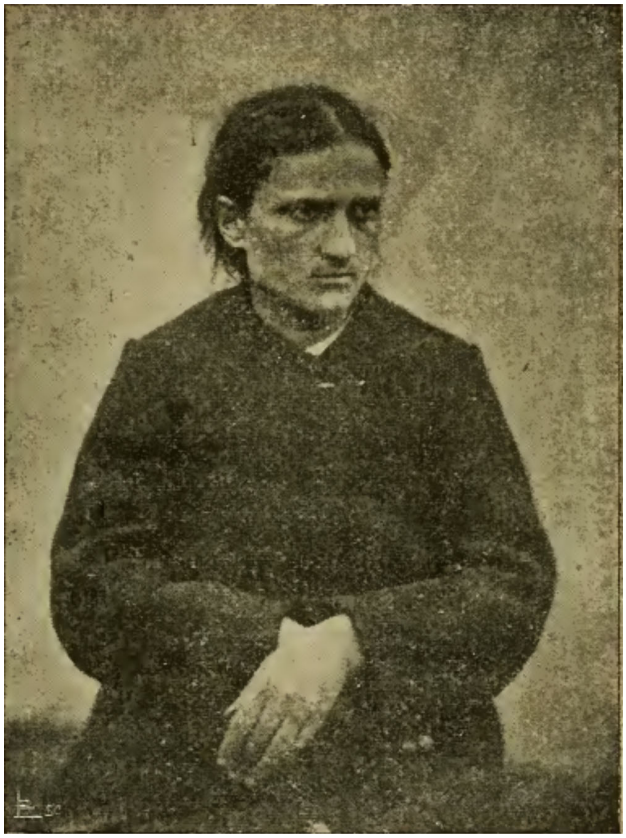


Figure 3. A case of delusional melancholia—p. 189 of the volume.

Hypochondriacal Melancholia

R&T write that

> Certain melancholics, in seeking the cause of their mental pain, *find it not in the impressions they receive from the outside world, but in those which result from disorders of their general or visceral sensitivity*. The gastrointestinal tract and the genitals in particular give them all sorts of painful sensations, which become the starting point for real conceptions of delusional and hypochondriac melancholics. pp. 190–1

The syndrome typically develops in the following sequence:

> The sick are sad, depressed. At first, they cannot give any explanation for their discomfort. But soon, they said they were worried about their health. They feel fatigue, weariness ... Sometime later, these still vague sensations become clearer: it's the stomach, it's the gut, it's the chest or even the head that hurts. The most careful medical examination does not allow the discovery of any objective sign in the incriminated organs, and yet the complaints are more and more serious, more and more pressing... under their influence the patient soon abandons his most important affairs, sometimes goes to bed and urgently demands care (7). p. 191

As they outline in Table 1 quote 6, these cases can be very clinically demanding. The course and outcome of such cases is often more severe than most other melancholic subtypes:

> The development of hypochondriac melancholia is often an alternation of bouts of anxiety and periods of depression. The duration is usually long (several months and even several years). The ending is very variable ... healing would be observed in a third of cases; another third would pass into a state of chronic hypochondriac melancholia; finally, the last third would slide into dementia (7). p. 193

R&T comment on two particular courses of melancholia, which they term *intermittent* and *circular*. They define the former as follows:

> As a phase of intermittent insanity, this variety is essentially a bout of mental illness which can occur several times in the same patient. In the intervals between bouts the disease seems to have completely disappeared. The bouts appear at regular intervals and present an almost complete resemblance to each other. The patient manifests exactly the same delusional conceptions, the same degree of resignation and abulia (7). p. 212

Circular melancholia, which they said should be viewed in the context of the prior literature on disorders termed "periodic, circular, [and of] double form (7) p. 212"—all of which we would now see as precursors of our current concept of bipolar disorder –they state that they will not address in this monograph.

Finally, we review what R&T write in this chapter on the course and outcome of melancholia. In general:

> the prognosis for depressive melancholia, considered as a whole, is rather favorable. But the prognosis becomes worse when the condition persists beyond a year or eighteen months (7) p. 174.

In mild cases, "the mental disorders can disappear quite quickly, after 3 or 4 months, especially if the subject is subject to a healthy and abundant diet and if you manage to improve your general nutrition. In other cases, and especially in melancholia with stupor, the affection can last a year and beyond (7) p. 172" However, "in other cases, and especially in melancholia with stupor, the affection can last a year and beyond (7). p. 172"

Interestingly, the taking a careful history of their melancholic patients,

> ... it is not uncommon to learn that they have had, at different periods of their life, small attacks of melancholia. These attacks lasted a few days, a week or two, then disappeared without apparently leaving a trace (7). p. 172.

These earlier episodes apparently occurred without asylum treatment. In the hospital,

> The progress of depressive melancholia is, in short, uneven. It proceeds in ups and downs, the patient sometimes showing signs of a beginning improvement, sometimes, on the contrary, those of a worsening. It is especially at the beginning and at the end of the illness that we observe these

> oscillations and in particular these aggravations which are very often accompanied by corresponding modifications in the physical state (constipation, insomnia, etc.) (7). p. 173

While generally positive,

> The ending of... melancholia is also very variable. *The most common is healing*. Sometimes also the affection transforms into agitated melancholy or even dementia in people with weak nervous systems, and particularly in adolescents ... Death can finally occur either due to the deep exhaustion into which the melancholic often falls, or also by suicide (7). pp. 173-4.

Discussion

In our view, the monograph on Melancholia by Roubinovitch and Toulouse is an important document in our history of the development of the diagnosis of depression/melancholia that has been surprisingly neglected in the Anglophonic literature. Berrios, typically the most thorough of psychiatric historians, ends his history of mood disorders in the 19th century in France in his major monograph (20) with Falret and Baillarger's key articles in the early 1850s on, respectively, circular insanity and insanity of double form. He is entirely silent on French writings on melancholia in the second half of that critical century. Neither Jackson's classical history of melancholia (21) nor the much more recent and thoughtful volume of Jansson (3) are any better, neither making any reference to the work of R&T. That this neglect might not have always been true is hinted at by a story we uncovered in our extensive search for references to this volume by English-speaking authors. R&Ts volume found its way into the library of William James, the great American psychologist and philosopher. When he was writing lecture V on the "sick soul" in his famous "Varieties of Religious Experience," he consulted R&T noting "I quote now literally from the first case of melancholy on which I lay my hand (22) p. 148."

Of the many major themes touched on by R&T in their monograph, we will here focus on six. The first and most obvious point is the thoroughness demonstrated by the authors in their descriptions. They covered all the major subdivisions within psychopathology often with considerable details: symptoms, signs, subtypes, course of illness, and outcome. Their descriptions of the signs are often vivid ("The eyebrows are contracted, vertical folds are formed immediately above the root of the nose ...in moments of great anxiety, the patient pulls his fingers, tears his hair, scratches his forehead, cheeks, neck, chest, tears his clothes.") The depth of the authors experience and knowledge of the manifestations of melancholia is impressive—more so in reading their full text with case histories than could be conveyed in this summary. The quality of the descriptive psychopathology of this volume is at least as strong as those of other classic descriptions of melancholia/depression in the English (e.g., Lewis (23)) and German traditions (e.g., Kraft-Ebbing (5) and Kraepelin (24)).

Second, we can see in their description, the key developmental features in the evolution of the concept of melancholia from the late 18th century—when it was conceived as a disorder of intellect or judgment, a "partial insanity" often but not always associated with sadness—to its modern form (1, 3, 4). These include, particularly, i) viewing melancholia as primarily a disorder of disturbed mood, ii) the recognition that non-psychotic forms of melancholia exist and are of clinical importance, and iii) the understanding that in the psychotic forms of the illness, the delusions and hallucinations can be understood as resulting from a primary disturbance of mood. We have two additional measures of the degree to which R&T's text aligns with modern concepts of depression. First, clear descriptions of all nine DSM-5 (25) "A criteria" for major depression can easily be found in its pages. Second, in a prior review of 20th century descriptions of depression, one of us (KSK) identified 18 characteristic depressive symptoms and signs from twentieth century psychiatric textbook authors (26). R&T's monograph describes all 18 of them.

Third, we also see in this monograph, important references to the most important explanatory psychophysiological model for melancholia developed in the middle third of the 19th century—melancholia as psychalgia or "mental pain" (16). Briefly, as clinical pathological correlation became a dominant medical paradigm in early 19th century, nervous diseases presented clear exceptions sometimes demonstrating "pain without lesions" or neuralgia, of which Tic Douloureux was the paradigmatic example. This disorder was assumed to result from neuronal hypersensitivity in spinal ganglia so that a normal stimulus (e.g., touch) were misinterpreted as excruciating pain. A parallel framework was conceptualized in the brain to produce psychalgia, thereby explaining how normal social and introspective experiences would, in melancholic patients, be interpreted in a distorted manner which caused mental rather than physical pain and reinforce themes of inadequacy, failure, and worthlessness, and produce a sustained melancholic mood state. We see a number of echoes of this theory in T&R's multiple use of the phrases "mental pain" and "mental suffering." They note that it is the psychalgia "which creates this constant sadness." The patients view of the world is "..no longer the same. all impressions from the outside world arrive in the patient's consciousness profoundly altered; this psychological dysesthesia."

Fourth, R&T attempted at several places in their text, to articulate psychological theories for delusion formation in melancholia: "the melancholic questions himself, and, in this perpetual need for explanations ... he finds, in the path of passive resignation... reasons to his sufferings; this is the origin of the delusional ideas ..." and "it is the consequence of a greater intensity of psychological disorders ... [as] part of the patient an attempt to explain everything painful he experiences. ...The melancholic then tells himself that he is ruined, that he is reduced to begging, that he is unworthy of living..."

Fifth, R&T are somewhat unusual in focusing on a pair of signs as foundational to the melancholic syndrome: psychological suffering accompanied with resignation and "psychophysical decrease."

Sixth, in their writings, these authors attend to the lived experienced of their melancholic patients. They consider themes now commonly emphasized in the phenomenological study of depression—for example, by Ratcliff (27)—including the symptom of derealization—feeling that the world around them has profoundly changed—and the struggles to understand what is happening to them which can, in certain cases, lead to explanatory delusions.

Finally, a series of smaller points are noteworthy. R&T noted that disease identification in psychiatry lagged considerably behind that in certain parts of medicine, especially in infectious disease and agreed that psychiatric diagnostic categories at their time (and ours) were "only provisional symptomatic groupings which will one day be replaced by more exact conceptions of the nature of the relationships which unite the facts." R&T agree with some modern psychopathologists (e.g., refs. 28, 29) that the so-called Schneiderian symptoms, often noted throughout the 19th century (17), were not uncommonly seen in mood disorders and thus are not diagnostically specific to schizophrenia. They noted, importantly, that melancholia—a psychobiological syndrome—is qualitatively different from episodes of sad mood, a diagnostic issue which persists in medical care to this day. They were aware of mild melancholic syndromes—which they termed "simple melancholia"—that did not typically require asylum care. Finally, aware of the problems of the differential diagnosis of reactive depression vs melancholia, they provide sound clinical advice to focus on the assessment of the level of hopelessness and anhedonia.

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The contributors have confirmed that no conflict of interest exists.

Author Contributions

KSK developed the original idea for the paper. VJ, with the assistance of KSK, translated the relevant sections of the book. KSK drafted the main manuscript with the exception of the authors' biographies, which was drafted by VJ. Both reviewed the final context of the manuscript.

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LA MÉLANCOLIE

by J. Roubinovitch and Édouard Toulouse
Paris, Masson et Compagnie, Editors
Libraries of the school of medicine

1897

In the courtyard of the Faculty of Medicine of Paris (École de médecine), Paris, France, European Congress of Mental Hygiene (Congrès européen d'hygiène mentale), 1 June 1922. Press photograph: Rol Agency.

Translator's comment: To allow direct comparisons between our translation and the original French text, the page number of the original text is added throughout this document in bolded square brackets ([]).

[1] CHAPITRE I

HISTORIQUE

Under the influence of medical theories in favor at various times, the study of melancholia has gone through several phases which it is necessary to summarize. Its history includes the following four periods: that of Greek and Latin doctors until the Decadence, that of the Middle Ages, that of modern times from the Renaissance to the Revolution and finally the contemporary period.

Physicians of the Hippocratic era, guided by their humoral theories, attributed to the darkness of bile (Μέλας, black; χολή, bile) a most harmful influence on psychological functions. According to them, it gave rise to agitated delusion, while phlegm, just as dangerous for the mind, gave, on the contrary, peaceful delusion. **[2]** Permanent excitement was therefore – and we must remember this – the dominant, essential character of melancholia, as the Ancients understood it. Clear proof of this can be found in Hippocrates' *Treatise on the Sacred Disease*. He establishes between epilepsy and melancholia a sort of parallel based on this idea that one and the other, being constituted by agitation, are determined by the action of black bile, which would spread throughout the body in epilepsy and would only infect the psyche in melancholia.[1]

According to the Hippocratic school, the ideas of sadness, fear, anxiety were therefore in no way necessary to characterize melancholia; it could even go as far as the most exuberant cheerfulness without losing its name. The theories of the Greek doctor were to have such a lasting influence that, at the beginning of the 18th century, alienists still admitted that melancholia was sometimes a gay madness. The melancholia moria of Sauvages is a typical proof of this.[2]

What seems to emerge from the study of ancient books **[3]** is that we attach to the word “melancholia” the idea of a delusion limited to a small number of morbid conceptions, that is to say of partial delirium. This results in particular from the definition given to melancholia by Areteus: “animi angor in una cogitatione detixus absque febre” (psychic anguish without fever relating to a single idea).[3] The history of melancholia in antiquity is reduced to these vague notions of pathogenesis and clinic.

You have to arrive at the end of the Middle Ages, in the 15th century, to hear again about madness and its different varieties. But religious traditions, the beliefs of the time have a great influence on mental pathology and even more than on other parts of medical science. In the eyes of the most serious doctors of this time, madness and all its manifestations, which no natural cause can explain, become not illnesses, but the effect of a supernatural, diabolical or divine force — more often diabolical, which takes hold of the human creature. This is because observers of that time judged maddness based on

[1] Here is how Hippocrates expresses himself: “Melancholic people usually become epileptic, and epileptics melancholic; of these two states, what determines one in preference is the direction that the black bile takes; if it is worn on the body, epilepsy occurs; if it affects the mind, it is melancholia.” (Hippocrates, Complete Works, ed. Littré, 1860, t. V, p. 355.)
[2] Sauvages (1706-1767), Nosologie méthodique, 1750, p. 359.
[3] Arétée (81 ap.JL-C), De causis et signis diuturnorum morborum, edit. Kühn, Leipzig, 1828, p. 74.

legends bequeathed by mythology or the Old Testament. The stories, taken from these two sources whose poetic charm far outweighs the truth of observation, were the documents which were used by the alienists of that time to make a diagnosis, **[4]** absolutely as the experiments today by Claude Bernard or Pasteur serve to support a medical opinion.

We must therefore admire those who, like Nider, had a presentiment of an imminent revolution and who dared to declare that the lycanthropes, the demoniacs, the possessed, all those unfortunate people who were being burned by the hundreds, were sick.[4] This weak protest is taken up later by Alciat, Leloyer, Montaigne;[5] and, from the 16th century, we begin to become a little more skeptical of the alienist-demonologists. From this point of view, the 16th and 17th centuries are a time of transition where we see, timidly at first, then more openly, the reappearance of Hippocrates' humoral theories on madness. Mixed with previously received opinions on supernatural interventions, these theories sometimes create a surprising amalgam. The finest example of this mixture of mystical and humoral doctrines is offered by the illustrious doctor from Basel, Félix Plater.[6] He understood melancholy like Areteus; his collection of remarkably well-taken observations indicates a consummate experience of mental medicine; we even believe that, as a **[5]** clinical description of melancholia, nothing close to it had been done before him. Nevertheless, and while speaking the humorous language of ancient times, he explains melancholia by the influence of a fallen spirit, and, alongside bloodletting and purgatives, he advises exorcisms.

A work that is also very interesting is that of Willis.[7] Under the name melancholia it describes all delusions other than mania, which supports what we have said about the confusion which has always existed regarding the meaning of this nosological term. But while in the thought of ancient doctors melancholia was a partial delusion, for Willis there are two species of this morbid form: in one the delusion concerns a single object — this is *melancholia specialis*; in the other, on several objects at the same time — it is *melancholia universalis*. From the point of view of the causes of melancholia, Willis is no more explicit than Plater. Animal spirits, their more or less strong effervescence in the human organism, the intervention of the devil, this is the pathogenesis; It is true that alongside these obscure factors he mentions the influence of heredity and moral causes, which, considering the time when it was said, was bold and new.

The voluminous document[8] left to us by Théophile **[6]** Bonet contains anatomo-pathological insights relating to melancholia; this author notes in particular that the gastrointestinal tract often presents considerable alterations in this mental illness; melancholia would thus have a reflex origin. Bonet brings back into honor the theory of sympathetic madness already outlined around the 11th century by the Arabist school.

In the 18th century, very remarkable notions, although given in a somewhat too concise and aphoristic form, were provided on melancholia by Boerhaave.[9] This author's definition does not differ much from that of Areteus. We call melancholia, he says, an illness in which the individual is delusional in a

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[4] In Calmeil, De la folie considérée au point de vue pathologique, philosophique, historique et judiciaire, etc., 1845, t. I, p. 191.
[5] Montaigne, Essais, 1725, t. III, p. 283.
[6] F. Plateri (1536-1614), In mentis alienatione observationes, 1641, p. 49.
[7] Willis (1622-1675), Opéra omnia, 1681.
[8] Th. Bonet, Sepulchretum,sive anatomia practica, 3 vol. in-folio, 1700..
[9] In G. Van Swieten, Commentaria in Hermani Boerhaave Aphorismos de cognoscendis et curandis morbis, t. III, § 1089-1127.

continuous and tenacious way about an idea which is almost always the same. The physical symptoms of this condition are described with the precision of modern observation: slow breathing, slow pulse, slow blood circulation of the large vessels (central circulation?), collateral circulation (peripheral circulation?) less good, cold extremities, decrease in secretions and excretions, anorexia, weight loss. The pathogenesis alone is of the time; it is based on the harmful effects of atrabile [black bile] on blood. The latter would be composed of solid parts and **[7]** fluid parts. The fluid elements being more mobile would evaporate and dissipate; then the blood would become black, earthy, thick, atrabilious, that is to say a true melancholic juice which would spread throughout the entire organism. And that is why man is melancholic.

The description of melancholia given by Boerhaave is taken up by Sauvages[10] who establishes a new clinical variety characterized by a certain degree of stupor: this is *melancholia attonita*. The author is not concerned with pathogenesis; a nosologist above all, he is mainly concerned with the symptomatic modalities of madness. We have also seen above that he admitted a variety of gay and happy melancholic people.

For Lorry,[11] another alienist from the second half of the 18th century who published a large work on *la Mélancolie et les maladies mélancoliques*, this mental affection is the consequence of a special temperament, of a congenital nervous impressionability. We are born melancholic, we do not become melancholic, such is Lorry's general idea. He gives a completely physiological explanation of this original disposition to melancholia; he invokes in particular a defect in the conformation of the nervous system or a defect in the composition of the blood. According to **[8]** him, a modification in the structure of a nerve fiber would necessarily lead to a change in its mode of vibration which could become less easy or less rapid. Melancholia ultimately results from the presence, in the blood, of impure humors, of the atrabile of the ancients.

Pinel[12] is content to give some melancholic observations, but without presenting a new doctrine. “The insane of this species (melancholia), he says, are sometimes dominated by an exclusive idea which they constantly recall in their words, which seems to absorb all their faculties; other times they remain confined in an obstinate silence for several years, without allowing the secret of their thoughts to penetrate; some do not reveal any gloomy air and seem endowed with the healthiest judgment, when an unforeseen circumstance suddenly bursts their delusion.” So for Pinel, melancholia is a partial delusion, most often sad. We recognize in the cases that he cites melancholics strictly speaking, persecuted people, megalomaniacs. He also sets out to show that melancholia can present two opposing forms: “it is sometimes a fullness of pride, and the chimerical idea of possessing immense wealth or boundless power; other times it is the most pusillanimous dejection, **[9]** profound consternation, or even despair.”

Let us now turn to Esquirol's ideas on melancholia.[13] He first attacks the term melancholia, which seems to him to be devoid of any scientific precision. According to him, it would be best to leave this word to

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[10] Sauvages, Nosologie méthodique, 1730, p. 369.
[11] Lorry (A. G.), (1725-1777), De melancholia et morbis melancholicis, 1765, 2 vol. in 18.
[12] Pinel, Traité médico-philosophique sur l'aliénation mentale, 1809, p. 163 and following.
[13] Esquirol, Des maladies mentales, 1838, t. I, p. 398 and following.

poets and philosophers. In his eyes, this term had two defects: the first of corresponding to an erroneous humoral theory, the second of having in vulgar language a completely different meaning than that given to it in mental pathology. Because the fundamental sign of the melancholia of ancient authors, of Areteus for example, was that the delusion concerned a single conception or a very limited number of conceptions; melancholia was therefore above all a partial delusion, but not necessarily of a sad nature. Also, for this term understood in the manner of the ancients, Esquirol substituted that of monomania (Μόνος, alone, Μανία, madness), which perfectly indicated the fundamental character of these partial delusions relating only to one object. He reserved the name of lypemania for delusional conceptions based on sadness. So that for Esquirol partial delusions or monomanias were divided into monomania proper, having as its dominant symptom a cheerful element, and into *lypemania* (λύπη, sorrow), characterized by a sad and depressing passion **[10]**. We do not have to discuss Esquirol's classification in this quick review. What matters to us above all is to determine how he understood from a clinical and pathogenetic point of view what he called lypemania.

For Esquirol, lypemania is a form of partial delusion[14] which is accompanied by depression and sadness. It constitutes a modality completely opposite to mania, in which the delusion is general, extends to all kinds of objects and is accompanied by excitement. Understood in this way, lypemania sometimes involved a hypochondriac idea, sometimes an idea of persecution, sometimes an idea of suicide. This constituted, with stupor, so many varieties.

In his study of the causes of lypemania, Esquirol emphasizes the role of heredity, predisposition, different temperaments, especially bilious temperament. He notes the greater frequency of this affection at the most emotionally turbulent periods of life, between thirty and fifty years of age; he also indicates the influence of puberty and, particularly in women, that of menopause. He studies, as etiological conditions, the seasons, the climates, the professions. **[11]** He was struck by the greater frequency of lypemania in women and he explained it by the disorders of menstruation or the puerperium and also by their greater emotionality and excitability. It deals with the influence of the social environment, religious passions, the degree of civilization, political events; this is how he states that, during the revolutionary excesses of the Terror, suicide-lypemania had acquired an unusual frequency. Psychological causes have, according to Esquirol, a large part in the etiology of lypemania; and he notes them almost in each of his observations (loss of loved ones, upset love, disappointed ambition, etc.).

Unlike Esquirol who, in the manner of the ancients, described melancholia as a delusion relating only to an object, Baillarger strives to demonstrate that, most often, delusion with sadness and depression constitutes, to the same degree as mania, a general problem of the understanding. This delusion, he says, imprints on all psychological manifestations a uniform stamp of despondency, anxiety and sometimes even stupor.[15] Baillarger therefore proposed to completely distract lypemania from partial delusions, that is to say from monomanias, to classify it in the group of general delusions alongside mania. For this author **[12]** melancholia is therefore a mental illness characterized by delusional ideas

[14] Esquirol often comes back to this: “As for what is foreign to their delusion, they (the melancholics) are like everyone else, appreciating things very well, judging people and facts very well, reasoning just as rightly as before becoming sick. » (Des maladies mentales, vol. I, p. 1122.)

[15] Baillarger, De la mélancolie avec stupeur, Ann. méd.- psych., 1843, t. I, p. 76

of a sad nature and by depression sometimes reaching the point of stupor. It includes *all cases of depression of the mental or psychological faculties*[16], including events of suspension of understanding, confused by Pinel with *idiotism*, called by Esquirol *acute dementia*, described by Georget and Etoc-Desmazy under the name of *stupidity*, and which were, for Baillarger, the only varieties of melancholia already observed by Guislain[17], *delusional melancholia*, in which the sick believe themselves to be dishonored, lost, ruined, criminal, damned, etc. ; finally *melancholia with stupor*, where are grouped all these mute and immobile insane people who, under a mask of apparent torpor and numbness, continue to delude in silence in an active manner.

The exposition of these ideas had a very great influence on the alienists; also, for a long time, melancholia was considered as Baillarger understood it. Marcé[18], who completely accepted this doctrine in 1858, added very important notions on the somatic state of melancholics. **[13]** He studies their breathing and circulation in particular and analyzes the modifications that these two functions undergo in their rhythm and in their relative frequency.

At the same time Morel[19], while opposing melancholia to mania, only made both symptomatic states, denying them the quality of particular forms of madness. He endeavored to show that these two symptoms, exaltation and depression, were encountered in all the varieties of mental illness, in hereditary madness, epileptic, hypochondriac, sympathetic, etc., that they followed one another and alternated frequently and none of them had any nosological significance. We indeed find in his works observations of melancholia which he links to the supposed cause, to hypochondria above all, to hereditary mental illness, to intoxications.

But at the same time clinical work continued; and observers distinguished melancholia from special forms such as hypochondria, which Falret, Morel, Guislain described as a particular mental illness. For his part, Lasègue[20] isolated another morbid form, persecutory delusions, which was itself dissociated into different elements, among which we must cite the *chronic delusion* **[14]** of Mr. Magnan. In recent times, a new attempt was made in France by Cotard[21] to separate from melancholia another nosological entity, *delusions of negations*, and in Germany by Kahlbaum[22] for *catatonia*.

But in recent times a question has particularly interested alienists, who have asked themselves in what capacity melancholia or lypemania should appear in mental pathology, as a distinct morbid entity or only as a syndrome? Twenty years ago, Foville made[23] his opinion known in this regard. There it is. Depression, like excitement, can exist as an accessory symptom in several species of madness, in general paralysis, double-form madness, madness of acts, and even in imbecility and dementia, and it then constitutes what should be called symptomatic lypemanic delusion. But, other times, this morbid state, instead of being secondary and accessory, constitutes the very essence of a special illness, different from any other and from which it seems difficult to refuse, from the clinical point of view, the value of a pathological entity. It is to all the cases which constitute this **[15]** entity that it is appropriate, according to Foville, to assign the name of lypemania. By such a definition of melancholia

16 Baillarger, Des différents genres de folie (1853), in Recherches sur les maladies mentales, 1890, t.I,p. 72 et suiv.
17 "The union of melancholia with ecstasy (stupor) is a combination which presents itself quite frequently; it is the Melancholia attonita ecstatica of the authors" (Guislain, Traité des phrénopathies, 2e édit., 1835, p. 264.)
18 Marcé, Archives de médecine, 1855, and in Traité pratique des maladies mentales, Paris, 1862, p. 312 et suiv.
19 Morel, Traité des maladies mentales, 1860, p. 469 and following.
20 Lasègue, Du délire des persécutions (1852), in Études médicales cliniques, 1884, t. I, p. 545.
21 Cotard, Du délire des négations (1882), in Études sur les maladies cérébrales et mentales, 1891, p. 325.
22 Kahlbaum, Klinische Abhandlunsen über psych. Krankheiten, I Heft, Die katatonie, 1874.
23 A. Foville, art. Lypémanie, Nouveau Dictionnaire de Méd. et de Chir. prat, t. XXI, 1875, p. 105 and following.

its circle is noticeably narrowed; because to justify such a diagnosis it is no longer enough to simply be dejected and in a state of sadness; In addition, a whole set of symptoms with a special evolution is required.

This is how melancholia seems to be understood today by the majority of French and foreign alienists. M. Magnan,[24] for example, considers it as a well-characterized morbid form which he places in his classification among the psychoses in the same way as *chronic delusion with systematic evolution*. There exists a pure melancholia which constitutes according to him a simple element, that is to say a morbid form with clear contours, with invariable symptomatology, with a fixed course, most often exempt from any hereditary influence and generally including a favorable prognosis. Such a definition further restricts the scope of melancholia. For Mr. Joffroy, on the contrary, there are no essential melancholias, there are only symptomatic melancholias. Our opinion is closer to the latter.

It is interesting now to see how this disease is described abroad. One of us **[16]** did a particular study on this question.[25] We will limit ourselves to citing the German alienists who have carried out extensive research on this subject. From a clinical point of view, they understand melancholia almost as we do, but since German mental pathology is little known in France, we will be permitted to insist on this.

Krafft-Ebing and Schüle, whose opinions are accepted by a large number of their colleagues, rank melancholia among the psycho-neuroses, that is to say, among the mental affections which occur in individuals whose organic and psychological development was normal. In the thinking of these authors, melancholia is not an affection dependent on the poor nervous organization of the patient; it constitutes an accidental illness surprising an individual whose brain functions had previously operated in a normal manner and in whom there was nothing to predict the outbreak of this psychosis. So what is the cause? It is, they say, a temporary predisposition to this psycho-neurosis, for example a very serious somatic affection, alone or associated with some other accidental and powerful factors. We can even, they add, observe a certain hereditary predisposition, but in a purely latent state, that is to say that, until the appearance **[17]** of psychosis, the brain functioned well; then, when the subject was affected by a fever, trauma or psychological shock, this brain fell into a state of less resistance and became disorganized. Another general characteristic of melancholia, as of all psycho-neuroses, is its tendency to a clear ending, without recurrences. The evolution is typical, and the main symptoms are always and everywhere the same: a state of inexplicable or insufficiently motivated sadness, then a general slowing down of all psychological processes which can go as far as complete cessation.

Concerning the detailed symptomatology we will see that the German authors have analyzed with great finesse the mental state of the melancholic. Let us content ourselves with indicating here the different varieties which they admit.[26] They describe simple melancholia and melancholy with stupor. Their *melancholia simplex* includes several modalities: one in which the phenomena of psychological arrest are determined by the *idea-pain*, another — much more serious — where these disorders have an organic cause, which hinders the free functioning of the psychomotor centers and can cause a real muscle spasm

[24] Magnan, Leç. clin, sur les maladies mentales, 1893, p. 204.
[25] Roubinovitch, Variétés cliniques de la folie en Finance et en Allemagne, Paris, 1896, p. 29 and following.
[26] Roubinovitch, Variétés cliniques..., works cited, p. 41.

such as tetany and catalepsy. In these two clinical forms the dominant phenomenon **[18]** is passivity or the impossibility of freely expressing one's will; so we still call them by the name of passive melancholia. But this passivity is in no way fixed, according to Krafft-Ebing, and it can be transformed into a completely opposite state of permanent excitement and activity when the pain-idea manifests itself externally in a very lively; we are then dealing with *melancholia errabunda* and, in more serious cases, with "melancholia agitans sive activa". If we add that the melancholic is subject to paroxysms of his mental illness and that, in his agitation, he sometimes resembles an excited maniac, we will understand the difficulty we often experience in making a precise diagnosis. It is with this aim of differentiation that Rikhartz[27] studied the cerebral work of active melancholia in comparison with that of mania.

The most general current opinion of German alienists is that the ideas of the melancholic form isolated groups. The patient is incapable of examining a thought in all its aspects; the chain of ideas is constantly broken for him and at every moment he returns to his first conception. Also melancholics constantly complain of having a real obsessive need to think, which is a sort of *pressure of ideas* **[19]** (Ideenszwang), and at the same time it is impossible for them to stop on a single conception and to examine it carefully. In a word, they lament the emptiness of their consciousness when it seems, on the contrary, filled with a crowd of thoughts. According to Emminghaus, the mental state of the melancholic would be a sort of universal obsession relating to all psychological operations.[28] This proposition must undoubtedly be understood in the sense that the melancholic considers all the ideas that pass through his head being completely foreign as he does.

The simple melancholia of the German alienists offers a host of sub-varieties classified according to this or that grouping of symptoms or their intensity. The three main ones are: melancholia without delusion, precordial melancholia in which anxiety is the main phenomenon, and delusional and hallucinatory melancholia. The latter is subdivided into religious melancholia and hypochondriac melancholia.

Baillarger's melancholia with stupor is described in Germany in the same way as here; we will therefore not stop there.

One question must still attract our attention before closing this history. How do we explain **[20]** in France and abroad the production of the two cardinal phenomena of melancholia: mental pain and the decline of psychological functions?

Modern pathogenetic notions about this mental condition are still mere hypotheses. The nature of the illness being generally dependent on the nature of the cause which produced it, most agree that melancholia is caused by weakening and depressing physical or psychological agents. The action of exhausting physical factors, whether of a traumatic, infectious or toxic nature, is understandable, although we do not know why the physical factor produces in one case an attack of mental confusion, in another

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[27] Rikhartz, Allg. Zeitschr. fur Psychiatrie, F. XV, p. 28.

[28] Emminghaus, Psych. Pathologie, p. 199. The German term expresses this state well : massenhaftes Zwangsvorstellung.

neurasthenia, in a third the melancholia. The difference in reaction of each individual is undoubtedly the reason for these varied effects. As for psychological causes, their influence on the production of melancholia is even more mysterious. It is accepted in principle that all sorrows, all depressing emotions influence general nutrition by disrupting the functions of the main systems (digestive, circulatory, etc.) — and by causing self-poisoning. But a truly scientific explanation is still lacking.

Some authors, like M. Séglas[29] for example, **[21]** have noticed, in the initial physical symptoms of melancholia, a striking analogy with neurasthenia: disorders of digestive functions, loss of appetite, constipation, gastrointestinal autointoxication, vasomotor disorders, palpitations, precordial anxiety, throbbing in the temples, ringing in the ears, vague pain, headache, general weakness, weight loss, increased density of urine. Mental pain would therefore only be the expression of a disorder occurring, in the general nutrition of the nervous system, under the influence of one of the causes listed above and among which auto-intoxication would occupy an important place. But what does this decline, this cessation of psychological functions, depend on? Is it the consequence of this mental pain or is it, on the contrary, the cause?

Some maintain that the psychological shutdown is primitive. Some of our mental representations, says Schüle,[30] are directly linked to the functioning of our viscera. Under the influence of a nutritional disorder, the centers of these representations may undergo some alteration. This will result in a modification from the point of view of the sensitive functions of these centers; there will then be a defect in the relationships that normally exist **[22]** between sensations and perceptions; these will be disfigured, strange. Finally, all of these bad mental representations will influence the general psychological state by creating mental pain.

According to another theory developed by Krafft-Ebing,[31] the slowing down of psychological functions is secondary to mental pain. Melancholia would be a central neuralgia similar to peripheral neuralgia. This cerebral neuralgia would have the consequence of slowing down all the mental, sensitive and motor functions of this organ. It is useless to point out how metaphysical all these pathogenetic conceptions are; we can only see purely verbal explanations there. Direct observation only proves one thing, that is, that mental pain and slowing down of functions are intimately linked and have a reciprocal influence on each other.

We have also seen that the domain of melancholia considered, as a morbid entity, tends to be reduced more and more. Today we no longer make the diagnosis of melancholia because we have noted in the patient an idea of guilt, damnation or ruin; each of these ideas, formerly considered as a pathognomonic symptom **[23]**, today has nothing specific. Observation proves that they are encountered in almost all mental forms (madness linked to neuroses, hysteria, epilepsy, chorea, toxic madness, circular madness, delusions of the degenerate, paranoia and its different varieties, madness of the elderly, dementia, general paralysis). But then what constitutes melancholia?

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[29] J. Séglas, Leçons cliniques sur les maladies mentales et nerveuses, Paris, 1895, p. 285.
[30] Schüle, Klinische Psychiatrie,1886, p. 21.
[31] Krafft-Ebing, Handbuch f. Psychiatrie, 1890, p. 403.

[24] CHAPTER II

MELANCHOLIA IS IT A MORBID ENTITY[32]?

Reading the presentation of these multiple and different opinions, one is overcome with doubt about the nosological reality of this disease, which everyone understands in a different way. For these opinions to be so numerous, must the subject not be singularly vague and imprecise? And then must we not admit that what the authors call *melancholia* is a heterogeneous compound of physical and psychological disorders, which no natural link unites, something comparable to the chest inflammation or the cerebral fever of the ancients?

We cannot, in mental pathology, be as rigorous in the categorization of morbid disorders **[25]** as, thanks to progress in microscopic and bacteriological analysis, it is permitted to be in general medicine. Here a disease — pneumonia for example — is clearly characterized by special lesions and a microbe which ensure perfect identification among all lung diseases. But, in psychiatry, what can we use to delineate a morbid state? It is not about the microbe, nor about experimental transmission — as in infections; nor is it about the visceral lesion, which is still unknown. So is it necessary to forbid ourselves from any study of phenomena, because they are more complex than elsewhere? No, certainly; and we are obliged to create morbid categories, as naturally or rather as less artificially as possible. This, without hiding the fact that these are probably only provisional symptomatic groupings which will one day be replaced by more exact conceptions of the nature of the relationships which unite the facts. However, we are entitled to think that these nosological concepts will not disappear completely and that the general idea which gave birth to them will remain. And if this idea is truly clinical, if it reflects one of the main aspects of the phenomena, it will live. Other explanations, more concrete and more extensive, will not eliminate it.

So let us seek among the numerous symptomatic **[26]** characteristics given as pathognomonic of melancholia, those capable of relating to all the facts that alienists have in mind in their descriptions. If we manage to retain a few of them — even just one[33] — we will have justified the quality of morbid species granted to melancholia.

The ancients and Esquirol thought they noticed that melancholia was a partial delusion, relating only to one object. Although this is true in a sense, since patients continually entertain the same ideas and appear — at least some — lucid apart from their morbid conceptions, this is not a characteristic common to all cases, nor special to them. A melancholic is most often affected in all his intellectual faculties, and his lucidity does not exclude the generalization of the illness. This epithet of partial can be applied more happily to other delusions, to the delirium of touch to cite an example, where the morbid idea coexists with an intelligence that is in no way or little troubled elsewhere. It is useless to point out **[27]** how bizarre the concept of “gay melancholia” was; because — the public was right in this before Esquirol — what characterizes melancholia is sadness; we

[32] Absolutely there are no morbid entities, which are artificial and all subjective creations of our mind. But there are more or less well-defined symptom complexes.

[33] In fact, there is no pathognomonic symptom of a disease, which is rather characterized by a small number of signs. However, in theory we must admit that there are some and that their search is the ideal goal of pathology. Besides, isn't tuberculosis rigorously characterized by the bacillus and its experimental effects? Certain diseases, which are currently difficult to define, will probably one day be modified in their nosological framework: such as general paralysis, hysteria, even emaciation.

will try to demonstrate this later.

So Baillarger was truthful when he fought this theory of partial delusion and when he made melancholia a mental illness affecting, in the same way as mania, the whole individual, and including all the facts of depression. He was right to place stupor in melancholia[34] but he was wrong, in our opinion, to expect — to legitimize this connection — that, in all cases of stupor, there was an active melancholic delusion, so active that the subject was essentially inhibited. We can conceive that stupor is a form of melancholia for other reasons, because it is due to the psychological shutdown which ordinarily accompanies great mental pain. But, admitting that melancholia is a general mental illness of the whole being, this hardly advances the question. Because the generalization of morbid disorders is a characteristic common to most mental illnesses. What, then, characterizes it more specifically? It is not delusion, since it can be absent, the subject nonetheless remaining a lypemaniac: **[28]** we then say that it is a question of melancholia without delusion. On the other hand, delusional conceptions of a sad nature are encountered in a host of illnesses without dominating the scene and making one think of lypemania. But if melancholic delusion is not necessary for the diagnosis, even more so are morbid conceptions of negation, of immortality, of hallucinations, all of which may or may not exist in the mental disorders that we are trying to characterize. Nor is it the depression understood in the sense of attitude and gestures and even also of thought, since anxious melancholics are sometimes agitated to the highest degree. So, what do we rely on?

There are other characteristics, these constant ones, and which are pathognomonic, especially in their association, of what we call melancholia. It is the mental pain and the slowing down of mental functions. German alienists have contributed most to the study of these two obligatory symptoms of melancholia. Mental pain, even more than the cessation of the mental faculties, is the attribute of the melancholic. It is the pain which creates this constant sadness even under the attacks of rage and the paroxysms of anxiety. And we can say that melancholia is above all a pathologically sad emotion.

This psychological suffering must still present itself with particular characteristics, and — to put it **[29]** straight away — with a certain resignation. Because many mental illnesses, all of them, said Guislain,[35] begin with a period of melancholia. At this time, nothing appears to clinically distinguish this vague depression from that which is pathognomonic of so-called essential lypemania. In all cases (mania, persecutory delusions, etc.), the psychological suffering is very great and determines an attitude, gestures and a feeling of discouragement. We can assume that the somatic basis of this suffering is alterations in nutrition, which generate coenesthetic disorders. The individual no longer receives from all his organs, from all his tissues, the usual sensations which accompany the state of health, that is to say the state of perfect balance. This change in perceptions determines a distressing emotional tone. We can also see that the reduction in organic functions, which is constant in these cases, is a physical condition very likely to cause sadness. But, at this moment, the patient unconsciously tries to react against these modifications with his whole being. This is where each person's particular tendencies manifest themselves. Some will react by getting excited; it is then a more or less great disorder of thought and actions (mania). And in fact it is a common observation that mania begins with **[30]** a phase of depression. Likewise in circular madness, which presents itself to us as a sort of laboratory experiment carried out by nature to illuminate this special point, melancholic periods bring equivalent periods of agitation. But other patients, instead of giving in to this somewhat

[34] He was right about most of the facts; because it is quite certain – and we will see this later – that there are stupors that cannot be linked to melancholia.

[35] Guislain, Traité sur les phrénopathies, 1835, p. 186.

reflex or automatic reaction, question themselves and seek an explanation for the discomfort that has invaded them. Here again there are two paths open, which lead to two clearly different morbid states. If the patient, with the reactions specific to his character, attributes his illnesses to foreign maneuvers, he enters into persecutory delusions which, as we know well from the works of Morel[36] and especially of M. Magnan[37], begins from the usual way through this phase of depression and worry to arrive at the period of specific accusations. But it happens other times when the patient, always obeying his own tendencies, immediately resigns himself to these sufferings, which he undergoes passively (melancholia with a depressive form). Even, when he tries to react (anxious melancholia), it is with a feeling of impotence by which he resembles children, all the weak, who are irritated by their **[31]** misfortune and do not manifest, in short, beneath a noisy exterior, only complete resignation and helplessness. For far from accusing others, he accuses himself to the point of usually seeking an end to his ills in suicide.

We will also have the opportunity to return to this way of interpreting the facts.
In the meantime, we must remember that psychological suffering, which is the general attribute of all melancholic states, including essential melancholia, is only pathognomonic of these insofar as it is accompanied by this resignation particular on which we have just insisted. Otherwise it would just as well characterize certain delusions, of persecution for example, where on the contrary, when the period of worry is over, the psychological suffering which persists sometimes causes very great resistance and aggressiveness.

Mental arrest, which starts from simple dulling and ends in complete stupor with or without delusion, is an almost equally constant phenomenon. We say almost, because in certain cases of anxious melancholia, where psychological suffering is at the highest point, it seems that we must hesitate to speak of stopping the psychological processes. And yet, when we carefully observe patients of this type, we easily convince ourselves that, beneath their deceptive loquacity, there exists a real poverty of ideas, and that the monotonous work of thought **[32]** gravitates around psychological suffering and the few delusional ideas that this has generated. This mental arrest, as we have said, does not have the absolutely special character of psychological suffering, since we encounter it in certain other forms of alienation, for example in what has been called *acute dementia or mental confusion*, a state which is characterized by a reduction in psychological processes without there appearing to be psychological suffering, that is to say in short without melancholia. But, nevertheless, we must keep this sign, although secondary, because, attached to psychological suffering, it allows us to link together the very varied facts of melancholia. Next to the mental cessation we will place the cessation of physical processes, which is probably the condition of the former; they exist as frequently as each other.

We are therefore armed with two criterial signs sufficient to limit the clinical field of melancholia: psychological suffering and psycho-physical decrease. The first especially, psychological suffering with resignation, is absolutely characteristic of the illness. But before beginning the detailed description of the symptoms of this affection, we must first establish a broad division of the facts that we are going to study. In the first group, we will deal with melancholia occurring during serious morbid disorders (alcoholism, infectious diseases, **[33]** organic lesions of the brain), which are for us an immediate explanation of psychological disorders. Because, obviously, melancholia, a psychological illness, has somatic conditions, which are the alteration of nutritional processes; and the mind is loath

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[36] Morel (Traité des maladies mentales, 1840, p. 707) has insisted on a hypochondriac past in certain persecuted [patients].

[37] Magnan, Le délire chronique, in Leçons cliniques sur les maladies mentales, 2nd edit., 1893, p. 236 et suiv.

not to consider these as the cause of the latter. In these cases, it would be, if you like, symptomatic melancholia. We could compare them, in the neurological field, to nervous diseases with known lesions, that is to say organic nervous diseases.

In other situations, we find nothing other than the physical and psychological disorders which form the complex of melancholia. These states are analogs of neuroses, where the lesions are still unknown or poorly understood. It is then a question of so-called *essential* melancholia, of *pure psychosis*. Is this distinguishable from other symptomatic melancholia? This is another point that we will have to consider.

Although we must return to this issue, we will make a statement here about how we understand essential melancholia. This term essential does not mean, in our opinion, that the disease is not linked to any close etiology; rather it proves our ignorance. In biology, nothing is created from nothing. A psychosis, even of those called pure, must necessarily have causes, let us say conditions and certainly somatic conditions **[34]** which provoke and maintain it. When we can grasp them and we are well aware of the chain of cause and effect which links these two orders of phenomena, we say that morbid disorders are symptomatic. When, on the contrary, this relationship escapes us, we say that the illness is essential. But it would be illogical to maintain that the latter does not have immediate causes, disorders which maintain it and which are its necessary generators. What we only mean is that in these cases the disease appears autonomous and seems to evolve in its own way, on its own account. Obviously, this is only an appearance, under which nutritional disorders exist, which, as long as they last, give rise to mental disorders.

An example will make our whole thought better understood. It is common observation that certain infectious diseases cause psychopathic disorders which often extend well beyond the major apparent symptoms of hyperthermia or local lesions, which in our eyes represent the whole infection. Should we therefore deny the links between infectious deterioration and psychological disorders? This would be to judge the question somewhat narrowly. Because what happens during an infectious disease, typhoid fever for example? First of all, we witness **[35]** a well-known set of symptoms (fever, enteritis, etc.), which reveal typhoid fever. Then the patient goes into convalescence and is said to be cured. Is he really? It is fever, tachycardia, diarrhea, pulmonary congestion, all the symptoms that most attract the doctor's attention. But beneath these symptoms, an underground work continues its work for a long time to come. The vitality of the cells is affected, nutrition is retarded; certain viscera, the endocardium, the kidneys — to name just a few — remain or become diseased, their tissues degenerate or become sclerotic. There is therefore a set of disorders, less noisy than those of the acute period, but which are no less very serious. It is these disorders, which evolve in a way that we do not know well, which very probably maintain for a more or less long time the persistent post-febrile deliriums and especially this cerebral torpor, so clearly linked to the languor of all the functions of the energy. What is the cause of these mental disorders? It's typhoid fever if you like; but more precisely it is the nutritional disorders which were caused by the illness of the first seven symptoms and which in turn evolve in a somewhat autonomous way. However, as we do not see them, and on the other hand the symptoms which represent typhoid fever have disappeared for a long time **[36]**, we hesitate to admit a causal relationship between a delirium which continues its evolution and an illness — typhoid fever — which seems to have finished it. And yet delirium may very well be the consequence of typhoid fever through these hidden intermediaries.

In cases of this kind, the link which unites the two orders of phenomena (somatic illness and mental disorders) is barely visible. However, we can still accept it hypothetically, since we have witnessed the evolution of somatic disorders whose previous existence is not in doubt. We can only discuss the character of occasional causality or efficient causality of this precedence. But if, instead of a well-known disease like typhoid fever, a serious nutritional disorder developed, gradually causing and maintaining mental disorders, the doctor would be led to see only the latter, and, in his inability to link them to a morbid antecedent, he would proclaim them essential. The disease would thus become essential, idiopathic, whereas there cannot be any, since it must be admitted that, no more in pathology than in biology, there is no spontaneous generation, and that a disorder always comes from another.

But we will have the opportunity to return to this point later. So, for us, essential melancholia must have proximate causes **[37]**, as yet unknown; but we accept that they have — at least in a certain number of cases — characteristics that are a little different from melancholic states where the somatic conditions are much more apparent. We will first of all have in mind the description of these pathological forms, initially studying the constant symptoms, the psychological suffering and the psychic slowing down with their immediate consequences, that is to say anxiety on the one hand and the amnesia, aphasia, abulia, and stupor on the other hand. Because it seemed to us that it was more logical to describe immediately after its immediate generator the morbid phenomenon which is in short only the exaggeration of the former. Thus, stupor is only the perfect form of psychic arrest. It is not in itself a constant symptom, and as such it should not appear in the chapter where we only deal with signs of this kind. But it is above all the exaggeration of a usual sign, the reduction of mental processes. To avoid repetitions, and for greater clarity — because nothing beats knowing the relationship of the facts — we will describe the stupor with regard to the psychological shutdown, of which it is the ultimate consequence.

After examining the constant psychological and physical symptoms, we will study the inconstant ones, those which, like hallucinations, various delusional ideas, acts, are contingent, and **[38]** may or may not be present without altering the diagnosis of melancholia. The description of the clinical varieties of lypemania, especially considered as pure, essential psychosis, will come quite naturally later. The forms with consciousness, anxious, stuporous, etc., will be examined in this place. All that will remain for us, to complete the clinical picture, is to review the symptomatic melancholic states, those linked to an apparent cause (melancholia of the degenerate, puerperal, alcoholic, post-typhoid, etc.). But — to say a word about each of them — shouldn't we basically look at the whole etiology? That's what we thought too. During this chapter of causes, which we will follow with some considerations on pathological anatomy, forensic medicine and the treatment of melancholic patients, we will also have to examine heredity or rather degeneration, menstrual function and the puerperium, intoxications, neuroses, hysteria and epilepsy, as producing more or less special melancholic states, the clinical particularities of which it will then be useful to note — if there are any. And this will help us to formulate some thoughts on the rational treatment of melancholics, which can only proceed from an etiological conception.

[39] CHAPTER III

SYMPTOMATOLOGY
1. CONSISTENT SYMPTOMS.

A. Psychological symptoms. — We have already said above what we mean by the name “melancholia”: it is a state of sadness without sufficient reason with a tendency to resignation, a state of which *psychological suffering* is the fundamental symptom. To this sign is added another no less important one: the *slowing down* of psychological processes, which in certain cases can go as far as complete cessation. Now let's look at each of these two symptoms.

a. The *psychological suffering* of the melancholic is a chronic painful emotion, which, in serious cases, gradually invades the entire field of consciousness. Is there a difference between this psychological suffering **[40]** and that which occurs in a normal individual under the influence of a reasonable motive? Apparently, no. And yet, in the normal individual with excessive grief, the possibility of receiving pleasant perceptions still remains, and there remains some hope of emerging from the painful phase he is going through. The true melancholic has completely lost the faculty of experiencing sensations which can distract from his sorrow; and he is convinced that he will never be able to get rid of his psychological suffering. He no longer sees any favorable solution; there is a real wall between him and the outside world against which all hope is shattered.

The intensity of this suffering makes it unlike any other. The recovered melancholic people we interviewed always told us that the pain they experienced could not be compared to any physical pain. What sometimes adds to this suffering is that patients remember with remarkable clarity their entire previous emotional life, they then remember that previously, even when they were grieving, they were sensitive to what was happening around them. They could have joyful feelings, sympathize with the pain of others, console others, love; in a word, their affectivity was normal. Whereas, once ill, they became deaf to all the calls **[41]** coming from the outside world; nothing touches them anymore, nothing moves them. And from this comparison between their previous psychological state and their current state, they conclude that they have become unworthy beings, monsters having lost all human feeling.

Moreover, in certain cases, quite frequent even, this psychological suffering absorbs the melancholic so much that he does not hesitate to destroy himself. It happens, thanks to the solidarity which closely unites all the manifestations of emotional life, that everything that happens around him, all the ideas that arise in his consciousness, all the acts that he performs exaggerate the suffering that he experiences. Thus, if he happens to think of a person he knows, it immediately seems to him that he has bad thoughts about them. If he tries to write a letter, he is immediately convinced that it is impossible to express himself in a more unintelligible way. Looking at his photograph, the idea comes to him that no one has ever seen a face more unpleasant than his.

This close dependence between all his thoughts and psychological suffering means that the melancholic often believes himself to be an abject being with no equal in the world. We are speaking, of course, of cases where the psychological suffering has reached its highest development.

Certainly, there are melancholic states in which everything is limited to mild pain. What **[42]** then allows it to be considered pathological is the absence of sufficient reasons and also the patient's belief that he no longer has the same emotional sensitivity as before. Moreover, the intensity of this psychological suffering is not always equal in the same individual. There are oscillations; and, on the same day, the melancholic can feel more distressed in the morning than in the evening; sometimes several days pass in relative calm.

In addition, we can observe exacerbations of psychological suffering which take on the proportions of a real attack: this is then anxiety, which, when it is continuous, constitutes a clinical variety which will be studied further. This paroxysm of suffering, a true affective hyperesthesia, is often accompanied by intercostal neuralgia, a feeling of chest compression, in a word, symptoms of anxiety. The attack lasts a varying amount of time; then it disappears to return again. During the attack we can notice a characteristic asthenia: the pulse becomes rapid and sometimes weak, breathing is short, shallow, muscular strength decreases to the point of no longer being able to take the slightest step. The form of attack also varies with each individual.

Sometimes sadness is replaced by terror. The patient has the sensation of a terrible, imminent and inevitable danger; and this fear is capable, if it is very intense, of plunging the subject into a stupor.

[43] But whether the patient remains depressed, anxious or inane, this mental suffering always has the characteristics of being accompanied by a feeling of resignation, of helplessness. Instead of the persecuted person — who also suffers — not accepting his bad fate and becoming aggressive, full of hatred and driven by deep resentment towards others, the melancholic, on the contrary, feels overwhelmed by his ills. “The burden is too heavy for his shoulders,” said Mr. Joffroy in one of his clinical lessons, and he lets himself be crushed by it. Furthermore, the persecuted quickly accuses others of being the cause of his suffering; he poses as a victim and dreams only of revenge; — while the melancholic thinks that he deserved his ills and, to explain his sorrow and his remorse, even convinces himself that he has committed faults and crimes.

Let us now try to show how the psychological suffering of the lypemaniac arises and develops and on what it is based. We have already said that it was necessary to suppose at the origin of a melancholic state an alteration of the functions of nutrition, a modification in the intimate life of the cells. The thousand sensations, which continually come from all the organs, are no longer the same. The coenesthetic sense — that is to say, organic sensitivity — is probably altered. The patient no longer recognizes his usual sensations; he no longer feels like he is living as before. Sometimes these **[44]** coenesthetic modifications generate ideas of transformation and even negation of the organs. It should be noted that the consciousness of our vegetative life is ordinarily obscure. As soon as we feel our heart, our lungs, our muscles, we suffer. We can in this way explain how simple alterations of coenesthesia can cause somewhat serious discomfort.

In addition, sensory sensitivities (vision, hearing, etc.) undergo similar alterations in their functioning. It is then that patients say that they feel transformed and that they no longer see the outside world in the same way. Griesinger[38] has well analyzed this *psychological dysesthesia*. “It seems to me, says the melancholic, that everything around me is still as it was before, however there must also have been some changes; things still have their old forms, I can see them clearly, and yet they have also changed a lot.” The patient isolates himself, since all external impressions arouse and maintain his suffering. These modifications in internal and external perceptions do not occur with impunity; and the patient is

[38] Griesinger, works cited, p. 265

surprised and suffers from this alteration of his sensations. The melancholic always has his thoughts concentrated on unpleasant mental representations. “Everything within”, as **[45]** Mr. Magnan says when contrasting melancholia with mania, where on the contrary “everything is outside”.

The conditions necessary for the production of a sad emotion are given in melancholia. Melancholia is, as we have said, a morbid sadness[39]; it resembles it psychologically and also in physical symptoms. It is therefore necessary, to fully understand this illness, to say a few words about the physiology of emotions.

Today we tend to admit that any emotion presupposes a somatic state which is its physiological condition. Lange[40] even maintained that this was the immediate cause and that one was sad because one had weak and shallow breathing, a tense pulse, relaxed muscles, and not that one presented all these signs because they were sad. In other words; the consciousness of sadness would be the result of all the physical phenomena listed above and other analogues. When these occur — whatever the original nutritional disorder **[46]** which gave rise to them — the conscience is invaded by a sad emotion. We see that this theory reverses the order of facts that was previously accepted. What we called the effects of emotion are its proximate causes, the necessary conditions.

It seems interesting to us to expand somewhat on this question of the precedence of organic phenomena, especially since it has often been debated in recent times. Here, according to Mr. Dumas[41], are the arguments in favor of this theory.

In a certain number of cases it seems that this particular state of consciousness called “emotion” occurs after the vascular disorders. This is the case when following the administration of potassium antimony tartrate, a vasoconstrictor drug, a depressive state occurs. It is the same in certain mental illnesses, in circular melancholia where the emotional state changes suddenly, periodically, without psychological cause, and follows the parallel and probably antecedent (?) change which takes place in the vascular system (lowering of blood pressure, slowing of the pulse) and in various functions.

But in other circumstances, how can we prove that the organic state is earlier? An individual suddenly learns of a misfortune that has struck him. He is conscious of mental pain at the same time as he falls into a state of sadness, characterized by the circulatory and other modifications which usually condition this painful emotion. It seems that this is the idea that caused both the organic syndrome and the consciousness of sadness; but it is difficult to say that the latter is only the consequence of the former.

The problem is difficult. M. Dumas, relying on the ideas of Lange, resolves it this way: “We must admit the following succession: 1° idea; 2° emotion; 3° circulatory phenomena, or should we interpose the last two elements and place the idea first, then the circulatory phenomenon and finally the emotion? For anyone who was willing to follow the previous analysis, the answer is not in doubt. If in very simple cases where the emotion coexists with a particular organic state, without the intervention of mental phenomena, it is conscious of this state, we are obliged to admit that in the more complicated cases where the emotion accompanies the same states organic, with the intervention of mental phenomena, it always has the same nature and must lend itself to the same analysis; otherwise we would have to grant the absurdity that a given affective state can sometimes be the consciousness of an organic state, and sometimes a purely mental state devoid of physical basis; that it is sometimes the result of certain circulatory variations and sometimes the cause of the same variations... Emotion **[48]** always remains the ultimate term of the series, which can be simplified as follows: 1st cause physical or

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[39] The comparison of melancholia with sadness is not absolutely accurate; because in lypemanic states, we do not only find passive sadness, but also active sadness, fear and other emotions whose combinations explain the diversity of physical disorders observed in the clinic. For the purposes of description, we have mainly had in mind passive melancholia, that which comes closest to simple sadness. But we must not forget that this is a schematic conception.

[40] Lange, Les émotions, trad. G. Dumas, 1895.

[41] Dumas, Happiness and sadness, Revue philosophique, 1896, n° 6, 1 et 8.

mental; 2nd circulatory variation; 3rd emotion."

But how then does the idea act on the organic state? It is quite obvious that mental representations have nothing pleasant or unpleasant in themselves. "The sight of a lion in the wild is the same for an indifferent man and for a frightened man," says Mr. Dumas, for whom "a pleasant idea is an idea which determines in our mind a large number of new associations, both conscious and easy, and a painful idea, it is on the contrary an idea which hinders our usual associations, which tires and stops our thinking... The disagreement of a representation with our usual representations, dissociation of ideas which constitute for the mind an intense and difficult work, analogous to the exhausting excitement which physical pain produces in the brain. The consequence is the functional cessation of thought, the vaso-constriction of cerebral arterioles, and anemia of the tissues. The vaso-constrictive function of the cortex is thus exaggerated and is maintained as long as the functional cessation of mental activity persists. There would therefore be a first phenomenon of exhaustion, followed or accompanied by a mental shutdown, and this primary exhaustion, like this shutdown, would result in a vaso-constriction first cerebral, then peripheral. At the same time, as a result of the psychological shutdown **[49]**, breathing diminishes in its magnitude and slows down in its rhythm, after the dyspneic period of which we spoke in connection with psychological suffering. Finally, cerebral hypoactivity has an impact on the heart: the heart beats less quickly and less strongly, and blood pressure decreases at the same time as the speed of blood flow. "

This ingenious explanation is based on disputed facts. It is likely that in prolonged sad emotions mental processes are slowed down, although short sad emotions act rather as cerebral stimulants.[42] But the vasoconstriction of cerebral arteries is not sufficiently proven. It is admitted because the peripheral arterioles appear contracted. However, Mosso[43] established that there was no connection between the two circulations, cerebral and peripheral, and that vaso-constriction of the limbs did not necessarily lead to vaso-constriction, any more than cerebral vasodilation, so that it would be necessary to assume that the vasomotor system of the brain is autonomous. It seems probable, however, if we accept that there is a psychological shutdown, since, in the opposite state, in mental work, the brain increases in volume (Mosso). As for Meynert's hypothesis, according to which the cerebral cortex **[50]** has a dual role of ideation and vaso-constriction, one occurring opposite to the other, it seems contradicted by the fact[44] that in mental work, the capillary pulse (given sign of vasodilation) contracts and on the other hand the volume of the forearm does not decrease in a constant way.[45] Psychological arrest, on the contrary, perfectly explains, as Mr. Dumas indicates, the slowing down of breathing and the heart, as well as high blood pressure. Because in short-term mental work, where fatigue phenomena do not yet occur, we observe the opposite phenomena (acceleration of breathing and heart rate, hypertension).[46]

But the problem of the precedence of the phenomena remains intact. We can object to Lange's theory that this precedence of the major physical phenomena studied, and in particular that of vasomotor modifications, has not yet been proven experimentally and even seems doubtful, since, when we provoke an emotion in a subject from which the capillary pulse is taken, the vasoconstrictive reaction occurs noticeably after the perception of the emotional state.[47] Moreover, these muscular reactions **[51]** would only be, even in the aforementioned explanation of M. Dumas, the effects of supposed modifications in the cerebral centers. So why not admit that these are the real conditions of such early consciousness? These phenomena, currently outside our explorations, could just as easily be

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[42] Binet and Courtier, Année psychologique, 1897, p. 90.
[43] Binet and Courtier, Année psychologique, 1897, p. 45 and 46.
[44] Binet and Courtier, Année psychologique, 1897, p. 48.
[45] Binet and Courtier, Année psychologique, 1897, p. 45.
[46] Binet and Courtier, Année psychologique, 1897, p. 48. Binet and Vaschide, Année psychologique, 1897, p. 155
[47] Binet and Courtier, Année psychologique, 1897, p. 44.

awakened by intoxications (potassium antimony tartrate), by nutritional disorders linked to psychoses, by an idea, and would in their turn produce muscular and vascular signs of emotion, which would thus be, according to former opinion, posterior to the fact of consciousness.

In the clinic, whether we study sadness or melancholia, the problem of the antecedent nature of the phenomena can be temporarily left aside. It is certain that the sad mental state, physiological or pathological, has somatic conditions. Among these, there are some which cause other symptoms; for example, changes in brain activity have an impact on circulation and breathing. We thus find ourselves in the presence of a complex whose causal links are indistinguishable. We can also say that all these signs, some of which (muscular and circulatory modifications) are probably only effects already distant from the phenomena linked to the events of consciousness, are as a whole the conditions or at least the accompaniments of sadness or melancholia. We will try later to determine the sequence of these phenomena.

[52] What then are the signs of sadness, to which we usually compare melancholia? By going through the descriptions that all doctors and in particular Lange[48] have given of sad emotions, we see that the signs are the same as the somatic symptoms (mimics, phonetics, etc.) observed in lypemaniacs. What is characteristic is first of all an action paralyzing the muscles. The movements are difficult and painful, hence a feeling of discouragement. The voice is weak, the gestures are slow, the gait is unsteady; the features of the face sag. In short, there is a generalized hypotonus.

"The vasomotor system," says Lange, "behaves under the influence of sadness in a manner quite opposite to that of the voluntary motor system. While the latter weakens and relaxes, the vasomotor system, on the contrary, contracts more than usual; in this way the blood is expressed from the small vessels and the various tissues or organs are bloodless; the immediate consequence of this anemia is pallor, sagging, collapse; the flesh is less full, its color is white; the relaxation of the features caused by the flabbiness of the muscles gives the face its characteristic expression and often produces the impression of emaciation so rapid that it cannot be explained **[53]** by changes in nutrition, such as wear and tear of the tissues, not followed by compensation."

"The small vessels of the lungs contract spasmodically, so that these organs become empty of blood; we then experience a sensation of lack of air (dyspnea), we feel a weight on our chest (oppression), as happens in all cases where respiratory chemical relationships are hampered[49]". Finally, brain anemia causes a slowdown in mental processes.

It should be noted that Lange does not provide direct proof of this vaso-constriction, established in some way by reasoning. Others after him tried to fill this gap. Mr. Dumas believes that the absence of a capillary pulse is proof of vasoconstriction, an opinion that Mr. Binet[50] criticizes by saying that the latter can, if it is small, not be recordable and yet be in vasodilation. This author would be inclined to see in this absence of the capillary pulse only the sign of a sluggish peripheral circulation. Whatever its significance from the point of view of vaso-constriction, the capillary pulse does not generally exist in states of pathological sadness, as noted by M. Dumas. But is this disappearance linked to the emotional state, to cerebral hypoactivity or **[54]** to another cause? The first hypothesis seems contradicted by this fact, observed by MM. Binet and Courtier[51], that all fleeting emotions, happy or sad, contract the capillary pulse, as well as the cerebral effort, as well as any nervous excitement, of external or internal origin?

Among the other elementary organic phenomena underlying sadness, we have mainly studied

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[48] Lange, works cited, p. 37 and after.
[49] Lange, works cited, p. 42.
[50] Binet and Courtier, Année psychologique, 1897, p. 545 and 546.
[51] Binet and Courtier, Année psychologique, 1897, p. 126.

circulatory and respiratory modifications, but especially the former.

M. M. de Fleury[52] admits that the most constant condition of sadness is arterial hypotension. "In neurasthenic neuropaths whose medical observations serve as the basis for this study," he says, "pressures of 13 to 16 centimeters of mercury (cmHg) generally correspond to the indifferent balance of the mental faculties. Below is the zone of fatigue; above is the territory of *cerebral excitement*."

According to MM. Binet and Vaschide[53] blood pressure would rise in any *fleeting* emotion, happy or sad, as in any mental effort and generally in any nervous excitement.

The pulse and breathing slow down in **[55]** sadness, as all observers have noted.

In recent times M. G. Dumas, who had, in an earlier work, tried to relate melancholic states to various somatic conditions,[54] has continued his research.[55] He accepts several groups of sadness: one with low blood pressure, slowing of the heart and breathing and reduced brain activity; another with hypertension, caused, according to Marey's law, by peripheral vasoconstriction, same slowing of pulse and respiration, and even reduction of cerebral activity (in the latter case hypertension, due to vasoconstriction, would be, according to Meynert's hypothesis, the consequence of cerebral hypo-activity); finally a third group of active sadness would be characterized by relative arterial hypertension, acceleration of pulse and respiration, and cerebral activity.

He follows from this that blood pressure cannot be used to characterize sadness, since it is sometimes exaggerated and sometimes reduced. Neither does vaso-constriction, since, according to Mr. Dumas himself, there are feelings of joy associated with vaso-constriction. Only the **[56]** pulse and respiration, which are both slowed down, except in sadnesses with excitement which form a separate and close group to states of excitement, are truly characteristic. Let us also remember the fact that mental slowdown is a sign of passive sadness. Finally, we must separate fleeting emotions, which appear to act as stimulants (Binet and Courtier), from prolonged emotions which are perhaps accompanied by generalized hypotonus. But the study has not yet gone very far. Mr. Dumas has done his research on patients, and the physical signs corresponding to their emotional state are certainly influenced by other causes which significantly complicate the problem.

Which of the phenomena studied above are the immediate causes, the antecedents of the perception of sadness? Perhaps none of these, but others that are more hidden. What seems certain is that, in the emotions provoked, the capillary pulse contracts after perception. These phenomena also have close relationships with brain activity and also with each other. How to orient yourself in this maze?

As we see, the study of the somatic conditions of emotions and in particular of sadness has barely begun, and we cannot currently arrive at definitive conclusions. What must be remembered is that the somatic basis of sadness **[57]** appears to be that of melancholia, as we will verify in the following chapter. And we must think that whenever these organic conditions are seen, psychological suffering appears.

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52 M. de Fleury, Sadness and its treatment, Nouvelle Revue, August 15, 1896.
53 Binet and Vaschide, Année psychologique, 1899, p. 162 and after.
54 G. Dumas, Les états intellectuels dans la mélancolie, th. of Paris, 1894.
55 G. Dumas, Happiness and Sadness, Revue philosophique, 1896, n° 6, 7 et 8.

It remains to be explained why this suffering does not provoke reactions in melancholic people and on the contrary is suffered passively. Where does this difference come from in the tolerance of the lypemaniacs and that of the persecuted who, both of them, suffer? We can only make two hypotheses on this subject. One, it is the somatic conditions which are different in some and which necessarily lead either to ideas of resignation and helplessness, or on the contrary to aggressive reactions. Or — what is more likely — it is the subjects who are different, and who bring their own tendencies into their ways of reacting, manifesting their character, so much so that we could say with Mr. Joffroy taking up[56] the idea of Lorry, that one is born melancholic as one is born persecuted, that is to say with a disposition to let oneself be defeated or to fight energetically in the event of mental suffering. Mr. Joffroy often points out that the most different causes (typhoid fever, emotions, trauma) can determine in the same subject the same melancholic state **[58]** which is almost always identical despite the variation in causes.

Among the consequences of this mental suffering, we must note the feeling of helplessness which invades the patient. When psychological pain is at its maximum, sensory perceptions and ideas lose all pleasant or unpleasant meaning for the melancholic, and the individual falls into a true emotional *anesthesia*. This psychological anesthesia reflects the indifference that the patient shows for everything that was dear to him before his illness. But before arriving there, the melancholic questions himself, and, in this perpetual need for explanations which is specific to the human mind, even when sick, he finds, in the path of passive resignation indicated above, reasons to his sufferings; this is the origin of the delusional ideas that we will describe later. In this the patient reasons logically. As he is in a somatic state analogous to that which accompanies remorse, these come naturally to his mind. To justify them, he accuses himself of imaginary misdeeds; he says he is a great culprit, having committed serious mistakes. Also M. Juffroy is right to declare that emotional pain is without mental cause, but not without organic cause. Griesinger[57] said: “The patient feels prey to sadness; **[59]** but he is accustomed to being sad only under the influence of untoward causes; moreover, the law of causality requires that this sadness have a motive, a cause, and, before he questions himself on this subject, the answer already is clear to him; there are all kinds of lugubrious thoughts, dark presentiments, apprehensions, which he broods on and digs at until some of these ideas have become strong and persistent enough to take hold, at least for a while. Also this delusion has the characteristics of attempts by the patient to explain his condition.”

Mr. Séglas[58] made the same remark about the pathogenesis of these delusional ideas linked to mental suffering: “The feeling of psychological pain, analogous to that which a criminal must experience after the accomplishment of a crime, brings in a person sick of the idea that he is guilty, that he has committed a crime. Another, formerly religious, in the presence of the change he feels in himself, in his feelings, will believe himself reprobate of God, abandoned to infernal powers, as a result of faults, imaginary sins, feeling incapable of acting; another fears for the future of his family, believes himself to be ruined, sees himself as a burden to everyone.” This is how we could say that the delusion of the melancholic was secondary. Now if we accept that certain persecutory **[60]** delusions begin with a phase of depression, brought about by coenesthetic changes and other sensory disorders, we are obliged to admit that this characteristic of inferiority is not absolutely special to delusionally melancholic conceptions.

b. *Mental decline*. — In the melancholic, we observe a general slowing down of psychological

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[56] Joffroy, Lessons given at asile Sainte-Anne, 1896.
[57] Griesinger, works cited, p. 269.
[58] Séglas, Leçons cliniques, works cited, p. 300.

processes, which is probably related to the somatic conditions of sadness. We have seen that sad emotions could be *psychologically* characterized by difficult associations of ideas; the two phenomena, sadness and mental slowness, would therefore be linked. Clinically we know that in all painful emotions there is a certain cerebral torpor: the head seems empty, according to the expression of patients. Lange[59] pathogenetically explains these phenomena by the brain anemia produced by the contraction (?) of the capillaries of the nervous tissue.

What is certain is that all mental processes are slowed down and weakened in the melancholic: perceptions, memory, ideation, attention, judgment, even imagination, especially will. We will focus on some of these disorders.

[61] Memory, that is to say the faculty of recalling mental images, is generally weakened in melancholic people. This disorder has repercussions on all psychological processes and in particular on what has been called by this vague term *ideation*, which is largely confused with the reliving of images; because in mental work, new images are not so useful as old images.

The difficulty of ideation in turn becomes a new source of mental pain. It is this which causes the psychological emptiness, the incapacity for mental work; also the sick declare having lost their memory, having become stuporous. And when the slowdown in brain work is considerable, subjects often have bouts of despair and anxiety.

The disturbance brought to mental functioning by the weakening of the memory of melancholic patients, that is to say by the reduction and difficulty of reliving mental images, is therefore considerable.

We can divide the images or rather the ideas into: abstract ideas, ideas relating to the personality of the patient and ideas relating to the external world, some of which depend more specifically on the exercise of the senses and motor skills. The reduction of images relating to abstract ideas has its influence above all on the judgment **[62]** of melancholics. The weakness of images with an organic basis, which tend to constitute the personality of the subject, plays a large part in the production of hypochondriac ideas and in particular of negation, on which we insisted above. The reduction of those relating to the outside world leads to greater or lesser difficulty in recognizing objects or people around the patient.

Let us now study the disorder of sensory images.[60] We know that each sensation leaves a residue which is the mental image preserved by memory. In melancholic people, the sensations are weak and consequently leave a light imprint on the brain; moreover, they have difficulty awakening analogous images already stored. This is how we can explain the blindness and mental deafness often observed in these patients. We know in fact that they sometimes complain of not being able to understand the meaning of what they see and what they hear.

Some of these sensory images, which we have just discussed, are specialized for the function of language. Their reduction causes the various forms of aphasia. Thus we can observe more or less complete verbal deafness. The patient then has difficulty understanding verbal sounds. **[63]** And yet he is not deaf; because, if a noise is produced in his presence, it manifests by movements and by a sudden and temporary coloring of the face that he has heard. But he seems incapable of relating these verbal sounds to the ideas they express.

Other patients, having retained their visual acuity, can no longer read writing. What sometimes sets them apart from other individuals with word blindness is that they cannot seem to recognize even

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[59] Lange, works cited, p. 43

[60] Séglas, Les Troubles du langage chez les aliénés, 1892.

alphabetic letters; it is then a matter of literal blindness. This event is, however, very rare. We see melancholic people, who were writing long before the onset of their illness, trying to trace a word and only succeeding in tracing a few meaningless outlines; This is agraphia. Sometimes, however, we recognize one or two letters in these strokes. Among musicians, instrumental performance can also be impaired (dysmusia) as a result of manual unfitness.

But it is the articulation of words that is most often troubled. Patients seem to be searching for words, probably because the verbal motor images are too faded to allow easy speech. What we encounter most frequently is speech in a low voice, sometimes unintelligible, a veritable whisper in which the sound is almost lacking and where we can nevertheless see the movements — very slow and barely pronounced **[64]** — of the lips and cheeks. From time to time, the subject, whose attention has been strongly requested, utters a few words, leaving long intervals between them during which he seems to make considerable efforts to overcome the difficulty of speaking. Patients suffering from melancholia with stupor become completely mute at some point. The mutism of lypemaniacs can also have causes other than the psychological decline with which we are concerned here; We will therefore return to it in the next chapter.

These different language disorders are mainly consequences of psychological decline, and this is why we examine them in this chapter. But mental pain, pushed to a very high degree, can produce them. However, the ordinary pathogenesis is in this reduction, this slowing down of mental images which is a constant sign in melancholia.

Motor images are also weak. This results in modifications in the attitude and actions of the melancholic, who cannot clearly conceive and consequently execute his desires. His movements are accomplished with difficulty. It is impossible for him to engage in the slightest work; most often he spends his time in complete idleness and sometimes in bed. As a result of the reduction in his psychomotor functions, the patient loses all confidence in his strength. He no longer formulates **[65]** desires because it is impossible for him to imagine their realization. Often the patient expresses this reduction in his voluntary power by saying: “I would like to, but I cannot. »

This weakening of motor images ultimately affects the processes of volition. What we call will is a psychological act which results in a movement. In this general slowdown, these tendencies towards movements are therefore also affected. No idea is accompanied by energy great enough to determine the individual in one direction rather than the other. Sometimes, however, a desire arises, but it is immediately opposed by an idea of powerlessness. This is how abulia can coexist with obsessions; they are two sides of the same phenomenon. Indecision is therefore a characteristic feature of the mental state of melancholic people. They are incapable of making a choice between several actions available to them, for example between these two: should we get up or should we stay in bed? The sick person tries to dismount, but he immediately thinks: “If I get up, great misfortune may result.” Then he goes back to bed. But the first idea comes back: why stay in bed when it's so late? Things like this happen when it comes to the most insignificant acts of life.

This indecision, this avolition of melancholic people is found in all their actions. Thus they call **[66]** for death, they sincerely desire it, but without having the strength to resort to it. However, we should not trust too much in the inertia of these patients. Under the influence of an attack of mental pain, of a paroxysm, the most inert, the most apathetic melancholic is capable of throwing himself out of a window, throwing his head against a wall or plunging a knife into his chest.

All psychological processes, we have said, are diminished. The association of ideas occurs slowly and poorly;[61] many intermediaries are missing, and the result is an inability to reason correctly, to encompass a large number of facts in a judgment. Attention is difficult. The research of Obersteiner[62] and **[67]** Buccola[63] tends to demonstrate that the reaction time for elementary psychological operations is considerably increased in melancholics — which would indicate a decrease in attention. We give below the reaction times of a circular melancholic.

Imagination is weaker than it first appears. If certain delusional ideas appear to have great intensity, it is because they live in a rarefied field of consciousness, where corrective ideas are lacking. Then this thought can easily impose itself on the subject in the form of an obsession. We further understand that a conception of a painful nature, provoked by the sad coenesthetic state, has every chance of remaining in the field of consciousness as long as this state does not change. It will impose itself all the more as ideations are slowed down and no new impression or mental representation will come to chase it away; it will thus give rise to a real obsession.

The slowing down of psychological functions can, in certain cases, go as far as complete cessation. It is then a question of melancholia with stupor, the melancholia attonita of German authors.[64] In these situations **[68]** cerebral functions are more profoundly affected than in other forms of melancholia. Indeed, alongside the extreme difficulty experienced by the patient in thinking, feeling and acting, we observe tension in the entire muscular system. We also see the patient maintaining the same attitude, being absolutely immobile and resisting all attempts made to move him, uttering no words, showing no emotion through his physiognomy; whether he is sitting or lying, he has the immobility of a statue.

There are cases — the most frequent according to Baillarger's opinion[65] — where this stupor hides a very active delusion of a painful nature; and we could not then link these symptoms to psychological decline. This theory is based on two orders of facts. The sick say, after recovery, that they remained immobilized by a terrifying spectacle or by the terror into which threats of death and torture plunged them; on the other hand, we sometimes surprise stuporous melancholic people with words and gestures which seem to be related to hallucinations or very painful delusional conceptions. Now all this does not prove that thought is really very active, but would rather indicate that certain images are intense. **[69]** We would be led to believe that the subject is, in these cases, in some way obsessed by hallucinations or delusional conceptions, which impose themselves with great force on his mind and all the more easily since, in the general slowing down of psychological processes, they do not find themselves in struggle with other competing images. We can further understand how these delusions arise. We said above that the melancholic, finding himself in the somatic conditions of remorse, comes to believe that he has committed crimes in order to explain his feelings to himself. But if he finds himself in the somatic conditions of stupor, that is to say terror pushed to the highest degree, we can imagine that he will be led to involuntarily imagine fears or spectacles in relation to his emotional state. Whatever this explanation, which may be good for a certain number of cases, we must admit that stupor is sometimes accompanied by cerebral work which is not always as active as is commonly believed and sometimes is obviously linked to a suspension of psychological processes. In situations of this kind the cerebral work is perhaps not zero; but it is so weak that the memory of it is not kept.

B. Physical symptoms. — The external appearance of melancholic patients (fig. 1) always reveals more **[70]** or less clearly, and whatever the form (excitation or depression) of the lypemania, the two psychological symptoms that we have seen to be constant: mental pain and psychological decrease

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61 The processes of propagation of excitations being weakened in the melancholic, the muscular movements, which correspond to them in the normal state, have little tendency to occur; thus a link between the sensations and the muscular movements which are usually associated with them is destroyed in the patient. Through the sense of hearing we distinguish noises, musical and articulate sounds. Now hearing musical sounds and speech causes certain movements of the larynx, the vocal cords in particular, and the thorax; in a word, in the normal state, auditory sensations determine muscular contractions in the organs of phonation. In the melancholic, absorbed by his idea-pain, many auditory sensations go unnoticed; also the corresponding muscular movements occur only very weakly. What is observed for phonation is also observed for mimicry and for writing, the disorders of which partly depend on sensory alterations.

62 Obersteiner, Virchow's Archiv., B. IX, H. 3 and 4.

63 Buccola, Sulla micura del tempo negli atti psichici elementari, Riv. sperim. di frenialr., 1881.

64 Roubinovitch, Variétés cliniques de la folie en France et en Allemagne, 1896, p. 41.

65 Baillarger, De l'état désigné chez les aliénés sous le nom de stupidité, 1843, in Recherches sur les maladies mentales, 1890, t. I, p. 85.

[of activity]. It is above all the physical cessation, analogous to the psychological cessation, which is, in the organic sphere, characteristic of melancholia. There is a decrease in the activity of all somatic phenomena, all vital processes.

The disorders are, however, complex, and certain facts sometimes seem to contradict this general statement; it is that we lack explanatory intermediaries. There appear to be — for organic functions — several ways of betraying a decrease in energy; and we understand that certain phenomena can apparently be exaggerated. We therefore state that we have not been able to isolate the constant physical symptoms from the variables as clearly as we have done for the psychological symptoms. On the other hand there are reaction phenomena, which, by the excitation which they give to certain functions, in particular to respiration, circulation, calorification, partly mask — or at least for a time — the usual physical depression.

From this point of view we can establish a great division among melancholics: some do not react — they are the stuporous ones — and realize the psycho-physical arrest in its clearest form; the others, **[71]** the anxious, react on the contrary[66] and manifest [figure 1] **[72]** in a more or less noisy way the psychological work linked to mental pain. We will frequently have the opportunity to return to this division. Let us also add that some stuporous people are similar to anxious people in certain physical characteristics; these are probably those in whom active delusion exists. Cerebral action, invisible to gross clinical observation, is revealed in certain somatic, respiratory and circulatory modifications. On the other hand, anxious people are not always the same; at the time of paroxysms, the somatic phenomena linked to painful cerebral excitation are different from those observed in the resting state. Finally, anxiety can occur in the middle of a period of stupor; and the latter sometimes appears after an anxiety attack. These incidents disturb the schematic appearance and course of the two opposing melancholic affections, stupor and anxiety.

To avoid repetition we will describe here the usual somatic disorders of melancholic people, reserving for the following chapter the clearly variable disorders, which are more often complications. And we will see that these common somatic alterations still give quite clearly the impression of the law of general cessation which likely unites them.

The *physiognomy* of melancholic people expresses their psychological suffering and their lack of energy. The eyebrows are contracted, vertical folds are formed **[73]** immediately above the root of the nose; the forehead presents horizontal wrinkles as a result of prolonged contraction of the frontalis muscle; the angles of the mouth are lowered, the mouth itself is tight; the face, aged, seems longer than normal. When an external impression comes to solicit the attention of the melancholic, immediately the eyebrows and the forehead contract even more than usual. In moments when mental pain is at its peak, the appearance often takes on an expression of more acute suffering, but still retains the characteristics described above.

Fig. 1 — melancholic.

[66] In this case we are no longer dealing with sadness alone but with other emotions, active pain, terror, which modify the somatic aspects.

Melancholic people often lie down or squat, with their chin on their knees, as Guislain[67] noted. This attitude, where all the extensor limbs are relaxed, shows at first glance the weakening of muscular potency.[68]

This reduction in motor skills is seen on the patient's sagging features; it also manifests itself in his immobility. The muscles are often trembling, which indicates that the contraction is hesitant and the nerve impulse weak. Speech is sometimes trembling, which can suggest general paralysis; the voice is furthermore dull, monotonous, indistinct even in stupor. It has **[74]** been said that the writing of melancholics is heavy, hesitant, diminished, in opposition to that of maniacs which is bold, rapid, of exaggerated grandeur[69]; in double-form madness, writing could present these two opposing aspects in turn, especially in relation to the degree of cerebral activity. But we could not verify these facts. What is true is that the writings of melancholic people betray their delusion.

The muscles are also usually thin and generally have less vigor. This can be easily seen — as we did — with the dynamometer, which constantly gives figures below the average. This is because hand pressure is a highly psychomotor act; it is all the weaker as the power of representation of the act to be produced, that is to say, in short, attention, is diminished, as one of us[70] has shown: "Melancholic people are hardly ever dynamometrically superior to maniacs. With them, what disturbs voluntary attention is sometimes prostration, stupor, sometimes, on the contrary, anxiety. Always concentrated in their delusion, they lend themselves rather poorly to the experiments to which one would wish to subject them, and their pressures are hardly energetic **[75]**, since they only reach 18.1 and 16.9.[71]"

The melancholic does not know how or does not want to squeeze energetically; that's why he can't. The mental image of movement is too weak for him to provoke a volition manifested by an energetic act. In some cases of anxiety, temporarily higher dynamometer pressures may be obtained. This is because mental suffering is released in a way in a sudden contraction of the muscles of the forearm, which becomes a phenomenon completely analogous to paroxysm. What clearly shows that dynamometric pressure is related to the general somatic and psychological conditions of sadness is the observation of those with circular insanity. One of our patients, circular, had, in her happy periods, dynamometric pressures higher than those of the depressive phases.

Among the physical symptoms that appear at the very beginning of melancholia, sleep disorders should be noted. These are persistent insomnia or painful daydreams often accompanied by sudden awakenings. In other cases, the individual notices that, even after sleeping, he wakes up in the morning as tired as the night before; sleep then ceases to be restorative.

At the same time, the patient experiences a more or less intense headache, resembling what many neurasthenics experience. It's the same feeling of emptiness in the head, or excessively painful pressure in the forehead, occiput or temples. This headache may be the consequence of cerebral anemia produced by a permanent contraction of the vessels which, as Meynert and Lange suppose, occurs under the influence of a sad coenesthetic state. Perhaps it is also the expression of the increasing difficulty that the patient experiences in his cerebral activity.

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67 Guislain, Leçons orales sur les phrénopathies, 2nd edition, 1880, t. I, p. 17.
68 Féré, La pathologie des émotions, 1892, p. 366.
69 Féré, La pathologie des émotions, 1892, p. 365.
70 Ed. Toulouse, De la dynamométrie chez les aliénés, Comm, at the Society of Biology, 3 June 1893.
71 The experiments were performed on women.

The general *sensitivity* of melancholic people is often profoundly modified. He feels, like the neurasthenic, tired, achy, broken. Everything is painful for him, everything is pretext for unpleasant sensations.

Skin sensitivity disorders are common, and likely we cannot detect the main ones, because often we find nothing even though the coenesthetic state is profoundly altered. Hyperesthesia gives rise, in certain cases, to real neuralgia. These can be the starting point for paroxysms of anxiety or delusional conceptions. Sometimes anesthesia and paresthesias are observed, especially in the trigeminal sphere (Schule).

From this point of view the research of M. Kovalevsky **[77]**, professor of psychiatric medicine in Warsaw, is very interesting. Here are his conclusions: "The melancholic lives continually immersed in his sadness, insensitive to impressions coming from outside. It takes a very strong excitement to bring him out of his increasingly strong concentration; he gradually develops an insensitivity of all the sensitive organs. This insensitivity, which is initially functional, eventually becomes organic, as a result of insufficient nutrition of the cellular elements and also of venous stasis giving rise to edema which compresses these same elements.[72]" All these disorders are exaggerated in women during menstrual periods.

Sensory sensitivity is usually diminished in melancholic people. In the period of excitement of double-form madness, Clouston[73] noticed that visual and hearing acuity were greater, while they were less in the period of depression. Likewise, reflex sensitivity is reduced. Guislain[74] reports the case of a melancholic who no longer sneezed with snuff even though in a state of health it easily caused sneezing. Genital sensitivity is weakened; and Morel even believed that many **[78]** hypochondriacs were infertile. Sleep is often short and unrefreshing, disturbed by nightmares. M. Maurice de Fleury, who has carried out numerous research projects on neurasthenics, so close to melancholics, attributes their insomnia to arterial hypotension.[75]

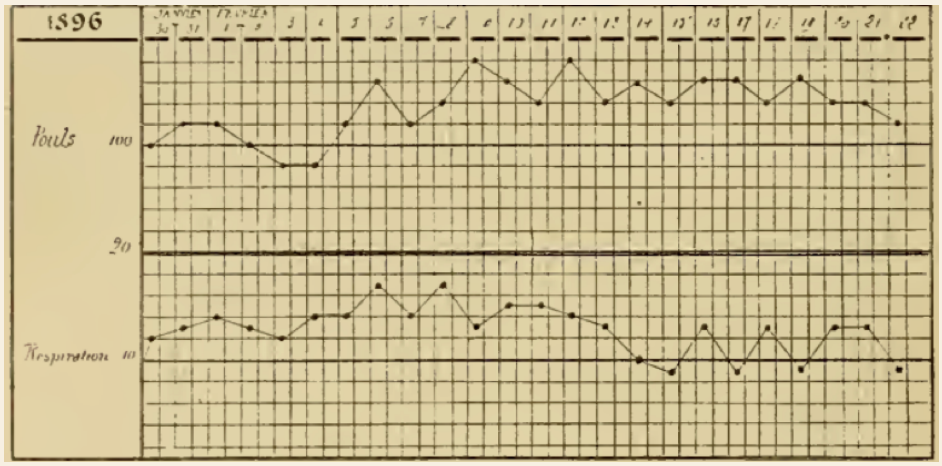

Fig. 2 — Dissociation of pulse and respiration in a melancholic.

Breathing undergoes a very significant alteration in its frequency and rhythm. Let us study these modifications in melancholia with stupor and in anxious melancholia.

Is the number of respirations increased or decreased in stuporous people? Marcé had observed that it was diminished, especially in relation to the number of heartbeats.[76] It should be noted that for Marcé

[72] P.J. Kovalevsky, Psychiatrie (in Russian), 1887, t. II, p. 7.
[73] Clouston, Clinical lectures on mental diseases, 2nd edit., 1887, p. 231.
[74] Guislain, Leçons orales sur les phrénopathies, 2nd edit., t. 1, p. 192.
[75] Maurice de Fleury, L'insomnie et son traitement, 1894.
[76] Marcé, Arch. de médecine, July 1855.

the normal concordance between the number of heartbeats **[79]** and that of respiration was not quite that which is usually found in healthy people. This is how he found that 70 heartbeats should normally correspond to 24 breaths; but this last number is clearly too high. Whatever may be the case with this sometimes observable dissociation (fig. 2), it remains Marcé's opinion that breathing slows down in stupor.

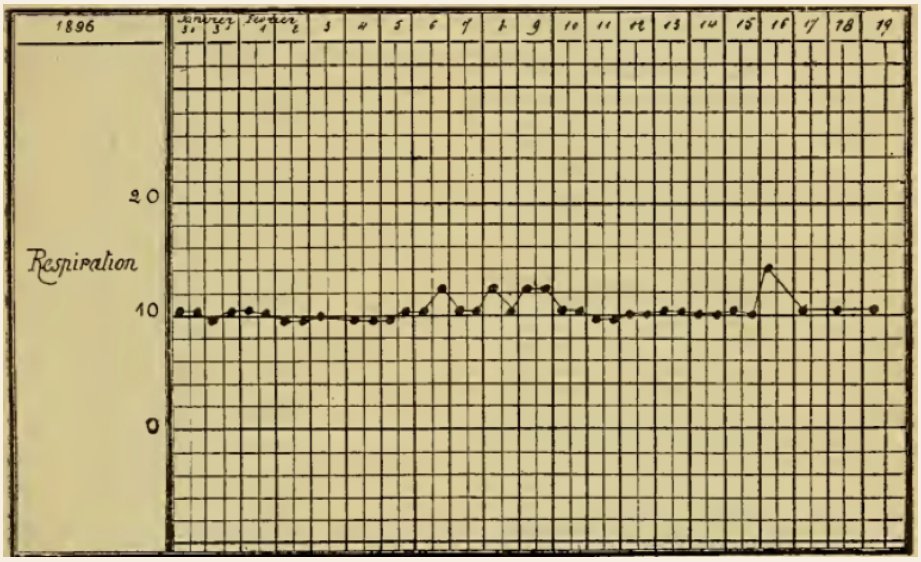

Fig. 3 [on p. 79] — Slowing down of respiration in a stuporous patient.

Mr. Pachon[77], who has carried out very conscientious research on this point, arrives at the same conclusions. We have usually observed this slowdown (fig. 3), but not consistently. We have even observed cases where breathing was very clearly exaggerated; it could be that in **[80]** stupors with active delusion breathing was more frequent.

The rhythm is obviously altered in stupor; — and it seems that most often the amplitude is reduced, except always in cases where there appears to be cerebral activity.

In stupor with more or less complete suspension of thought, breathing would therefore generally be infrequent and superficial; as Marcé[78] had noted, "the inspirations, instead of being done with breadth and regularity, instead of being accompanied by a regular lifting of the chest walls and a vesicular murmur perceptible on auscultation, completely lose their physiological characteristics. The thorax barely rises and the vesicular murmur is sometimes so weakened that it becomes difficult to perceive and even imperceptible in real pauses or respiratory arrests: in certain cases six or seven very weak inspirations are followed by a stronger inspiration, in other cases the inspiration is usually not long, but it occurs in a jerky manner, as if it were composed of several small secondary inspirations." We were able to note, in our observations, these three different types of breathing in stuporous people: the superficial type (fig. 4) and the type with **[81]**

Fig. 4 — Superficial respiration in stupor[79] (16 seconds)

[77] Pachon, C. R. Soc. Biologie, 5 March 1892.
[78] L. V. Marcé, Traité pratique des maladies mentales, Paris, 1862, p. 319 and after.
[79] The plot reads as follows, from left to right: the ascending line represents inspiration.

Fig. 5 — Superficial respiration with pauses and strong periodic inspirations in stupor (17 secs.)

[82] strong periodic inspirations with pauses (fig. 5), which often follow one another and appear to be only two different moments of the same respiratory form[80]; finally the shaky type (fig. 6). The latter type is found especially among anxious people; but we can also observe it in stuporous people. Would it rather be related to the variety of stupor which is accompanied by active delusion? It is possible, because it seems to betray pain. It is the breathing of the person who is crying. For MM. Klippel and Boëteau[81] this jerky contraction indicates a tremor of the respiratory muscles, which would always be related to the tremor of the other muscles of the body. In other words, muscular contraction has the same form everywhere, in the same individual. General paralytics, for example, show tremors in their speech as well as in their gait and in their breathing.

The reduction in the frequency and amplitude of breathing in the stuporous leads to a disruption of the balance which must normally exist between the quantity of blood which the heart sends to the **[83]** lung and the quantity of air which arrives through the

Fig. 6 — Shaky respiration in stupor (10 seconds).

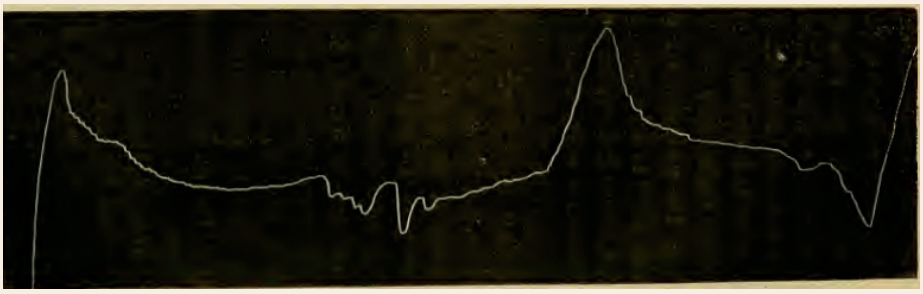

Fig. 7 — Shaky respiration in the anxious melancholic (17 seconds).

[84] respiratory tract. The blood mass oxygenates less; venous blood circulates more difficultly; the blood in the capillaries is charged with carbonic acid — hence in melancholic patients the cyanosis of the nose, the lips and all the extremities, hence also a drop in temperature, the languor of all organic functions.

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[80] Indeed we understand that heavier breathing comes at more or less distant intervals to compensate for the others; it is of reflex origin and is in some way necessary.

[81] Klippel and Boëteau, Breathing disorders in mental illnesses and in particular in general paralysis, Mem. of the Society. de Biol, 1892, p. 49.

In anxious people, we observe even more variety in the frequency and rhythm of breathing, because of the modifications that paroxysms impart to this function. Generally speaking, however, it is accelerated, and mainly in bouts of agitation; but it can also be slowed down. The form of breathing is especially irregular; and the various segments of the graphic plots are not superimposable. It is sometimes superficial; but usually it is more often ample. What would characterize it in paroxysms would be its irregularity and its tremor (fig. 7). It betrays mental pain, while superficial breathing above all manifests the cessation, the weakness of psychophysical energy.

In summary, it is difficult to determine the respiratory type of melancholic patients; this is the conclusion to which Mr. Pachon had already arrived. It varies depending on whether we are dealing with stuporous people or anxious people, and depending on the stuporous or anxious person we observe. Various very complex momentary causes **[85]** appear to change the respiratory rhythm in these patients. However, it is possible, as we have done, to identify, for the two main forms of melancholy (stupor, anxiety), the usual, if not constant, types.

What is the significance of these respiratory problems? Are these related to the emotional state or to the state of brain activity? We

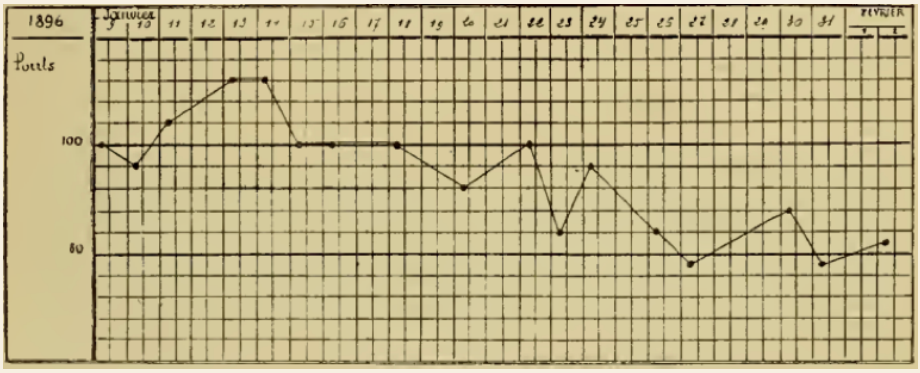

Fig. 8 — Pulse in an anxious melancholic.

would be inclined to admit that they are ordinarily linked to this last condition. Psychological arrest is certainly the cause, in stuporous people, of the slowing down and reduction in the amplitude of breathing. Likewise, the psychological excitement of anxious people would cause the opposite phenomena. Moreover, emotions seem to act on organic functions through the modifications they impose on cerebral activity (Binet and Courtier).

The same considerations apply to circulatory disorders in melancholia. The heartbeats **[86]** are generally weakened, so that it is very difficult to record them with the cardiograph, which instead follows the respiratory movements.

The pulse is usually slowed down in stupor, as in all states of depression[82]: this is what we were able to observe in our observations. Our circularly insane S... presents a slower and weaker pulse in her periods of depression than in her periods of agitation. In anxious people the pulse would be faster (fig. 8), even more so in paroxysms, but not necessarily.

Blood pressure is difficult to study. We used Bloch's sphygmometer, which was criticized for giving too subjective and even false information. The principle on which it is built has been attacked, since it is not proven or even probable that the counterpressure exerted on the artery to squeeze the pulse absolutely measures the pressure of the blood. It doesn't matter, as MM. Binet and Vaschide[83] provided

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[82] Guillaud, Des périodes et du rôle du pouls sur l'aliénation mentale, th., 1858. See also Huard, Aperçu historique sur la sphygmographie; Résultats fournis par cette méthode dans l'aliénation mentale, th. of Paris, 1892

[83] Binet and Vaschide, Année psychologique, 1897, p. 130.

that the sphygmometer gives the differences in tension in relation to other physiological phenomena (cerebral activity, emotions). In summary, we think that Bloch's instrument **[87]** — in the absence of other practices — can still be useful in research of this kind; if it is subjective, it is less so than the simple pressure of the finger on the artery.

Blood pressure is generally low in melancholic states[84] and especially in stuporous people. It would seem that in stupors with very active delusion the tension would be stronger (Greenless, Whitwel)[85] although we know that, in the furiously insane, we can find a weak and depressed pulse (Morel)[86]. Our circularly insane S... presents in her

Fig. 9 — Pulse in stupor.

melancholic periods a lower tension than that he has in her phases of excitement. Finally, we know that blood pressure increases during mental effort (Binet and Vaschide).

The form of the arterial pulsation varies again with stupor or anxiety. Stupor is characterized more than anxiety; the traces generally indicate **[88]** a short ascending line, as evidenced by our observations (fig. 9). S..., the circular melancholic, presents, in his phase of excitement, an ample pulse, and, on the contrary, in his phase of depression, a very contracted pulse.

The vasomotor innervation is also disturbed, as shown by the study of the capillary pulse. This phenomenon can be highlighted with the excellent plethysmograph of Hallion and Comte fixed on the digital extremities, and recording, in the form of graphs, the variations in volume in relation to the dilation and constriction of the vessels (pulse). In melancholia with stupor and psychological shutdown, the capillary pulse is zero, while in anxiety it can be observed, although very rarely. At least that is what we have often observed. S... gave us a capillary pulse during the period of anxiety, while she showed no trace of it during her melancholic period.

What is the significance of capillary pulse? It is not certain that its non-recording is always an indication of vasoconstriction, although this is most often true. But what is this contraction of the pulse due to? To any cerebral excitement (mental effort, short emotions), if we are to believe the experiments of Mr. Binet and Courtier. It seems difficult to agree with Mr. Dumas that it would be a sign of psychological arrest. The question must therefore be reserved.

[89] The consequences of these disorders of vasomotor innervation which most often manifest themselves in melancholic patients through vasoconstriction are not long in coming: the skin becomes dry, scaly and the extremities are cold; the latter are also the site of edema due to venous stasis. Montanus had noted scorbutic spots and Mr. Ritti described the local asphyxia of the extremities appearing during the depressive period of double-form madness. A variety of subacute *red edema*[87] has also been reported in the stuporous.

These changes in the skin and limbs often give young melancholic people the appearance of old people. Another consequence of this defective vasomotor innervation is precordial anxiety, a

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[84] Mr. Chéron and Mr. Maurice de Fleury noted the same hypotension in neurasthenics, who are similar to melancholics. (Maurice de Fleury, Épuisement nerveux, works cited, p. 87).

[85] In Féré, La pathologie des émotions, 1892, p. 361

[86] Morel, Traité des maladies mentales, 1860, p. 455.

[87] Manheimer, Tribune médicale, 27 July 1896.

precordial anxiety, a phenomenon so common in the patients we are dealing with.

The body temperature, which is related to the weakness of the nutritional processes, is very often below normal; in some cases, it reaches 36° and even a few tenths lower (Bechterew). In melancholia with stupor, Lamoure[88] would have found an average temperature below 36°. In moments of violent reaction, the temperature can rise. But generally speaking it is below average among the stuporous(fig. 10). The peripheral temperature is, especially in stupor, much lower than the central temperature; in anxious people

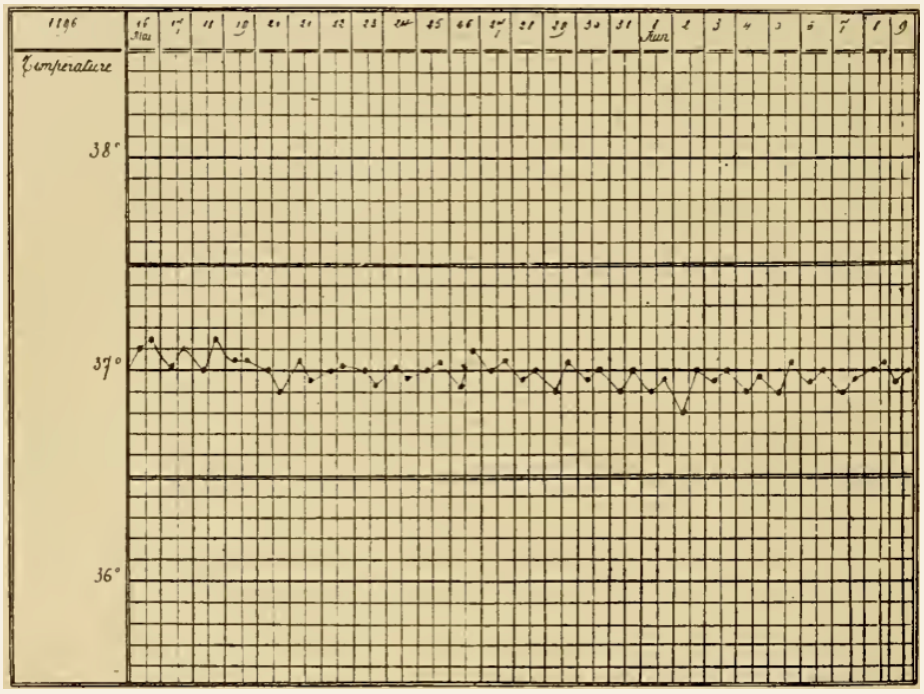

Fig. 10 — Temperature in stupor.

the normal temperature is even above average (fig. 11).

Secretions are usually diminished; however the extremities are sometimes moist. The eye is often dry despite the great psychological suffering. The saliva is thick, the tongue is covered with a yellowish coating, the gastric juices, sometimes more acidic,[89] **[91]** less abundant or diminished in their properties, cannot sufficiently digest food; hence anorexia, loss of appetite and refusal of food. These disorders are often the basis of delusions and in all cases lead to weight loss.

The feces are hard. This results in stubborn constipation which must sometimes be treated by curettage of the fecal bolus. Sometimes, but more rarely,

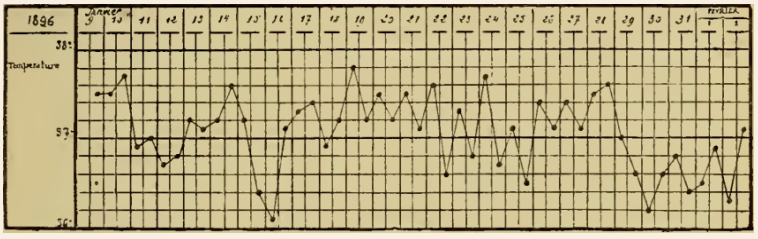

Fig. 11 — Temperature in anxious melancholia.

[88] Lamoure, De l'abaissement de la température dans la mélancolie avec stupeur, th., 1878.

[89] Pachoud, Recherches sur la sécrétion gastrique chez les aliénés atteints de mélancolie, in-8°, Lausanne, 1888.

there is diarrhea which has been attributed to nervous breakdown. Sweat is also diminished and altered; the skin is dry and smells bad. This alteration of the smell would explain the fact narrated by Alibert[90] of a dog which abandoned its master when the latter was suffering from his periodic attack of madness and returned to him after the attack had healed.

The quantity of *urine* is usually reduced (fig. 12); but, certain elements also decrease, the density can remain normal. The chemical composition is altered; and we usually observe a decrease in urea, especially in cases **[92]** of deep stupor, on the contrary an increase in uric acid and phosphates which indicates a great disassimilation mainly affecting the nervous tissue; finally the chloride level would drop. It is to these conclusions that we arrived after some research carried out, at our request, by Mr. Tiffenau,

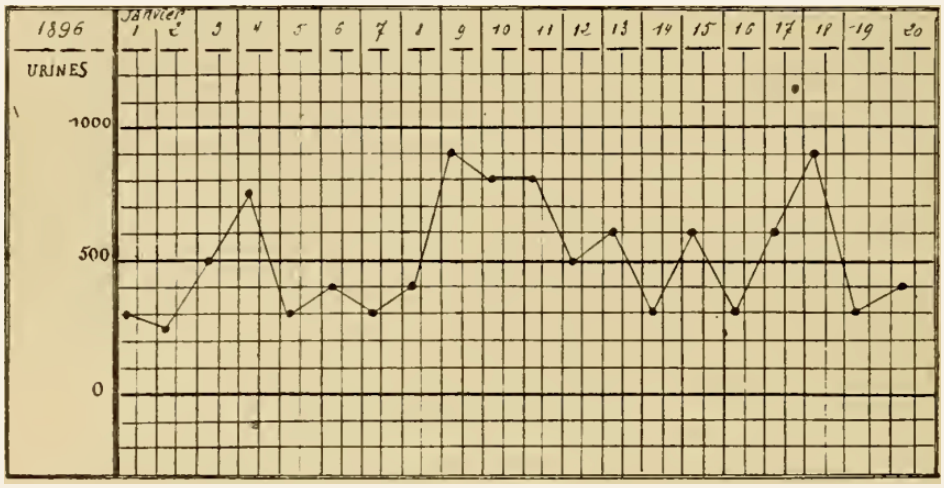

Fig 12. — Diminished urine in melancholia.

pharmacy intern at the Ste-Anne asylum, and summarized in the table below (p. 93).

In our circular melancholic S..., these alterations in the composition of urine are only encountered in the state of depression; urine is normal in the excitement phase. Furthermore, during the period of depression, indican is found in truly exceptional quantities.

Glycosuria has sometimes been reported in melancholic patients. Schüle[91] reports a case where the

[93] Urine of melancholics (Tests performed twice).

INDICATIONS	QUANTITÉS NORMALES		HOMMES				FEMMES		
	Hommes.	Femmes.	M... stupide.	Ce... stupide.	Cr... stupide.	S... stupide.	Ca... stupide.	D... anxieuse.	T... stupide.
Densité.	1018 à 1020	1018 à 1020	1014 1016	1014 1018	1020 1017	1016 1026	1020 1019	1026 1025	1026 1013
Acide urique.	0 gr. 30 à 0 gr. 70	0,30 à 0,40	0,95 0,75	0,75 0,80	0,70 0,75	»	0,40 0,45	0,55 0,60	0,52 0,59
Urée par 24 heures.	24 à 30 gr.	20 à 28	32 26	24 19	19 12	24 14	9,25 9,50	21,45 20,25	12,75 8 »
Acide phosphorique. Par litre.	1 gr. 65	1,50	1,66 2 »	1,10 1,80	1,20 1,60	3,50 3,90	2,25 2,50	2,10 2,30	1,80 1,95
Rapport par litre à l'urée.	1/10	1/10	1/12 1/8	1/14 1/10	1/15 1/11	1/9 1/7	1/8 1/7	1/13 1/12	1/9 1/9
Par 24 heures.	2 gr. 50 [1]	2,30	2,80 3 »	1,75 1,80	1,20 1,20	2,62 2	1,15 1,25	1,65 1,80	1,50 2,95
Chlorures en 24 heures (en chlorure de sodium).	10 à 12 gr.	8 à 10	7,80 7,35	11,70 8,25	3,70 3,45	7,15 3,65	2,80 2,75	3,25 3,10	3,8 3,10

1. Ces chiffres sont plutôt des maxima.

[90] Alibert, Physiologie des passions, 3rd edition, 1837, t. II, p. 11

[91] Schüle, Irrefreund, 1883, n°2.

[94] patient, cured of his mental illness, no longer had sugar in his urine. The author assumes that alterations of the bulb, which is both the center of vasomotor innervation and diabetes mellitus, plays an important role in the pathogenesis of melancholia. Meynert[92] agrees with this interpretation. Finally, Mr. Kovalevsky[93] cites a case of melancholia with stupor during which glucosuria appeared intermittently.

In recent times, several doctors have paid much attention to the question of urinary toxicity in the insane.[94] We have tried to determine the variations in madness, which would be assimilated to auto-intoxication, such as uremia for example. This theory, inspired by the work of Mr. Bouchard, explains certain cases. It is obvious that mental disorders are often the expression of poor nutrition, which leads to an exaggerated production or insufficient elimination of toxic substances and consequently to psychological disorders. Urinary hypertoxicity, in the case of **[95]** overproduction, hypotoxicity, in the case of insufficient elimination, would be objective signs of this auto-intoxication. We have therefore studied in mental illnesses, and particularly in melancholic states, variations in urinary toxicity which could explain mental disorders. These researchfindings are rational; because psychopathies and especially melancholia are usually general illnesses. In melancholia, for example, psychological disorders can arise from several causes; but among these, autointoxication — even if it is only secondary to other morbid processes — must occupy a considerable role. Unfortunately, research into urinary toxicity is still surrounded by too many difficulties for one to be able to arrive at a conclusion responding satisfactorily to these two questions: 1° Is the urine of melancholic patients more or less toxic than normal urine? 2° What is this toxic difference due to? For more details relating to these two questions, we refer to the memoir that one of us published in collaboration with Mr. Gilbert Ballet.[95]

Electrical resistance is usually increased in melancholic people — as the research of M. Séglas[96] and M. A. **[96]** Vigouroux[97] has shown. This is a fact which seems common to all depressive states and in particular to those following epileptic attacks.[98]

Anemia is a phenomenon that is frequently observed in the insane (Erlenmayer). It would be stronger in melancholic states,[99] as Seppili's research has highlighted. Burckhardt[100] noticed that the menstrual blood of melancholic people is less bright and browner than that of maniacs.

Menstrual functions are often stopped, especially in the stuporous.

It is not just under the skin that manifests the general disorder of nutrition. Vitiligo is common. Other times, on the contrary, we observe exaggerated pigmentation; and the skin becomes very brown. The hair can also change color.

Finally, more or less rapid malnutrition is the consequence of all these functional disorders. It is probable that the trophic centers themselves slow down, like all the other processes of the central nervous system, and that this also results in a reduction in the general nutrition of the patient. This is what we can see by weighing the subjects. **[97]** The circular melancholics are valuable for observing this phenomenon. Our patient S... constantly loses weight during her period of melancholia and on the contrary gains weight during her phase of excitement during which she eats more. In stuporous people, gaining weight can occur over time. This is a rather serious prognostic sign: dementia often occurs in these cases.

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92 Meynert, Viertheljahrschr. f. Psych., B. 1.

93 Kovalevsky, Psychiatrie, t. II, p. 26.

94 Chevalier-Lavaure, Des auto-intoxications dans les maladies mentales, th. Bordeaux, 1890. — Mairet and Bosc, Recherches expérimentales sur la toxicité de l'urine des aliénés, Arch. de Physiol., January 1892. — Régis and Chevalier-Lavaure, Des auto-intoxications dans les maladies mentales, Rapport au Congrès des aliénistes (La Rochelle, 1893). — Gilbert Ballet et Roubinovitch, Contribution à l'étude des auto-intoxications dans les maladies mentales, C. R. du Congrès des aliénistes, La Rochelle, 1893.

95 Ballet and Roubinovitch, works cited.

96 Séglas, Société médico-psychologique, July 1890.

97 A. Vigouroux, Étude sur la résistance électrique chez les mélancoliques, Th., Paris, 1890.

98 Féré, Les épilepsies et les épileptiques, 1890, p. 216.

99 Mr. Maurice de Fleury also observed this in neurasthenics. (Épuisement nerveux, works cited, p. 87).

100 Burckhardt, in Schüle, works cited, p. 308.

One of the consequences of this reduction in nutrition is a less resistance to infectious diseases and in particular to tuberculosis which, as we say below, seems to be more frequent among melancholic people. Pneumonia (Thore), pulmonary gangrene (Guislain) would also be more frequent; and we can generally admit that the function of phagocytosis is also slowed down.

Senility is sometimes observed among stuporous people.

The physical signs of melancholics do not lend themselves to general and absolute considerations. In short, we can say that there are two types: the anxious and the melancholic. In both, certain functions, such as breathing and circulation and perhaps some other physical phenomena (temperature), appear to be related to a simple element of the clinical syndrome, to cerebral work. Where the latter is exaggerated in an obvious way, as in anxiety, or in a hidden way, as in stupor with **[98]** active delusion, the same consequences result; likewise — and the consequences are opposite — wherever it is diminished. However, we must not forget that the work of brain cells may not be resolved into thought phenomena and may be spent in histo-chemical work, which would cause the same modifications in the functions of respiration and circulation, without there being any restlessness of the mind. In general paralysis, for example, there is a process which affects the nerve cells of the brain and which, without always causing phenomena of consciousness, seems to have an impact on certain functions of the organism. We also give this last opinion as a simple hypothesis.

1. VARIABLE SYMPTOMS.

A. Psychological symptoms. — We will now study the symptoms of melancholia which do not have the constancy of those we have just reviewed, the variable symptoms, psychological and physical. We will deal with the former first.

a. Hallucinations. — Confused with illusions and delusional conceptions by the first observers, they have always been reported among **[99]** melancholics. But authors disagree on the relative frequency of this phenomenon. Michéa[101] had observed it in 45 out of 72 cases, that is to say in the proportion of 62 per 100. More recently Mr. Revertégat[102] provided a statistic of 62 observations, in which hallucinations were observed 23 times, or 37 per 100. We have not carried out similar statistical research, because they target heterogeneous facts.

Not all forms of melancholia provide an equal contingent of hallucinations. This is how, if we consult the figure of M. Revertégat,[103] we see that hallucinations do not exist in melancholia with consciousness (J. Falret). Presented this way, the formula is too absolute. Because a melancholic state can be accompanied by hallucinations and yet coexist with little or no altered consciousness. What is true is that the so-called simple form of melancholia, one of whose characteristics is to not be complicated by hallucinatory elements, obviously does not present any [hallucinations]. The definition itself excludes cases where there are sensory disturbances.

Of the two other forms of melancholia, the anxious form is less often complicated by hallucinations than the depressive form (16 times out of 30, instead of 5 times out of 5 according to Revertégat). These facts are very well known. Griesinger[104] had reported the relative frequency of hallucinatory disorders during melancholia with stupor. For his part, Baillarger[105] showed that stupor is often — always, he said — accompanied by very active hallucinations of a very painful nature. It is certain that this remark by Baillarger is frequently verified in the clinic; but nevertheless there are cases — in what proportions? it is difficult to say — where the stupor does not seem to be accompanied by hallucinations. There would not be overactivity of the brain, but on the contrary the slowing down, stopping of psychological processes.

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101 Michéa, Délire des sensations, 1851.
102 Revertégat, Contribution à l'étude clinique dans la mélancolie, th., Paris, 1893, p. 94.
103 Id., works cited, p. 94 and 95.
104 Griesinger, Traité des maladies mentales (trad. Doumic), 1865, p. 270.
105 Baillarger, De l'état désigné chez les aliénés sous le nom de stupidité, in Recherches sur les maladies mentales, t. I, p. 72

Hallucinatory disorders can affect sensory brain centers or motor centers. In the first case, there are hallucinations of hearing, sight, smell, taste or touch. But not all senses are affected as frequently as the others. Sight and hearing would be most often and almost equally, if we are to believe M. Revertégat's statistics. It would seem that auditory hallucinations are more frequent than sight. But here again there are distinctions to be made. Sometimes we are dealing with elementary hallucinations, **[101]** with perceptions of noises, vague sounds, more or less clearly related to the external environment. These are probably vascular or other disorders affecting the sensory center or nerve and causing, through their constant irritation, morbid noises. This is the first stage of hallucination; and this is a frequent phenomenon at the beginning of melancholia, more frequent even than one would believe, because in general one does not look for it carefully. One more step and the subject — further interpreting his false sensations — perceives noises having a clearer meaning for him, cries, and also voices. The hallucination is then auditory-verbal. Often it seems to have shown itself from the start in this form, when in reality it took more or less time and effort for the subject to gradually create his hallucinations and give them the form of a voice. At this moment the verbal auditory hallucination is constituted; it fuels delusion, when it exists.

Almost always the voices say unpleasant things. These are crude insults, where the same filthy words are constantly found. These are threats, sinister warnings, which only increase the depression or anxiety of patients. Sometimes the voices are recognized; but often they also belong to strangers, or rather they appear to be those of the people around the patient. In the asylum, **[102]** it is the bed or table neighbors, it is the guards, even the doctors who speak to the melancholic unfortunate.

The voices — need I say it? — talk to the patient about his usual concerns and his affairs. Because hallucination creates nothing, and always manifests the ideas and intellectual knowledge of the subject; it is therefore *professional* — in the broadest sense of the word.

In certain cases where the psychological automatism goes as far as the splitting of the personality, the patient says that his thoughts are being stolen from him, that he cannot think of anything without a voice immediately repeating in his ear what he is thinking. In other cases they overhear dialogues between the subject and imaginary people.

Auditory hallucinations are usually bilateral; but they may only affect one side, especially in cases where there is sensory or even brain damage.[106] And it can still happen that the hallucinations affect both sides, but in a different way. On the right there will be painful voices; on the left, cheerful and consoling voices. This phenomenon was well highlighted by Mr. Magnan.[107] We wanted to see in **[103]** these curious facts the successive and independent exercise of each hemisphere. These hallucinations can influence the patient's actions. The voices command silence, which is scrupulously kept by the patient for a sometimes long time. It is not uncommon for cured melancholic patients to say, for example, that they did not speak because they were told: “If you say a word, we will kill you.”

Food refusal can have the same causes; and the sick person will not eat because he is forbidden to do so, because he is threatened with misfortune, or because he hears that the food is poisoned or even because he is reproached for being fed by others. Suicide attempts are sometimes committed under the influence of hallucinations. Even paroxysm, these impulsive crises, often of a panophobic nature, and sometimes dangerous for those around melancholic people, which cannot be the consequence of auditory hallucinatory disorders.

Sight is, after hearing, the sense most often affected by hallucination in melancholia. It is also necessary to distinguish cases where a cause foreign to the psychosis is added to produce the hallucinatory disorder. These are facts of this kind which have been well studied by M.

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[106] Ed. Toulouse, Les hallucinations unilatérales. Gazette des Hôpitaux, 1892, p. 609. — Joffroy, Les hallucinations unilatérales, Archives de neurologie, 1896.

[107] Magnan, Des hallucinations bilatérales de caractère différent suivant le côté affecté, Arch.de neurol, 1883, t. VI, p. 336.

Magnan.[108] An alcoholic **[104]** who is still heavily intoxicated, a hysteric, even an organically demented person are subjects who easily construct visual hallucinations, but each for different reasons.

There are certain forms of melancholia where sight is more often affected. Cotard[109] had in fact noticed that, in anxious melancholia, visual hallucinations were quite frequent. We understand that they must add greatly to the intensity of the delusion. The sight of a prepared torture is a far more terrible thing than hearing the threat of it. Also, when visual hallucinations appear and involve dramatic events, the anxiety is exaggerated. However the opposite effect can be obtained by intense emotion; and sometimes the subject sees, mute and stuporous with fear, spectacles full of terror. Visual hallucinations are sometimes elementary. The patient then sees black or red dots more or less reminiscent of butterflies, flies or flames. But other times visual hallucinations show more complex characters and scenes. It is common to observe the distressing nature of these hallucinations. It is a fire that is lit, a cemetery that unfolds with corpses lying in their shrouds, the death of a loved one, etc. More rarely we observe visual-verbal hallucinations **[105]**. One of M. Séglas's patients[110] thought she saw clearly written on the wall these words: You are cursed! The sense of smell and taste are sometimes impaired, and the subject says they breathe foul vapors or smell unpleasant flavors.

Tact sensitivity can be affected, as well as genital sensitivity.[111] In the Middle Ages, melancholic incubi and succubi were common. Alterations in visceral sensitivity explain these bizarre sensations that we do not really know how to consider, as simple painful perceptions or as delusional interpretations (illusions and hallucinations). Often it cannot be denied that we are dealing with hallucinations. The melancholic declares that he has gained weight, lost weight and in extraordinary proportions, when this in no way corresponds to reality. Sometimes melancholic people say that they have displaced, obstructed or even absent viscera. This is the origin of ideas of negation. In other cases, they report feeling electric currents, tingling, steaming, rippling, etc.

The *motor centers* are sometimes the seat of hallucinatory disorders. When these are the centers of the limbs, it seems to the patient that he is moving, that he is walking, this illusion especially takes place in the period between waking and sleeping.

[106] In some cases – numerous according to M. Séglas[112] – the injured motor center is that of the articulation of words. The patient says he perceives a voice coming from his mouth; and sometimes he unconsciously moves his lips and tongue, which clearly proves the excitement of the language center. These hallucinations were studied by Baillarger[113] and especially by M. Séglas[114] who gave them the name *psychomotor*. Often these voices seem to come from a part other than the mouth, for example from the neck, the chest, the stomach. Information[115] on the clinical side of this question will be found in a work by one of us. It should be noted that in all these regions there are muscles which help with phonation and breathing, and we understand that the externalization of the central hallucinatory sensation can take place in the muscles of the throat, the vocal cords and the diaphragm.

However, it seems to us that we include, among psycho-motor hallucinations, phenomena **[107]** which cannot be explained by the excitation of the verbal center of articulation. There are individuals who say they hear voices inside their heads, and voices that do remind them of voices already heard.

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[108] Magnan, De la coexistence de plusieurs délires de nature différente chez le même aliéné, Arch. de neurol., 1880, t. I, p. 49.

[109] Cotard, Du délire des négations (1882), in Études sur les maladies cérébrales et mentales, 1891, p. 325.

[110] Séglas, Leçons cliniques..., works cited, p. 327.

[111] Schüle, Leçons cliniques..., works cited, p. 30.

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[114] Séglas, L'hallucination dans ses rapports avec la fonction du langage, Progrès médical, 18 and 25 Aug. 1888. — Id., Les troubles du langage chez les aliénés, collection Charcot-Debove, p. 119 and following.

[115] Roubinovitch, Contribution à l'étude des hallucinations verbales psycho-motrices, Ann. médico-psychol., 1893, t. XVII, p. 98.

We believe that, in cases of this kind, it is really a question of psychological hallucinations in the sense in which Baillarger understood it, that is to say — to use modern expressions — of verbal images without very distinct form, being clearly neither motor, nor visual, nor auditory, and weakly projected externally. These are psychological images more intense than those which normally serve the work of ideation and which give the patient the illusion of external phenomena. In any case, verbal motor hallucinations are commonly observed in melancholia and are sometimes one of the psychological conditions of split personality.

The pathogenesis of hallucinations in melancholia is very obscure. We can assume that in this dull morbid work which affects more or less the entire organism in its functioning, there are small irritations sufficient to excite the centers of sensory and motor images. However, as the brain is deprived of its power of control, due to the reduction in the general vitality of all functions, a certain anarchy reigns. The psychological centers become emancipated and are given over to automatism, so well described by **[108]** Baillarger[116] as a necessary condition for the production of delusion and hallucinations and which M. Janet[117] has studied well in recent times in the subject of hysterics. It is this automatism, that is to say the involuntary exercise of the intellectual faculties which creates hallucinations and the externalization of sensations.

b. Melancholic delusions. — Delusion is a frequent element of melancholia, but not constant. There are clinical forms where patients do not manifest any delusional conception. But there are others — very numerous and varied — where melancholic ideas are clearly delusional. Beneath their apparent variety, it is possible to find common characteristics which make them equivalent expressions of the same mental state.

The melancholic delusion is of a distressing nature; and whatever form, whatever color it takes on, it is always a sort of nightmare. Such a patient says he is abandoned by everyone; another believes that all his relatives are dead; he hears utterances of terrible threats against him; this one is convinced that the scaffold will be erected to guillotine him. All these melancholic delusions, Griesinger[118] had noticed, have the same essential character, namely that the sick suffer, and are **[109]** passive, dominated, subject to an invincible power. Far from recriminating, as the persecuted constantly do, and trying to take revenge on the people to whom they attribute the evils with which they are overwhelmed, they submit, resigned. And this — we cannot repeat it enough — is one of the great clinical differences, this passivity opposed to the aggressive reaction of the persecuted.

Furthermore, the delusion of melancholic people is *monotonous* and fixed. "What," says Marcé,[119] "characterizes to a more advanced degree the mental state of melancholics, is not only the very special nature of their delusional conceptions, it is also the *monotony and passivity* of their delusion. Among them, the imagination has singularly lost its activity. Far from discussing their false conceptions, far from seeking to support them with ingenious and varied reasons as monomaniacs do, melancholics, oppressed by the nature of their ideas, limit themselves to repeating the same words and the same sentences."

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[116] Baillarger, Physiologie des hallucinations, in Recherches..., t. I, p. 490 and following.
[117] Janet, Automatisme psychologique, 2nd edition, 1894.
[118] Griesinger, works cited, p. 268.
[119] Marcé, works cited, p. 315.

It has been said that the characteristics of melancholic delusion are *secondary*. This is what Griesinger[120] highlighted. It has also been said that the melancholic delusion was divergent, and on the contrary that the persecutory delusions were convergent. These are somewhat delicate assessments.

[110] Finally, delusional ideas of melancholia can sometimes become *systematized*, that is to say, form a homogeneous group; and they were even opposed to delusional ideas of persecution. But they don't have the cohesion of the latter and are always a little confusing.

Sometimes it is the ideas of ruin that predominate. The patient is convinced that he has lost everything, his money, his position, his situation in the world, and that he will never be able to get them back; he sometimes refuses food on the pretext that he cannot pay for it. Sometimes we observe *ideas* of *humility*. The subject declares that he is nothing, that he is miserable, that he does not deserve the care given to him and he does not understand how anyone is interested in him. From there to *ideas of guilt*, there is only one step; and this step is very often taken. The subject is then a serious criminal. He is the cause of all the evil that happens on earth. If people around him suffer, it is his fault. A patient in a hospital ward, whose story was told by M. Joffroy, accused herself of contributing to the end of her roommates; it was her breath that carried death around her.

Sometimes this delusion of self-accusation takes on a particular intensity. And we hear patients declaring themselves guilty of misdeeds they never committed. It has even happened that these self-accusations have led the justice system astray. Witness the fact **[111]** observed by Morel.[121] It was about a woman who accused herself of having tried to have her husband murdered, even though she had nothing to do with this crime; we will return to this very instructive observation.

Cases of self-blame among melancholic people are not rare. But it would be wrong to believe that they exist exclusively in melancholia. We will find in a work by M. Séglas[122] numerous cases where these delusional ideas were symptomatic of other psychopathic states. Everyone knows how common they are in alcoholic delusion; and M. P. Garnier[123] reported in his interesting work on *Folie à Paris* very instructive facts about self-accusing alcoholics. Two new observations have been published by one of us.[124] It is almost constant that after each high-profile crime, alcoholics come and accuse themselves of being the perpetrators. M. P. Garnier was one day able to bring together two drunkards who, both convinced of being the murderers of Marie Aguettant, treated each other as liars. Dr. Magnan showed a patient who accused himself for **[112]** several days of having killed M. Constans, then minister. But alcoholics and melancholics are not the only self-accusers. General paralytics, senile lunatics and degenerates sometimes also blame themselves.

We can wonder if, in certain cases, these self-accusations would not take their origin in a dream of the patient, which would continue more or less long in the waking state.[125] Very healthy minds have sometimes been victims of this illusion. Look at Baillarger[126] who dreamt that one of his colleagues took over the management of a medical journal. The next day, he hastened to announce the news to everyone it might interest, when at one moment he suddenly realized that he was telling a dream. But, for melancholic people, the explanation of these self-accusations is in their tendencies to bring back to themselves the origin of the evil of which they are the spectators.

Hypochondriac ideas are often associated with melancholic delusions. Baillarger[127] had described a hypochondriac delusion which he believed was specific to general paralytics. But that was a mistake; and this same delusion belongs to non-paralytic melancholic patients, as Marcé[128] had already observed: **[113]** “The patients believe they have an obstructed digestive tract, they complain of not being able to urinate, of having their anus turned upside down, they are very concerned functions of this or that organ, and find in these fears about the physical state of their viscera, a new element of delusion.”

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120 Griesinger, works cited, p. 269.
121 Legrand du Saulle, La folie devant les tribunaux, 1864, p. 580.
122 Séglas, Leçons cliniques.., p. 349 and after.
123 P. Garnier, La folie à Paris, 1890, p. 103.
124 Roubinovitch, Sur le délire de persécution avec auto-accusation dans l'alcoolisme, Annales méd.-psychol, 1894 t. XX, p. 128.
125 Faure, Études sur les rêves morbides, Arch. génér. de méd., 1876, t. I.
126 Tissié, Les rêves morbides.
127 Baillarger, Du délire hypocondriaque, etc., works cited.
128 Marcé, works cited, p. 316.

Some feel transformed; and this idea is well described by most melancholics, "They feel that everything is changed within them and outside, and are sorry to no longer see things through the same prism as before."[129] A patient of Griesinger[130] described his state in the same way.

The result of these different perceptions is sometimes a set of delusional conceptions that Cotard[131] described under the name of delusion of negations. Marcé[132] had observed melancholic hypochondriacs, who believed that their body was “towards the same prism as before”.[133] A patient of Griesinger[134] described his state in the same way.

The result of these different perceptions is sometimes a set of delusional conceptions that Cotard described under the name of delusion of **[114]** negations. Marcé had observed melancholic hypochondriacs, who believed that their bodies were decomposed and gave off a bad odor, that they no longer had arms, legs, and finally that they were dead. Cotard studied these facts and observed that, among elderly anxious melancholics, a set of symptoms developed which gave a chronic and incurable course to the illness. We will study this delusion further in the chapter of clinical varieties.

The culmination of all these delusional ideas of a distressing nature is the *idea of suicide*, which, by the acts it pushes one to commit, is of capital importance. The pathogenesis of these suicidal ideas is very varied. Despair, remorse, and above all the desire to be rid of psychological suffering are the most common apparent psychological causes of suicide. Sometimes it is hallucinations which maintain or suddenly provoke these morbid ideas. Other times it is anxiety, this paroxysmal mental pain, which suddenly gives rise to the idea of suicide, just as it provokes the attack. But in general, thoughts of suicide have a slow progress and onset. It has been noticed that thoughts of suicide often return with greater force at daybreak; is it because melancholics sleep poorly and find themselves more tired, more depressed in the morning and consequently more inclined to sad thoughts, or is it on the contrary because the coming day gives greater excitement to all the psycho-physical processes and consequently delusional ideas? Both opinions can support each other. Contagion and perhaps heredity seem to play a role in the appearance of suicidal thoughts among various members of the same family, as we will see later with regard to etiology.

It should be noted that thoughts of suicide generally have the monotony and steadiness of all the conceptions of lypemaniacs. Patients constantly ruminate on them and design more or less complicated execution plans. But often these thoughts of suicide are too weak to turn into action.

The idea of suicide is not incompatible with the fear of death. Both even coexist quite often among melancholic people,[137] although the idea seems paradoxical at first glance. But everyone knows how the fear of something involves a certain attraction for that same thing. This complex feeling is comparable to the fear of falling from a high place which often produces vertigo, which determines the fall. “By this very fact,” says M. J. Falret,[138] **[116]** that these patients (the melancholics) have the fear of being pushed in spite of themselves to do harm and that they constantly think of the object of their fear, they feel as if they are invincibly attracted... The more we try to dismiss an idea, the more it voluntarily imposes itself on the mind.” It should also be noted that this fear of death is, in certain subjects, so distressing, so painful, that patients prefer immediate death — which is a way of deliverance — to the continuation of their suffering.

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129 J. Falret, Études cliniques...., 1890, p. 508.
130 Griesinger, works cited, p. 265.
131 Cotard, Du délire des négations, Arch. de neurol., 1882, t. IV, p. 158, 282.
132 Marcé, works cited, p. 316.
133 J. Falret, Études cliniques...., 1890, p. 508.
134 Griesinger, works cited, p. 265.
135 Cotard, Du délire des négations, Arch. de neurol., 1882, t. IV, p. 158, 282.
136 Marcé, works cited, p. 316.
137 Nicoulau, Thanatophobie et suicide, Ann. méd.-psych., 1892, t. XV, p. 189.
138 J. Falret, Études cliniques...., works cited, p. 509.

c. Associated delusions. — The delusions that we have just reviewed are part of the usual symptomatology of melancholia, not in a constant way, but in a way that is habitual for most. There are other delusional ideas which are rarer and which are elements simply associated with distinctly melancholic conceptions.

This is how mystical ideas are sometimes observed and orient delusional ideas in a religious sense. If the patient believes himself guilty, it is towards God, for having transgressed divine laws; his faults are among those punished most severely by the Church. In cases of this kind, it is not rare to find in the education of the subject, in the environment in which he lived, the explanation of his conceptions. Sometimes these mystical ideas **[117]** are transformed into *ideas of damnation*, which have the same meaning, and which, like the ideas of lycanthropy, were very common in the Middle Ages.[139] In these troubled times, how many unfortunate self-accusing melancholics have been burned, thus paying with their lives for the crime of being insane! Today these delusions are hardly found except in certain regions[140] outside the movement of business and ideas.

There are other delusional conceptions, *ideas of persecution*, whose association with melancholia is sometimes observed, thus establishing mixed cases which are very cumbersome for the clinician. It can then be very difficult to decide whether we are dealing with a persecutory delusion or a melancholic delusion; and there are facts which represent an association of these two mental forms (obs. VIII). The differential diagnostic characteristics of these two psychopathic modalities have been given many times. We have schematized and perhaps exaggerated — for a clearer differentiation — the opposing characteristics of the persecuted and the melancholic. What sets them apart most of all is the way they react. Both may have hallucinations of a distressing nature, hearing insulting or threatening voices. Both can believe themselves to be victims **[118]** of their relatives, their neighbors, and society. But one is a resigned victim, withdrawn into himself in his immense pain, a victim who humiliates himself, who accuses himself, who believes he is to atone for some wrongdoing. The other, on the contrary, is a hateful victim, who turns against his persecutors with all his energy; who is full of pride and sometimes becomes proud even of the persecutions he suffers because they indicate a remarkable, illustrious personality. The two degrees have the same basis, the same hallucinatory disorders; but the subjects interpret their morbid disorders[141] in a completely opposite way. We see above all in this difference in reaction the difference in the character of the patient; similarly in normal life, one person is passive and another aggressive. This influence of character on the color of delusional ideas has been well studied in Germany and by M. Charpentier[142] in France.

Ideas of grandeur are not, at least in their pure form, specific to melancholia; but they are sometimes observed there. However, most of the observations which tend to highlight this fact **[119]** relate to patients who are rather persecuted. When true melancholic people are ambitious, it is always in their own way. They are great culprits, accusing themselves of all the crimes and all the evils of creation; and if they are a power, it is only an evil, infernal power. This is the delusion of enormity described by Cotard[143] and which is found especially among melancholic deniers. The sick are, in a way, ambitious in reverse; because what they aspire to are bad things, defects, responsibility for horrible, even monstrous acts, as is observed in the melancholia with delusion of negations.

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[139] Calmeil, De la folie..., 1845.

[140] Constans, Relation d'une épidémie d'hystéro-démonopathie, Ann. méd-psych., 1862.

[141] It has also been said — especially in Germany — that the melancholic idea is secondary, that it comes as an explanation for the conscious psychological modifications of the patient, while the idea of persecution is a primitive fact. Finally, it has been said that the melancholic delusion is convergent and relates everything to the suffering personality of the subject, and that the persecutory delusions are, on the contrary, divergent.

[142] Charpentier, Les idées morbides et les délires de persécution, Ann. méd.-psych., 1887.

[143] Cotard, Le délire d'énormité (1888), in Études sur les maladies cérébrales et mentales, 1891, p. 374.

We have above examined obsession in its relationship with psychological cessation and the sad coenesthetic state and as a consequence of the mentality specific to melancholia. We also observe cases where obsessions, due to the degenerative nature of the subject, evolve a little outside of melancholia; it is then that we can say that they are associated with the latter. The subjects are, for example, obsessives, who one day fall into a melancholic state. In these cases, reported by Séglas,[144] it seems that the two affections run parallel without affecting too much about each other. **[120]** But it can happen that the melancholic state causes the appearance of obsessions and this in a temporary way, during its evolution.

OBS. I.[145] — Anxious melancholia with obsessions, mystical ideas and persecution.

Oa..., William, 41 years old, former County Sheriff in Ireland, entered the Ste-Anne asylum on June 7, 1894 (service of Prof. Joffroy, in Ste-Anne).

Father died at sixty-three. Living mother, aged seventy, very nervous; would have lost her mind lately. Insane maternal grandmother, died in an asylum.

Nothing is known about the morbid history of his youth. Intelligent, educated, belonged to a highborn Irish family; he was appointed County Sheriff at the age of twenty-five. Still very religious. No alcoholic bouts or syphilis.

In 1887 he was County Sheriff in Ireland. He had to apply a very unpopular law which dispossessed several of the country's great families of their land, and he witnessed violent scenes where blood was shed. He also overworked himself a lot, spending sleepless nights outside. Then, his conscience reproaching him for lending a hand to the execution of a law that all his compatriots considered iniquitous, he resigned as sheriff, an extremity which was, despite everything, very painful for him. He then became a collector of private annuities, a job which brought him income equivalent to that of a sheriff. But the emotions and overwork of recent times had greatly shaken his brain; and he even seems to have gone through a neurasthenic phase which lasted a few months. He was then and still is haunted by the memory of the dramatic scenes he witnessed.

[121] In 1888, he came to France under the influence of clearly delusional ideas. He was afraid of being assassinated by the enemies he had made during his public office. He also comes to save France's security, threatened by the Germans, because he believed he had a mission from the Holy Virgin.

In Paris he only received 1600 francs from his two brothers per year. He did not work and lived near the Pantheon. He spent his days at Notre-Dame-des-Victoires, saying masses and holding candles to protect himself against his enemies. He did not eat in public restaurants for fear of being shot or stabbed. He didn't even feel safe in his room. This conviction of being murdered was not based on any hallucination, but was and still is entirely private.

With this, he still believed himself called to play a role in the recovery of France. It was he who, through his writings and words, had German spies driven out of France. He is also being pursued by Germany. The Empress Frederick came to Paris as soon as he arrived there himself. He is followed, pursued by Germans whose mission is to kill him.

These ideas of persecution, mystics and grandeur, always persistent, evolve on a clearly melancholic mental background, of sadness and discouragement, of perpetual anxieties, as shown in the following letter written to the doctor in the department.

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144 Séglas, Leçons cliniques..., p. 316.

145 Most of the observations of this work were taken in the service of our master, M. Prof. Joffroy, whom we ask here to accept the expression of our deep gratitude.

“For a long time I have been in the greatest and terrible anguish of mind because of the intimate and terrible certainty in which I am of being murdered or of being stabbed, of being poisoned or even of being kidnapped and to be killed by some terrible means. I have no greater consolation or happiness in this life than that of being a child of the Holy Roman Church, of being Catholic. For a very long time, I prayed to the Most Holy Virgin for my eternal salvation, and I hope that soon she will grant me this long-desired grace. I hope and wish to see her soon in heaven, far from all sadness. I see very clearly that the Most **[122]** Holy Virgin chose me and made me an instrument (however very humble) for the recovery of France, to serve and to save France from its more than serious, perilous situation. and precariously alongside Germany since the war of 1870, to expose the intrigues of Germany, to drive out by my word and by my pen the German spies from France and to prevent any new invasion or possible invasion of France from Germany.

“For a long time I have been in the greatest mental anguish because of the intimate and terrible certainty that I am of being assassinated, and if France delivers me into the hands of my enemies, I will be assassinated in prison. I think I can say that since the war of 1870, perhaps no one has done more to help France recover from its misfortunes. But I didn't win anything. I did not ask for the Legion of Honor for great and beautiful services rendered forever to France, but nevertheless I won it, and more than won, and very little time will show what I did for the recovery of France.

“An Irish gentleman of a very old and very honorable name and family in my Catholic country, I have always and have loved France and all the French people very much. Friendship and love for France is natural to every Irishman and must also live deep in the heart of every Irishman. I am not talking about men without God, without religious principles, I am only talking about good Catholics, good fervent and faithful Catholics of the Holy Roman Church.

“My name will remain and live in history as one of the servants of France. My name will also remain in history as that of an Irish Catholic and patriot too, the only one to see and express the situation of France in Europe since the war of 1870 and to chase away German spies with my words and with my pen. of France.

“My name will also remain in history as that of a patriotic and Catholic Irishman who **[123]** awakened Catholic France more than ever to the intrigues and audacity of Germany, who (we hope) saved France from the intrigues of its enemies, Germany, and who with his hands prevented any invasion or possible invasion on the part of Germany. Yes, my name will remain and live in history as one of the rescuers of France, and although very humble and modest even among the great rescuers of France.

“I believe I really have the right to ask for asylum and protection from France, because if France delivers me into the hands of my enemies, I will be murdered either in prison by the English or the Germans. I have suffered for a long time the greatest anguish of being assassinated and that is why I ask for asylum and protection from France.

“But it is above all in the protection of the Most Holy Virgin under her name of Our Lady of Victories that I have placed all my confidence. I believe I can say that in all centuries she is the heavenly protector and support of all those who hope in her and trust in her. So far this is my experience. She is also the mother of the Eternal Word and of these poor unfortunate people, the Irish farmers and tenants. And I have also put myself under her protection forever and she will not allow me to be flustered. I hope and wish to see her soon in heaven far from all sadness and I have the firmest conscience in her for my eternal salvation. She will not allow one of her servants and her children to die who prayed to her for so long for her eternal salvation, who did everything for the salvation and recovery of France. You asked me about my family's health. My grandmother (my mother's mother)

died of mental illness. My mother's constitution and health are very weak and very nervous. I myself fear losing my sight. To have the happiness and consolation of fulfilling my religious duties, I want to see the priest on Sundays and I want to tell him that I **[124]** very much want to stay in the asylum by paying the monthly pension from my pension. As I am a rentier, I would very much like, with permission, for my eternal salvation, to enter a monastery as soon as possible.

“As I am of Irish birth and family, I add to my name that of O'C...

“For a long time I have suffered the greatest anguish of being assassinated and I very much want to see you to explain to you at greater length and more widely my great mental anguish.”

This letter is interesting in several respects. It clearly shows the obsessive nature of his delusional ideas. He is truly eloquent in his repetitions of words, which also betray a certain monotony of thought, as is observed in melancholic people.

Physical symptoms include a slight tremor of the hands and exaggerated knee jerk reflexes. Sleep is disturbed by the fear of being assassinated. Eye reflexes are preserved; there is no pupil inequality, nor speech difficulty.

Impulses are quite common among melancholic people. We have seen how they could be pathogenetically linked to moral suffering and also to psychological decline, to abulia (Schüle). They manifest themselves in the form of paroxysms, reflex acts, conceived suddenly and executed with the greatest energy. Their violence is sometimes very great and can become dangerous for those around the sick. Often these are movements of flight; other times homicide attempts are the consequences.

[125] Some of these impulses appear to betray a state of paroxysmal fear; and they have been described under the name *panophobia*. Frequently they are caused by hallucinations. The vision of terrible scenes, of assassins rushing towards the patient, of the flames of a fire that will destroy everything, of hearing terrible threats plunge the subject into extreme terror at one point. It is then that, to escape these spectacles and these pursuits, he wants to flee, throws himself through an open window or, on the contrary, expends his terror in acts of brutality on the people around him.

In unbalanced melancholic people we can observe impulses similar to the obsessions described above. Here is an example of impulses to masturbation.

OBS. II. — *Melancholia with various impulses; impulsive masturbation; heredity.*

Mme Du..., forty-seven years old, entered the St-Yon asylum on November 22, 1893.

Nervous father, perhaps suicidal. Paternal grandmother died of paralysis at fifty-two years old. Weird mother; ate wheat in secret; died of stomach cancer. Maternal grandmother died of cancer.

When she was very young, she started masturbating. She was told that when she was in the cradle (she was about a year old) she was found rubbing her legs together. She was sometimes drenched in sweat from the movements she made. Ever since she had personal memories, she remembers always indulging in this vice. Menstruating for the first time at **[126]** thirteen, she continued to masturbate, but no more than before. At the time of the menstrual flow, she was no more inclined than at other times. She has always had a bad temper. It was when she was inclined to sadness that she masturbated more; depending on how strong the annoyance was, she started again several times in succession, until she was destroyed and she could think of nothing. She masturbated with her hand and touched her clitoris. She never put anything in her vagina.

Married at twenty-three. She didn't hate her husband, but she wasn't very fond of him. “In these illnesses we don’t love,” according to his expressions. She continued to masturbate after her marriage; because she rarely felt anything with her husband. When “it got to her”, she did it in front of him. These impulses came to her in crises; and she sometimes went several days without thinking about it. She

repeats that it was not out of passion, but to overcome her annoyances. She didn't know why she was doing it. It seemed to her that she had to masturbate. When the idea came to her, she sometimes tried to fight it; but she felt an irresistible force pushing her. She felt oppressed, broken. As soon as she succumbed and indulged in masturbation, she felt relieved.

But this type of obsession is not the only one the patient felt. When she was young, she couldn't hear about crimes. Because it seemed to her that she had the idea of committing one, even on her mother. Around the time of puberty, she had thoughts of throwing herself down a precipice, a ditch or a well. When she passed their neighborhood, she felt like she was being drawn into it. After giving birth, at the age of thirty-four, she was tempted to kill her child. She had friends say prayers to be rid of this obsession.

The patient is subject to scruples. When people around her were sick, she feared they had left a match in their drinks. When she **[127]** was young, she often went to confession and always feared that she had forgotten some sin. She sometimes returns to an apartment several times to find out if she has set it on fire or to look several times to see if she has closed a door. She was doubtful about everything. When she got married, she spent several days in retrospective fear of not having signed the contract. She is aware of the morbid nature of all these ideas and deplores her state.

She entered the asylum for a period of melancholia, in which she has been for several weeks. Mental and physical depression; deep discouragement; desire to die; no hallucinations.

d. Actions. — We have described above the attitude and gestures of melancholics, which are symptoms of the mental state. It remains for us to study some acts which are observed more or less frequently during melancholia.

Muteness is one of these. The application of the word act to this symptom seems at first glance illegitimate, because it seems that silence is the opposite of action. And yet silence is sometimes a real action; the subject wants not to speak and maintains — in a real effort — his attitude of silence for a more or less long time.

Mutism is encountered in all forms of melancholia; but it is much more frequent in the form which is accompanied by stupor. This is where it is most durable; and it is not rare to observe stuporous people who go months without **[128]** speaking. Anxious people are rather talkative; but they sometimes suddenly fall into a more or less obstinate silence.

Generally, melancholic muteness is not absolute and does not have a consistent course. Indeed, it is rare for the melancholic to remain completely silent. However, this is visible, and then the diagnosis with aphasia and especially hysterical mutism can be made. When meeting aphasics, the melancholic does not try to speak; and his face expresses either complete stupor and indifference, or a stubborn desire to say nothing. Unlike hysterics, who are often mute and voiceless, the melancholic's countenance is not alert and he does not try to write spontaneously to satisfy the need to express himself common to these neuropaths.

But in the clinic, we repeat, the facts very rarely present themselves this way and melancholic muteness is not absolute. We can make them say a word, by pressing them, by tormenting them; and then a spoken word indicates that they are neither mute nor voiceless. Often, moreover, this word betrays delusion. It is an exclamation of pain, a curse, a word that puts people on the path to illness. This simple word can still allow the doctor to reject the hypothesis of muteness in a persecuted person. We know, in fact, that patients suffering from persecutory delusions sometimes lock themselves into a very tenacious voluntary silence, much more tenacious even than that of

melancholic patients. We have seen them remain silent and hide their delusion from all investigations, for months and years. If, in cases of this kind, we obtain a word, it is often a word of distrust, hatred, pride. This is how in mental clinics the tiniest fact allows the sagacious observer to formulate a diagnosis. But even if the silence were absolute and tenacious, the dejected countenance of one and the suspicious look of the other could point the way to the truth.

Furthermore, melancholic muteness does not have a consistent course. It does not appear immediately as in hysteria thanks to an emotion; and, even in stupors which develop suddenly, the phenomena of depression generally precede the mutism. Then the latter has a fairly indeterminate duration, but often with more or less long periods where speech returns, depending in some way on the physical and mental state. In hysteria, the same abruptness usually ends the silence.

Here is a very clearly established case of hysterical mutism, which imposed a melancholic mutism and had the subject interned, moreover incapable of providing for his needs, which fully justified his admission to an asylum.

OBS. III.[146] — *Hysterical muteness making one believe in melancholic muteness. Heredity.*

Pa..., Paul-Emile, fifty-eight years old, nurse, entered the Ste-Anne asylum on February 21, 1895 (service of Mr. Joffroy).

Father died at forty-two, victim of his dedication to the Angers bridge disaster. He was, it seems, sober and in good health. Mother died at forty-eight years old, from a heart condition (?). On the maternal side, we find two cases of cerebral affections? The grandfather died of dementia at the age of seventy and the grandmother died of general paralysis. A brother died at the age of thirty-two from general paralysis. Another brother, who died in Senegal at the age of twenty-three, had seizures during his early childhood.

At ten years old: typhoid fever. At nineteen: intermittent fevers in Africa.

The onset of the present nervous affection dates back to the age of forty-four. Following great mental and material pain (his wife had left him, taking everything he owned and leaving him in complete destitution), he had his first attack of hysteria, with a sensation of a lump, a tightness in the throat, a throbbing in the temples, a loss of consciousness, and clonic seizures. When he came to, he could no longer speak, although he made himself understood very well in writing and by gestures. He was transported to the hospital, where his hysterical muteness led to an attack of madness with melancholic ideas and refusal of food; so he was sent to an asylum, where he remained from 1880 to 1884, with bouts of muteness. Then, one day, his speech suddenly returned to him and he began to speak as well as before.

He then left the asylum, resumed his ordinary life, reunited with his wife and, for two years, from 1884 to 1886, **[131]** enjoyed perfect health. Then, again, his wife robs him and leaves him. New attack of hysteria, followed by silence. This time he enters the hospice. After fifteen months, the head of department organized a surprise for him by bringing in his sister-in-law without the patient's knowledge; this unexpected and very pleasant visit immediately brings him out of his silence.

Later, on seven different occasions, he fell ill again following annoyances and recovered under the influence of a happy event.

Currently the muteness is a little less pronounced. He utters a few words after considerable effort; its flow is excessively rapid; he said the following words: “Cha-cot (Charcot), Non (Guinon), moutin (Moutard-Martin); because, I; they have always; look now; and then... yes; what is it; sacred; Ah; no...” — He explains himself very well in writing; he understands perfectly what he reads; he tries to pronounce the written words; thus, we encourage him to read aloud the word “Observation”; he reads:

[146] Part of the observation of this patient was published by Charcot in his Leçons du mardi, 1888, and in M. E. Rabiner's Thesis, Du mutisme et du bégaiement chez les hysteriques. Paris, 1896.

Ob-ser-va-ti-on, slowly, stopping after each syllable and each time taking a deep breath.
Today there is a right-sided sensory-sensory hemi-anesthesia, contrary to what was previously noted. Eye examination (February 25, 1895) showed that the accommodating reflexes were very weak; that there was hyperopia and presbyopia in both eyes equally. He does not recognize faint shades of purple; narrowing of the visual field on each side. No central scotoma. Monocular diplopia on the right. Left patellar reflex normal, the right is very weakened.
In the *heart*: a great irregularity of the heartbeat; no breathing noises; frequent pain in the precordial region. Very persistent left hemicephalalgia.
His *mental state* does not currently appear to be very altered; memory is good; no delusional conceptions or hallucinations.
[132] The causes of melancholic muteness are quite numerous. Sometimes it is excess suffering which seems to produce it; the subject is then prostrate, in one of those great silent pains, such as one experiences after terrible emotions. Other times, it is the hallucinations that bind the subject's language. He hears a voice which says to him: “If you speak, you are dead”; or he witnesses terrible spectacles. Fear and terror suspend his voice, and he remains nailed to his seat, mute and as if petrified. Among these hallucinations, there are some — verbal motor hallucinations — which act according to another mechanism.[147] Stricker remarked that while it was possible to think of two different words using two *different* verbal images, for example one visual and one motor, it could not be done with two motor images. Thus verbal motor hallucinations would prevent speech; because the subject could not use both a group of motor images for his hallucinations and another group for his speech. This would be a cause – uncommon, it must be admitted – of silence among melancholic people.
Finally, a fairly important cause of muteness in melancholia is the erasure of verbal images. The result is a variety of aphasia[148] or rather **[133]** paraphasia. The subject no longer understands, or poorly understands, the meaning of the words he hears pronounced. He has the greatest difficulty coordinating the images which must contribute to understanding. He is therefore and above all a paraphasic. But we also understand that this erasure of verbal images must often have a lot to do with the more or less voluntary muteness of patients. The melancholic is prostrate; on the other hand, he only has at his disposal weak, almost erased verbal motor images. The effort costs him, and he remains silent.
A phenomenon which is similar in its pathogenesis to mutism is *abasia*.[149] Patients cannot walk, although they have retained their muscular strength and can use their muscles for actions other than walking and standing. The patients observed by Charcot and Blocq, who were the first to study this disease, were hysterics. These authors admitted that there was a loss of motor images necessary for walking in them. Mr. Séglas's patient was above all emotional; and the obsession with not being able to walk seemed the proximate cause of the abasia. However, if these emotional abasias can be found in melancholia, it is legitimate to admit that, in this disease, the erasure **[134]**, the weakness of motor images plays a role in the production of astasia-abasia. This is, moreover, a very rare phenomenon, or perhaps little researched.
The refusal of food is a fairly common fact in the history of melancholics. It is observed just as well in anxious forms as in stuporous forms, but more often in the latter. However, in stupor, patients are more docile or more passive and resist less the efforts made by doctors to make them take food by natural or artificial means.
The causes of food refusal are delusions in some cases. The sick believe they are ruined and do not want to eat food that they know they cannot afford. They are, they still say, too criminal to eat; and by

147 Séglas, Leçons cliniques..., works cited, p. 338.
148 Séglas, Les troubles du langage chez les aliénés, p. 100 and following.
149 Blocq, De l'astasie et de l'abasie, Arch. de neurol., 1888, t. XV, p. 24 and 187. — Séglas, Leçons cliniques..., works cited, p. 792 and following.

letting themselves die of hunger, they think they are atoning for their sins. Other times, there are voices that command them to act in this way or that threaten them with the greatest misfortunes if they take food. Sometimes they are afraid of being poisoned. Finally, in certain cases, patients do not want to eat without a very clear reason; they resist in this sort of madness of opposition which characterizes them.

Somatic disorders are generally the basis of these delusions and food refusal. It should be noted that the digestive functions are very **[135]** impaired in melancholic people, who very often refuse to eat simply because they are not hungry, because they have lost the sensation of appetite. This hypothesis — the simplest of all — is sometimes rejected in favor of others that are much more problematic.

The refusal of food by melancholic patients varies in its evolution. Sometimes it sets in quite suddenly, other times it is preceded by a period where the patient's disgust for food becomes progressively more pronounced. First the meat is put aside, then another dish. At certain meals, the patient refrains from touching the dishes. At this moment the sitophobia is constituted and becomes total, absolute. The patient would almost starve himself to death rather than eat. When the subject is with his family, he can stay a few days without accepting anything. The breath becomes fetid, the tongue and lips become covered with soot, the disgust for food increases the longer the abstinence lasts. The patient is thus in a vicious circle. This state of malnutrition, of inanition, is a very favorable basis for the production and aggravation of delusion which in turn can maintain the refusal of food. Sitiophobia is not always constant and sometimes it alternates with phases of gluttony.[150] It would then be the manifestation **[136]** of one of those sudden impulses to which melancholic people are subject.

The sitophobia of melancholics is sometimes quite similar to the sitophobia of hysterics. In both of them the sensation of appetite is lost and the disgust for food absolute. In both of them there can be an undercurrent of sadness, of complete discouragement. When there is delusion, hallucinations revealing a melancholic psychosis, the diagnosis becomes clearer; otherwise it remains uncertain. On the other hand, anorexic hysterics are sometimes melancholics, and then what dominates is no longer the neurosis, but the new psychopathic state which evolves with its own symptoms.

Self-mutilation is common among melancholic people. They manifest in these patients mental pain, which they sometimes try to calm with some very strong physical pain. Some scratch the skin of their foreheads with their nails until they bleed; the others bite their lips; others continually pinch their arms and thighs; still others pull out their hair and beard hairs one by one. Some bang their heads against the wall or against the bar of their bed; a few break their fingers or attempt to remove their genitals. Cases are cited in which patients gouged out their eyes. Mr. Korsakoff reports the observation of a melancholic who pierced his eye with the tip of a needle. **[137]** It should be noted that these self-mutilations are generally only observed in delusional melancholic people who are driven to it by some corresponding morbid conceptions.

Some mutilations have an epidemic nature. We cite a Russian religious sect, the scoptzi, who practice voluntary castration. This self-mutilation was already observed in the first centuries of the Christian era. But this is about collective suicides, which are not always individually linked to a clearly characterized melancholic state.

Suicides are very common during melancholia. They are found in all clinical forms; delusional melancholics and anxious people should especially be monitored from this point of view. Moreover, we must be wary of any patient with a melancholic attitude. Obviously acts of suicide are the expression of thoughts of suicide; and when these manifest themselves, attempts at execution are to be feared. But it happens that patients, who do not seem at all to be prey to thoughts of suicide, kill themselves in an unexpected way.

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[150] Schüle, Traité clinique...., works cited, p. 30.

The causes of suicide are quite varied. Sometimes — most often — it is mental suffering, which, having become unbearable, panics the patient and pushes him to murder himself. And in this regard it is good to recall here that the fear of death — which sometimes manifests itself in an agonizing manner **[138]** — is not at all a guarantee against suicide attempts. It can even grow there.[151] In other cases, it is a particular delusion that causes the impulsions to suicide. A melancholic person wants, by killing himself, to escape the dishonor into which his faults and crimes have plunged him; his death will also be an expiation. He cannot survive the loss of his fortune or his parents. Another rushes into death following a hallucination that commands him to do so.

Suicide attempts are very often timid and then easily hampered in their execution, either because the more or less aboulic subject does not have sufficient will to go through to the end, or because his calculations, which are wrong in some way, have been foiled at the last moment by those around them. However, there are melancholic people who know how to marvelously combine the means of killing themselves and who demonstrate, in the execution of their plan, extraordinary tenacity and courage.

The means that melancholic people use to commit suicide are numerous. They have varied according to the historical period, and still today they vary depending on whether the subjects are free to move or closely monitored. In times of public unrest, some of these patients face danger, seeking in a glorious or, on the contrary, infamous death **[139]** the realization of their greatest desire, which is to no longer live and sometimes to atone for their mistakes. At the time of Roman decadence, under the tyranny of certain emperors, compulsory suicide imposed by an order from the sovereign was carried out with the most complete indifference by the first citizens of the country, many of whom, shaken by the idea of the insecurity of their lives and the loss of their possessions, were probably affected by melancholia.

Later, in the Middle Ages,[152] many melancholic people confessed to demonolatric practices in order to find a death capable of making them atone for crimes and faults that they had only committed in thought. Torture, decapitation, burning at the stake thus became means used by melancholic people to annihilate themselves.

At the moment these doors of suicide are closed. At most, we can accuse ourselves of crimes committed by others and whose culprits are unknown. But these methods are rarely used by melancholic people, if we do not wish to consider as such self-accusing alcoholics, daydreamers and dupes even more than deceivers, who behave quite differently.[153] However, it has happened **[140]** that melancholic people have committed crimes in order to be killed. But these are indirect and exceptional means of suicide. More ordinarily, it is the individual who kills himself.

Each sex has its means. Women hang themselves more willingly, while men prefer sharp weapons and, for example, cut their throats — a delicate maneuver that frequently fails. For hanging, which is often just a simple strangulation, everything is good. Outside a tree, and on a window latch, a nail, the rungs of a ladder, an exposed lead pipe, everything that projects and can hold a tie is used by melancholic people. The link is often a simple rope, a handkerchief, a garter, a scarf. Strangulation is obtained with these objects and in fact frequently replaces the desired hanging. The subject hangs badly; she hits the ground and chokes. There are sick people who try to tighten their necks with the strings of their skirts all day long. Witness one of our patients, who, as soon as she was not supervised, tightened herself with the strings of her skirt or even with her fingers, without however managing to do herself much harm.

Submersion is mainly used, but not especially, by women. It is sometimes used to carry out suicide for two, made fashionable by the famous Chambige. But more often **[141]** — as the latter did —

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151 Nicoulau, Ann. médico-psychol., 1892, t. XV, p. 189.

152 Calmeil, De la folie, works cited.

153 Roubinovitch, On persecutory delusions with self-harm in alcoholism, Annales médico-psychologiques, 1894, t. XX, p. 128.

melancholic lovers who kill themselves use firearms, the revolver for example. In these cases, the man first kills his mistress, then points the gun at himself. But it frequently happens that, either through clumsiness, lack of courage, or providential chance, the weapon fails to have its effect and only slightly injures the lover. In recent times there has been a veritable epidemic of double suicides, some of which have been nothing more than disguised assassinations, carried out by lovers to get rid of troublesome mistresses.

Charcoal poisoning has also been used for double and multiple suicides. We sometimes read in the newspapers of tragedies where a mother suffocated with her children. Often these are dramas of madness. The stove is rarely used by lonely melancholic people.

Poisoning tests with laudanum, chemical matches, are common. All the substances that can be more or less easily obtained are used by melancholic people: copper water, sulfuric acid, morphine, arsenic. Some people have tried to die by becoming deeply intoxicated with rum, absinthe or any other alcoholic beverage. More often alcohol is absorbed as providing the stimulation necessary for suicide to occur. Sometimes it is by taking nothing, no food **[142]**, that melancholic people try to destroy themselves; but they are not usually allowed to go all the way down this path. Others throw themselves from a high place, from a window for example; This is a method of suicide to be feared in an apartment located above the ground floor. Other means, even rarer, have been observed. This is how in the Far East it is customary to cut open the stomach. Besides, it is easy to kill yourself when you have firmly decided to do so. M. Magnan[154] reported the fact of a woman who pierced the top of her heart with a hairpin and died.

M. Tillaux[155] related the fact of a melancholic who had inserted an iron rod 16 centimeters long into the region of the heart; it was not visible at the time of the examination, but it could be felt under the fingers vigorously lifting the skin with each contraction of the heart. The following year, this insane person having succumbed following a new suicide attempt, M. Tillaux noted that the iron rod had passed through the anterior edge of the left lung, the posterior wall of the ventricles, and that it was involved in the right lung.

Suicide is often imitated. There were times, during the period of romanticism, when it **[143]** became truly contagious. Currently, it is rife in certain circles of unbalanced people. It has been said that there were suicide clubs in Russia. Family suicides are most often linked to melancholic delusions; we will have the opportunity to mention them in connection with heredity.

The crimes of melancholic people are quite rare. They can be caught wandering or stealing.

Homicide can be the consequence of thoughts of suicide, as we said above and as proven by a remarkable case observed by Marc.[156] Sometimes it can be caused by a sudden and blind impulse, a paroxysm. Some melancholic people can therefore become dangerous for those around them: they want to kill and they kill, in fact, a member of their family, a friend, etc. It is true to say that this is relatively rare in melancholia, infinitely rarer, for example, than in persecutory delusions. In the latter case, the patient, by killing someone, is convinced that he is destroying an enemy. Quite different is the motive from which the melancholic acts: he kills his children to spare them the misfortunes that await them in life; sometimes also, he kills in a moment of excessive mental pain, in a state of semi-consciousness.

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[154] Magnan, Suicide par blessure du cœur avec une épingle mesurant à peine 3 centimètres de longueur, Bull. de la Soc. de Méd. lég. de France, 1890, t. XI, 2nd part, p. 283.

[155] Tillaux, Traité d'anatomie topographique, 1886, p. 627.

[156] Marc, De la folie..., works cited, 1840, t. II, p. 159 and following.

[144] B. Variable physical symptoms. — We have described the physical symptoms which are part of melancholy, and which appear more or less reinforced or attenuated. Other somatic symptoms relate to the apparent causes of certain varieties of lypemania. In melancholia of alcoholic origin, we encounter the physical signs specific to this particular intoxication, tremors, atheroma, diffuse sclerosis. In melancholic states symptomatic of general paralysis, we can observe ocular and speech disorders, epileptiform and apoplectiform attacks linked to lesions of the brain. But we do not have to dwell on that.

Finally there remain the functional or organic disorders which are sometimes associated with melancholia without being linked to it by a very obvious causal relationship. This is how we quite often observe tuberculosis in melancholic patients. Anorexia, refusal of food, weakening of digestive functions create in patients a favorable environment for the evolution of Koch's bacillus.

It was also believed to be noticed that melancholic people, especially women, were subject to gallstones.

[145] CHAPTER IV

CLINICAL VARIETIES OF MELANCHOLIA

A very considerable number of varieties of melancholia have been described. We do not claim to analyze them all; we will only try to put a little order into these numerous descriptions, reserving to insist on the most important ones.

Melancholic states can be divided into two groups:

1°: Those where we find no visceral lesions, of the brain or another organ, no nutritional disorder capable of explaining more or less well the appearance of psychological disorders. These melancholies occupy, in mental pathology, a place symmetrical to that held, in neurology, by neuroses. Both appear rather functional or – what is more precise – cannot be linked to any specific lesion. **[146]** Also the melancholies of this group can be called melancholia-psychoses.

2° Those where an immediate etiology is very apparent. These include, for example, melancholic states occurring during alcoholism, infections, circumscribed brain lesions. Although the pathogenetic link which unites these mental disorders with these determining factors is still obscure and each psychiatric school interprets it in its own way, granting more or less importance to tangible causes, it is no less obvious that these psychopathies are distinguished from others in this way. We can give them the name of melancholic states or *symptomatic melancholia*.

We will therefore successively study melancholia-psychoses and symptomatic melancholia, — one could say organic. But, by studying the facts closely, we were led to note that the same clinical forms can appear during another more general affection and that then they deserved the epithet of symptomatic; or without the coexistence of other diseases, and that then they could be called essential. As for the somatic disorders which accompany all melancholic states, if they constitute immediate pathogenetic conditions, they nevertheless presuppose more distant causes which escape in these latter cases. Stupor, for example, can arise somewhat spontaneously; but we also observe it **[147]** with all its usual characteristics — except perhaps a shorter duration — in subacute alcoholism.

In order not to redo the description of the forms of melancholia twice, we will content ourselves with giving them first of all and with some details in the first paragraph of this chapter (melancholia-psychoses), reserving to indicate, in connection with the etiology, the variations in appearance and duration that are influenced by an apparent pathogenic element (symptomatic melancholia).

In summary, the psychopathies that we are going to describe under the title of melancholia-psychoses are indeed those which usually occur without a visible link with a pathogenic element, — apart from the somatic conditions which are inseparable from them.

1. MELANCHOLIA-PSYCHOSES.

Melancholia-psychoses can be considered from several points of view.[157] And first, from the point of view of the degree of motor reactions. When the latter are weak or non-existent, we are dealing with depressive melancholia or melancholia with stupor. If, on the contrary, they are very violent, it will be **[148]** anxious melancholia. Between the two lies the *perplexed melancholia* of Lasègue.

[157] The discussion, which took place at the Société Médico-Psychologique (1890) on the varieties of melancholia, shows the number of these points of view and these nosological opinions. Among these, the classification of M. Marandon de Montyel, which is based on etiology, seems to proceed from the fairest principle.

The presence or absence of delusions and hallucinations naturally gives rise to two other varieties: *melancholia without delusions and delusional melancholia* with or without hallucinations. The latter is divided according to the nature of the delusion into several sub-varieties: *hypochondriac melancholia,* often accompanied by ideas of negation, *religious melancholia, demonomaniac*, etc.

If we consider the degree of cohesion of the delusion, we can separately describe the *systematized melancholic delusions* as we understand them in Germany. A division according to the course of the affection separates the following clinical forms: *continuous, remitting and intermittent melancholia*. *Circular madness* is composed, in one of its two elements, of a melancholic state.[158]

A. Melancholies divided according to the degree of motor reaction. — a. *Depressive melancholia*. — Still described under the name simple melancholia, it is characterized by the reduction of biological energy. Sadness is a most striking objective aspect. Sometimes the patient is perfectly aware of his condition, and it has been said that these conscious melancholia are observed especially among **[149]** degenerates. Then impressions coming from the outside world reach the patient only with great difficulty, and he realizes this; in the same way he is aware of the slowness with which his ideas are formed and the impossibility with which he is, most of the time, of deciding to take any action whatsoever.

This triple difficulty of feeling, thinking and acting, which asserts itself as the affection evolves, passivity, the absence of any spontaneity, of any psychological activity manifests itself more and more. There may, at times, be a total shutdown of all ideation processes. Not only the patient's actions, but his words, all his movements become slower and slower, more and more difficult.

All his acts are accomplished with intervals of rest; and it is still necessary to continually stimulate the subject by strong and repeated external excitations. Later, when simple melancholia has reached a greater development, the patient only manifests intentions to act; he can no longer even begin an act. Finally comes the moment when the affection is at its maximum intensity; he is then incapable of making the slightest gesture, of uttering the slightest word. At this degree, passive melancholia forms a sort of transition to a much more serious variety: melancholy with stupor.

But apart from these cases, in which the apparent arrest of **[150]** psychological functions only present themselves in a completely episodic manner, passive melancholia is an affection in which self-consciousness is not deeply affected; it is only invaded by conceptions and images of a sad nature.

In simple melancholia, ideation is difficult, the circle of conceptions is very narrow; but the power of synthesis is not destroyed and the subject can exercise his thought and is the master of it to a certain point. It is this fact which partly differentiates simple melancholia from melancholia with stupor. Indeed, in the latter, it can happen that the patient is in a complete mental darkness. Other times, as Baillarger demonstrated, there is an active delusion resembling a long and restless dream or a toxic delirium, in which poorly or completely unrelated conceptions appear, completely beyond the control of consciousness. The power of synthesis is in this case destroyed, and automatism reigns supreme. However, in passive melancholia the patient retains the ability to control and associate his ideas. He generally combines them in the direction that his mental pain gives them; and he sometimes manages to imagine a real delusion later. Note also that the melancholic can become very agitated, dangerous for himself and for others.

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[158] Our classification is entirely artificial and separates clinical facts which are often mixed; it only has a didactic interest for us.

The form of melancholia that we came from **[151]** describing is the one that is most often observed outside asylums. Here is an example.

OBS. IV. — *Depressive melancholia without delusion.*

M..., consistent, thirty-nine years old, sales representative. (Service of Prof. Joffroy, in Ste-Anne.)

Mother died at twenty-five, during a nervous illness? Father was found drowned at fifty-five years old. He was a drinker who very often got into binge drinking.

Poor health; at fifteen, scarlet fever. At school, he was a mediocre and undisciplined student. Later, in all the positions he occupies, he needs to make considerable intellectual efforts to maintain his position. So he was always convinced that he could never achieve anything. For six or seven years, he has suffered from pseudomembranous enteritis, and this for periods of two or three weeks per month; he then has six or seven mucus-like stools per day, then he becomes very constipated.

For about three months the patient has been unable to do any work. At the same time, he blames himself for this inactivity. He spends his days without moving, gloomy, staring, crying at times. His wife often tries to get him out of this depression with all kinds of affectionate words. From time to time he replies: "It's true everything you tell me, and I can't get out of there." The more she insists, the more her discouragement increases. He then declares that he wants to end it, to disappear: "I cannot remain in your care, we can no longer get along, I must die."

Whole days pass like this. His wife has to get him out of bed, otherwise he would stay there continuously. He resists everything we want to make him do, always repeating: "There is nothing more to do." He often hides in the corners of the room where he would like to be left. He refuses all food and puts up strong resistance to his wife who tries **[152]** to feed him with a spoon. She often finds him with his arms crossed, his head leaning heavily on his chest. At times, he suddenly starts walking with jerky steps, hitting his temples several times and very hard. "I am unworthy," he said, "incapable." Other times he says "that he should stay in bed all the time or in a corner so that no one sees him; because he is a contemptible being."

Physical symptoms. Tongue covered with a thick, whitish coating. Constipation and diarrhea, alternately. The temperature generally varies between 36° and 36.4°. The pulse is small, tight, there are sixty beats per minute. The dynamometer marks on average:

M. D. 14,

M. G. 11.

Towards the end of the third month, very rapid improvement began one evening. The next day he set to work, which he has carried out ever since with as much ease as before.

b. Melancholy with stupor.— It frequently develops as a result of passive melancholia, of which it is only an exaggeration. For three, four months, the individual is moderately depressed; then the slowing down of psychological processes reaches its maximum intensity, and the patient falls into a sort of torpor which forces him to complete immobility for days and even weeks. In this period he looks like a real statue. The face loses all expression, the look is vague; sometimes with a half-open mouth **[153]** lets the saliva flow, mucus comes out of the nose without the patient trying to blow their nose.

The extremities are cold, cyanotic, the arms hang along the body like the sleeves of a jacket, clothes are messy; often the patient urinates and lets out his excrement without moving. It takes vigorous intervention to force him to be toilet trained. Even more often he does not ask for food; he can even refuse any food when it is presented to him ready to swallow, and many times we are obliged to resort to feeding through a tube. The patient does not generally exert active resistance when we want to make him change position; he mainly opposes the force of inertia. His body and limbs keep the

behavior given to them for more or less time.

We cannot repeat, regarding the description of each clinical variety, the physical symptomatology that we exposed in the previous chapter. We will only recall, with regard to the stuporous and the anxious, the main physical characteristics that we have observed in these two different types of melancholics. It is among the stuporous that we can most clearly observe the phenomena of arrest: slowing and low amplitude of breathing, slowing of circulation with hypothermia and cyanosis of the extremities, slowness and weakness of the pulse, reduction of **[154]** weight and dynamometric force, hypoxia.

All these phenomena are also found in non-melancholic stupor, which clearly proves that what characterizes all these clinical forms is the suppression of psycho-physical functions; stopping brain processes would somehow paralyze all functions. However, there are stuporous melancholic people who seem, at certain moments, different from those we have just chosen as examples. Their breathing is accelerated and full, sometimes trembling as in anxious people; traffic is more active; the pulse, of normal or exaggerated tension, is frequent. We can then wonder if, as we have sometimes observed, there is not, under the stuporous appearance of these patients, an active delusion, which, like any intense cerebral work, would influence, by exaggerating it, circulatory and respiratory movements.

From a psychological point of view, the feeling of helplessness is pushed to its extreme limit in the stuporous. And as, on the other hand, the emotional and affective disorder is also at its maximum, it is around these two pivots, complete helplessness and infinite sadness, that the psychological state of the melancholic evolves with stupor. Schüle says that "melancholia with stupor is the pinnacle of inhibitory phenomena". This formula sums up all **[155]** the symptoms that we observe in this serious form of melancholia and that we have already listed.

Such a psychological state constitutes one of the most favorable grounds for the emergence of catalepsy. We cannot better understand this than by studying the movement disorders which, in melancholia with stupor, develop in parallel with mental disorders. In the light forms of this variety, the position is slumped, the movements are slow, heavy, as if hampered by invisible ties, the walk is dragging, the feet seem to have difficulty in lifting themselves from the ground. The voice is low, sometimes muted, as if strangled, the speech excessively rare, remarkably slow and monotonous.

In severe forms of melancholia with stupor the patients maintain, as we have said, an almost absolute immobility. They no longer feel the need to rest certain muscles and contract new ones; and they seem to fear above all spontaneous activity, effort.

The annihilation of the ideomotor synthesis dominates in them. "Mental synthesis, says M. G. Dumas[159] could take place in the field of ideas, but the ideomotor phenomena are inhibited by the representation of the fact to be accomplished, and the event is**[156]** not accomplished." In some cases we can accuse emotional disorders of being the generators of this stopping action. If these patients cannot will, it is because the slowdown in ideation is so great that they no longer conceive of projects. And when a project is conceived, he is too weak to awaken a desire capable of leading to an action. What is therefore admissible is that the motor images are too weak to cause a movement. Same disorder, same annihilation of emotional feelings. The indifference of the melancholic with stupor is well known clinically. The sight of their family members, their children, all the beings who were once dear to them, is no longer pleasant to them.

Sensitivity disorders are very common in melancholia with stupor. Anesthesias are numerous and varied. Sometimes analgesia can be observed. Sensitivity is especially altered, perceptual disturbances are constant. In fact, all operations, which require voluntary effort, activity, attention, no

[159] Dumas, Les états intellectuels de la mélancolie, 1895, p. 43.

longer exist, so to speak, among the melancholic with stupor. They only have to use a few distorted sensations, which easily transform into delusional conceptions.

Their psychological disorders explain how these patients can maintain prolonged immobility and uncomfortable positions. They feel the **[157]** pain passively, probably worse than normal; their cerebral torpor does not allow them to perceive it clearly and to localize it well. It is likely that they feel a general weariness, that they have a vague notion of fatigue. But it is impossible for them to make the mental effort sufficient to relate the various elements of this fatigue to its true cause. Can the stuporous person change the position he has been given and the degree of contraction his muscles have taken? To do this, he would have to bring his voluntary activity into play in order to stop the contraction of a certain number of muscles. However, his psycho-motor centers are in such a state of inertia that he cannot accomplish this effort. He therefore keeps the position that was imposed on him. He leaves his arm in the given position until his muscles are exhausted; the arm then falls little by little with a slight tremor. His motor apparatus therefore operated automatically; it was quite impossible for him to actively intervene, to resist, to bring about any change in the imposed attitudes. Sometimes we observe in melancholic patients with amazement the coexistence of a very intense delirium with these disturbances of perception and this motor abulia.

These patients usually recover, and it is interesting to ask them about what they felt during their illness. Everyone most often tells **[158]** a similar story. They lived in a world apart, like in a dream. External impressions had virtually no influence on them. They only had a very limited number of ideas, and it was especially difficult for them to produce new ones. These ideas absorbed them, held them like true obsessions. Often they had hallucinations, which had connections with the ideas which occupied the field of their consciousness. In certain cases — very rare, it is true — a single idea constantly predominates; also its intensity takes on unusual proportions.

As in simple melancholia, the mental state then recalls to a certain extent the dream state; but here it is a nightmare that the patient would like to get rid of without ever being able to do so. He finds himself torn from real life and transported into an imaginary, fantastic world, which provokes continual impressions of terror.

Esquirol[160] relates the following response from a patient of this type who had recovered: “My laziness resulted from the fact that my sensations, my impressions were too weak to have any influence on my will.”

In some cases,[161] the sick come out from time **[159]** to time of this mental and physical torpor, they begin to speak and walk; it lasts half an hour, an hour, then they fall back into their dream. Frésé,[162] from Kiev, relates the following fact. A melancholic was astonished to see the number of his mental representations gradually diminish; after six to eight months he had only one idea left: that he found himself placed on the summit of a cone; around him an immense and bottomless abyss; the slightest movement could compromise his balance and throw him into the abyss. So he made every effort not to move. When someone approached him, his terror was immense, so much did he fear losing his balance. Now it happened that one day, during the visit, the patient suddenly began to laugh out loud, to leave his usual place and to speak volubly. Asked about the cause of his cheerfulness, he replied: “Just now, finding myself on the summit of the cone, I saw a prodigious number of dwarves and monstrous and grotesque beings appear; They engaged in such a funny dance and such extravagant somersaults that I couldn't help but laugh.” Half an hour later, the patient fell back into his usual stupor which never left him until his death.

Melancholia with stupor reminds some of **[160]** external features of certain forms of dementia and

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[160] Esquirol, Traité des maladies mentales, t. II, p. 238.
[161] P. J. Kovalevsky, Psychiatrie, 1887, vol. II, p. 9.
[162] Frésé, in Kovalevsky, Psychiatrie, works cited, p. 100.

varieties of stupor not linked to lypemania. We are therefore led to present some ideas concerning differential diagnosis.

The state known as stupor has always been observed in mental pathology. In some cases it appeared isolated, in others on the contrary as a symptom occurring during an affection such as melancholia, alcoholic delirium, epilepsy, hysteria, etc. The stupor had different names, depending on the cases in which it was observed and the authors who described it. Esquirol[163] had studied a variety, acute dementia. Georget[164] and Etoc-Demazy[165] understood some of these facts in the group of *stupidity*. For these authors and for a few others who accepted their opinion, notably Scipion Pinel and Calmeil, stupidity was mainly characterized by the suspension of thought; it constituted an independent morbid form, which could complicate other psychological afflictions.

Or, Baillarger[166] tried to show, in 1843, that stupor was ordinarily associated with melancholia, of which it was a symptomatic expression, **[161]** and was accompanied by very intense delusion of a distressing nature. This memoir had a great impact among alienists, most of whom, except a few, including Delasiauve[167] and Dagonet,[168] admire the conclusions. The stupor was always melancholia.

In recent times, and following work by M. Chaslin[169] on mental confusion, one of the clinical aspects of which is stupor, the question was raised again, and the memoirs on this question became very numerous in recent years; we will find the analysis and bibliography in a book by M. Chaslin.[170]

We currently tend to consider stupor, if not as a morbid entity, at least as a particular clinical syndrome which can appear during various mental illnesses and not only in melancholia. When this syndrome manifests itself in isolation it is idiopathic stupor; when it occurs in other conditions such as melancholia, mental confusion, epilepsy, etc., it is deuteropathic or symptomatic stupor.

[162] In Germany,[171] Binswager[172] divides idiopathic stupor into two varieties — stupor proper and acute dementia. Schülel[173] rises against such a way of considering stupor and stands by the division exposed above.

For us, we are inclined to admit the existence of stupor syndrome independently of melancholia. In our opinion, what characterizes stupor is the psychological decline which can go as far as complete cessation. Whenever its somatic conditions are given this mental state appears. Now they are frequently encountered in melancholia; and this is why stupor is often observed there. There, it usually manifests itself with delusional conceptions related to the coenesthetic state; but it is certain that it can, when the psychological decline is pushed very far, present itself with a complete suspension of thought and not be masked by any delusion. It is equally certain that stupor can appear apart from melancholia. What led us to believe the opposite is that the behavior of the subjects, whose psychological processes are very slowed down, is very close to that of the lypemaniacs. Following a concussion **[163]** or acute intoxication, stupor can occur suddenly and not be accompanied by any feeling of mental pain which allows it to be legitimately linked to melancholia.

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163 Esquirol, works cited, t. II, p. 239.
164 George, De la folie, 1820.
165 Etoc-Demazy, De la stupidité considérée chez les aliénés, research done at Bicêtre and at Salpêtrière, th. Paris, 1833.
166 Baillarger, De L'état désigné chez les aliénés sous le nom de stupidité, works cited.
167 Delasiauve, Du diagnostic différentiel de la lypémanie, Ann. méd.-psych., 1831, t. 111, p. 380.
168 Dagonet, De la stupeur dans les maladies mentales, 1872.
169 Chaslin, La confusion mentale primitive, Ann. méd.- psych., 1892, t. XVI, p. 225.
170 Id., ibid., 1895. — Ed. Toulouse, Gazette des hôpit., 1893, p. 153. — Marandon de Montyel, Gazette hebdomad., 1897.
171 Roubinovitch, Des variétés cliniques de la folie en France et en Allemagne, 1896, p. 110 and following.
172 Binswager, Charité, Annalen, VI, Jalirganz, p. 25.
173 Schüle, Allgem. Zeitschr. für Psych., Bd. XXXVIII, 1882.

Can we go further and objectively differentiate delusional stupor, which would more likely belong to melancholia, from the other, non-delirious stupor? It seems that the capillary pulse of the fingers would be related to cerebral excitation and that it would be missing in the case of psychological decline. Theoretically, stuporous people with active delusion should therefore have a more or less pronounced capillary pulse, which would be very weak or non-existent in other stuporous people, with simple psychological decline. But our research does not allow us to answer affirmatively to this question, the solution of which would, we understand, be very important from the diagnostic point of view.

Catatonie is a clinical modality of melancholia with stupor. It was first in 1868, at the Congress of German Physicians and Naturalists in Innsbruck, and later in 1874, that Kahlbaum[174] described under the name catatonia a morbid variety characterized on the one hand by a cyclical evolution of five phases and on the other hand by **[164]** motor disorders with phenomena of muscular stiffness. In the thinking of this alienist, catatonia must constitute a sort of mental pathology counterpart to general paralysis and, like the latter, included motor symptoms closely linked to manifestations of a psychological nature. But this is only a purely external resemblance.

The five stages of catatonia would be as follows: melancholic depression, manic excitement, catatonic period itself, consisting of a state similar to that of melancholia with stupor, period of intermittent madness and finally dementia. We will only say a few words about the catatonic period itself or, as Kahlbaum calls it, the stage of *Attonität*.

We can characterize this state by saying that it is a great depression with decline of all psychological functions. The sick refuse to respond, to eat, to make any movement; and some manifest ideas of negation. Some patients present, in this phase of stupor, a tendency to adopt stereotypical attitudes or to always make the same grimaces. One of the most important symptoms of this period is the cataleptoid state of the muscles. In a few, choreiform or epileptiform convulsions and tetany may also be observed.

[165] Patients go weeks and months without speaking. Their face is remarkable for the tension of the muscles: the lips are tight, the eyes closed, the chin pressed firmly against the chest; in a word, the entire facial musculature is in a state of very pronounced tonic stiffness. The arms are in forced flexion or extension, and when we try to get the patient out of his state, we provoke considerable resistance. Sometimes, after several hours of this immobility, the patient gets up suddenly, takes a few steps in the room, eats, urinates, then lays down again and resumes his stiff positioning. From time to time, in the midst of silent apathy with refusal of food, muscular stiffness or céréeuse flexibility of the limbs, we see the patient smile or have a small bout of agitation, for example when he is under the influence of hallucinations or numerous delusional conceptions. This is the main phase of Kahlbaum's catatonia. Alternating catatonia was observed by Nacke[175] who admits that mental alternatives would be related to vasomotor modifications (anemia and hyperemia).

For us catatonia is not a morbid entity; it is a syndrome often associated with stupor, and which can be observed in all cases where **[166]** the latter is observed. It is frequent in the hypnotic state, among hysterics, where it is called catalepsie, and we can meet it in all the essential and symptomatic melancholic states,[176] for example during subacute alcoholism. The pathogenesis must be sought in the psychological decline, as we said above.

Here is an example of melancholia with stupor and catatonic phenomena.

OBS. V. — *-Melancholic stupor with active delusion and catatonia.*

Sa... Jean, twenty-five years old, accountant, entered March 23, 1895, at the Ste-Anne asylum. (Service

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[174] Kahlbaum, Klinische Abhandlungers über psyschische Krankeiten, I, Heft. Die Katatonie, Berlin, 1874. — Roubinovitch, Des variétés cliniques de la folie..., works cited, p. 158 and following.

[175] Nacke, Allgemiene Zeitschrift für Psychiatrie, t. L, p. 630.

[176] Le Maître, Contribution à l'étude des états cataleptiques dans les maladies mentales, th. Paris, 1895.

of Prof. Joffroy.)

Father, sixty-five years old, in good health; mother, fifty-eight years old, in good health; sister a little nervous(?). No venereal excesses; but some alcoholic excesses. He really liked alcohol, “which gave him ideas”, but which he tolerated very badly, quickly becoming tipsy. During the six months preceding his internment, mental overwork. In the last week, his conversations revolved almost exclusively on God and mystical subjects.

When he arrived at the asylum, he seemed plunged into a state of melancholia. Dejected, sad, with contracted features, he has a characteristic physiognomy. He seems very fearful and does not lend himself well to medical examinations. Then all of a sudden he has a fit of excitement; he undresses completely and declares that he is neither man nor woman. He then starts shouting that he has the face of a donkey and rushes **[167]** his head against the wall saying he wants to break it. After this bout of agitation, he has slight epistaxis. The next morning, he is still agitated and asks for straw to eat.

Shortly after, he fell back into a state of melancholic depression where he remained for several months. The facial expression expresses sadness, the look is fixed, ecstatic, he does not usually respond to the questions asked of him. However, when we obtain a few words, they betray his melancholic delusion and above all manifest ideas of self-accusation. For example, here is what he says:

“I am hopelessly lost. I lost everything because of me. All I have to do is bow and hold out my head to the ax. I do not count ; I am a human wreck.”

On March 5, 1895, the patient seemed like an automaton. If he is asked to walk, he takes a certain number of steps, then he stops when he thinks he has carried out the order. He responds by signs to the questions asked of him. He presents symptoms of catatonia and his limbs maintain the position given to them for several minutes. Sometimes he also imitates the positions that we take in front of him. The cutaneous plantar, cremasteric and corneal reflexes are energetic, but the patellar reflexes are diminished; no reaction to pinching; no pharyngeal reflex. We feed him through a tube without any difficulty. He gets up spontaneously to have a bowel movement, but urinates beneath himself. Sometimes he cries at night; during the day, he neither speaks nor moves. He lost a lot of weight. Breathing is shallow and slow, his pulse is usually slowed and contracted, his temperature is normal, leaning towards hypothermia.

Mars 1896. Persistent catatonia, tube feeding, resistance when fed. Five days ago, he had an attack of manic overexcitement with screams lasting a few minutes. Mutism, refusal of food, indulgence, frequent epistaxis. The pupils are equal, sensitive **[168]** to light, but react lazily to accommodation.

May 7 at noon, he watched the other patients eat. The guard asked him if he wanted to eat; he then replied in the affirmative, and he had a good meal. He drank milk at three in the afternoon. Questioned about the causes of his silence and his refusal of food, Sa... replied that it was so because he was afraid and had lost all will: at times voices forbade him to act. He heard various voices, those of God and the devil, those of his parents, his friends, some said pleasant things to him (but rarely), others insulted him: “Pig! Bastard! » He did not know how to decide between contrary orders; it scared him and prevented him from speaking and eating. He believes that he is not master of his person, that he is commanded by the unknown and by God. He saw balls of fire, flames, a fire-headed rooster, dogs, men, women (his parents, his friends), and also God and the devil. All this only increased his anxiety. This morning he felt he could speak and he talked. He complained of having a heavy head and feeling like a vampire was crushing his forehead. Catatonia persists despite the patient's state of semi-consciousness.

May 8, 1896. The patient continues to speak and eat regularly.

July 2nd. Melancholic attitude, catatonia with *flexibilitas cerea*; only responds with gestures or monosyllables to questions addressed to him.

Q. Where are you suffering?

A. The patient does not say a word, but points to the head with his right hand.

Q. Do you hear voices in your ears?

A. (Affirmative sign.)

Q. Pleasant voices?

A. (Negative sign.)

Q. Unpleasant voices?

A. (Affirmative sign.)

[169] Q. Who is talking to you?

A. (No response, no gestures.)

Q. Do you still see globules of fire?

A. (Negative sign.)

The patient does not lend himself to questioning and responses through mimicry.

No reaction to pinching or stinging.

Good intake of food; the patient has gained considerable weight since eating alone for some time. In the ward, the patient appears very passive; he behaves spontaneously to satisfy all needs: appetite, urination, defecation; he draws happily, reads a lot and writes easily.

Here is a letter from the patient which is characteristic of his melancholic delusion. It is addressed to a friend of his and was written on June 1, 1896, in a period of relative improvement.

“My dear R...,

“I am writing to you on the advice of my sister who gives me your address. I have to apologize to you for not having responded to certain death notices that I received at the office.

“I don’t know what death is, and what pain comes with losing a loved one. Having received throughout my life only rebuffs from my parents as well as from strangers, exposed more than ever to the wickedness of men as well as those who do not forgive. But the fact remains that if, by chance, the relative whose death you announced to me suffered what I have suffered for a year and three months in this hospice, the rest of the grave is worth a hundred times better for him. Why am I in his place! Or rather that I was never born! Today I bear the responsibility for having been brought into the world. But if there were divine justice in the absence of human justice, it would be my parents who would be the first to be punished, my mother especially.

[170] “I would be very grateful to you if you knew of some poison with a devastating effect that would take you from life to death without you feeling anything, because of the too great speed with which it would act, so as not to forget me.

“I suffer too much in this hospital, both physically and morally. An entire system of “Terror” is organized against me; and in addition to the burns and insomnia (I no longer sleep since my internment, the little rest I take is haunted by nightmares and I am suddenly awakened by terrible visions, lightning, thunder, etc.), the fear, the depressing fear, atrocious, grips me constantly, never leaves me. What an ordeal I am going through! What a cross I bear! Where is the justice in all this? Did I deserve this excess severity?

“My sister told me that my cousin would take me to T... with him, to spend quite a long time. She added that she would find a place for me after my recovery... In short, I don't know what to think anymore, and

crazy I was, crazy I stay. If I leave Sainte-Anne, what will happen to me, and what terrible events still await me? In what forms will fear crush me? Ah! I am much to be pitied, I assure you. I only ask to die, and to achieve this goal I don't know how to go about it.

“How much I would be indebted to anyone who took my life away! Eating, drinking, not sleeping, suffering incessantly, going to the bathroom, the beautiful gift left by my mother!

“I thought this would all have an ending here, happy or unhappy. But no, it seems, according to my sister, that it's all starting again. I am obliged to bow. " The reason of the strongest is always the best. What I don't understand much is the abuse of force. There are limits to everything, as well as a happy medium. God knows no more limits than middle ground. I say God. For what? So far I have only seen the devil. Besides, I have as much fear of God as of the devil, which makes me drift, **[171]** like a helpless boat, haunted by thoughts of suicide, without having the courage or the means to carry them out. Then nothing tells me that the known means of destruction lead to complete annihilation, the eternal sleep. So I leave it to time, crying and suffering in vain.

“You will have no difficulty, reading my letter, in ascertaining my madness. The inconsistency of style and ideas is quite accentuated. I realize this myself. But I cannot help being mad or stupid; and in the circumstances, from whom should we implore pity? Ah! do away with the hand that tortures, to then appear to console! I like open battles and I don't care if I succumb in the fight, but at least the enemy shows himself. What merit has an assassin to plant a dagger in your back while you sleep! I am defenseless against the invisible enemy who surrounds me with his nets; I would not be better armed when I saw him or had seen him; but let him kill me, what the hell!

"Death ! once for all.

“I will stop myself. It's quite unreasonable, I say unreasonable since I can no longer do otherwise, no longer having reason or brain.

“Ah! God, what a misfortune to be born! born in spite of oneself! born like a mushroom, no doubt, from evening to morning, and as I was right, when in philosophy I was brooding with the pessimists. Yes, there is more pain than joy in life, it is a long agony before the grave.

“Judge what gaiety fills my soul, and when I think that this terrible sadness, complicated by a nameless fear, can last 50, 100 years, perhaps more, what do I know? (Methuselah would have lived 900 years according to the Bible.) I rebel against the injustice of fate. Do you think that these are not strong enough reasons for suicide?

“I wish you the peace and tranquility that I lack, and may the name of your street carry me **[172]** happiness! There's the Eumenides almost and I believe that the Eumenides were benevolent Greek goddesses, unless they were the famous vengeful Furies. But these were, I believe, the Erynnies. Am I wrong? I don't have the house number where you are staying. Remember to give me your exact and complete address and if you wish, let's stay in touch. It's a way of not losing sight of each other. V.... would be in Douai, it seems. Can you give me some news?

“Good handshake.”

The course of the different forms of depressive melancholia varies according to the causes which provoked them and according to the intensity of the symptoms which compose them and finally according to the terrain on which they evolve. In mild forms of simple melancholia, in those, for example, occurring following an infectious disease, the mental disorders can disappear quite quickly, after three or four months, — especially if the subject is subject to a healthy and abundant diet and if you manage to improve your general nutrition. In other cases, and especially in melancholia with stupor, the affection can last a year and beyond. By interviewing certain patients suffering from

depressive melancholia, it is not uncommon to learn that they have had, at different periods of their life, small attacks of melancholia. These attacks lasted a few days, a week or two, then disappeared without apparently leaving a trace. Their intensity was often not very pronounced and, in most cases, **[173]** they seemed linked to alterations in the coenesthetic state occurring under the influence of physical ailment or grief. These small attacks generally go unnoticed; we only attach importance to them later, when we find ourselves in the presence of a great attack with all the symptoms of melancholia.

The progress of depressive melancholia is, in short, uneven. It proceeds in ups and downs, the patient sometimes showing signs of a beginning improvement, sometimes, on the contrary, those of a worsening. It is especially at the beginning and at the end of the illness that we observe these oscillations and in particular these aggravations which are very often accompanied by corresponding modifications in the physical state (constipation, insomnia, etc.). But does this coincidence indicate that physical disorders are the cause of mental disorders or that both kinds of accidents are determined by a more general cause, analogous to this vaso-constriction which we consider as one of the conditions of psychological suffering? This latter opinion is more likely.

The ending of passive melancholia is also very variable. The most common is healing.

***Sometimes also the affection transforms into agitated melancholy or even dementia in people with weak nervous systems, and particularly in **[174]** adolescents. This phenomenon is only observed in certain varieties of intermittent madness. But what is more common are attacks of agitation which interrupt the development of melancholia. MM. Voisin and Burlureaux[177] studied the existing relationships between melancholia and general paralysis. In the cases they cited it is most often the symptomatic melancholia of the first period of general paralysis; other times it is a question of individuals who have had an attack of melancholia and who, later, become general paralytics, but without it being possible to clearly establish a cause and effect link between the two affections. Mr. Ballet recently drew attention to these facts.

Death can finally occur either due to the deep exhaustion into which the melancholic often falls, or also by suicide.

In short, the prognosis for depressive melancholia, considered as a whole, is rather favorable. But the prognosis becomes worse when the condition persists beyond a year or eighteen months. Anatomical alterations, notably the atrophy of the nervous elements, do not take long to occur in the cerebral cortex; improvement and even more so complete recovery then become more and more improbable.

[175] *c. Perplexed melancholia.* —This form of melancholia is essentially characterized, according to Lasègue[178] by the weakening of the will; the sick, incapable of making any decision, spend their time in a sort of lazy sadness, from which they cannot escape. Obsession also seems to be, in some of these cases, the dominant element.

Here is an example given by Lasègue: “X... has just retired, his fortune made; his apparent taste often expressed is to retire to the countryside, he is offered to buy a large property in accordance with his situation, with the habits he has adopted or which he intends to adopt. He goes to visit the terrain, examines it like a connoisseur and returns enchanted. The enthusiasm is almost excessive, it does not last long; and only a few days have passed when anxiety gives way to a contentment that skillful observers would have already declared incorrect. Is the acquisition appropriate or not? What are its disadvantages and benefits? Deliberation, which presents itself less in the form of a dilemma than in that of a sort of mental seesaw, gradually takes on the characteristics of obsession, but obsession is, in mental pathology, considerable and barely studied.”

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[177] Voisin and Burlureaux, De la mélancolie dans ses rapports avec la paralysie générale, Paris, 1880.

[178] Lasègue, Perplexed melancholy (1881), in Études médicales, works cited, t. I, p. 703.

Since the time when Lasègue wrote, obsession has been the subject of considerable work, notably **[176]** by Mr. Magnan. Also currently we would be less embarrassed to classify these cases of perplexed melancholia of Lasègue, which are melancholies with obsessions, as we observe in certain emotional or degenerate people.

d. Anxious melancholia. — It can occur after a period of depression. Other times the onset of this variety is manifested by a change in the character of the individual who becomes sad, irritable and quite abnormally sensitive. Attributing the cause of his bad mood to his own faults, he accumulates within himself a real hatred against his personality. The more he examines the details of his previous life, the more he finds evidence of his guilt or unworthiness. As the affection develops, the patient becomes agitated in the circle of a small number of painful ideas, usually self-accusing.

Sensitivity disorders then provide new materials to consolidate this mental state. First in his dreams, and later in his waking state, he hears insults, taunts, reproaches and threats. Day and night, and for weeks, the same hallucinations appear, the patient always hearing the same reproach, the same insult. We understand how he is led to sometimes become dangerous for himself and for others.

[177] The number of ideas is very limited for him; but, contrary to what occurs among passive melancholics, a very great activity reigns in the narrow circle of his monotonous conceptions. It manifests itself through the incessant repetition of the same complaints, the same accusations. Every day, for months, the patient approaches you, explaining with great volubility the two or three misdeeds he blames himself for, the punishment he deserves, the punishment he fears. His delusion gradually becomes systematized with the help of illusions and hallucinations.

Things often happen like this. A banal event, which, in other circumstances, would not have aroused his attention, on the contrary greatly worries the patient. He thinks about it continually; he is obsessed with it. A lady Do... remembers that she once had a miscarriage. This memory haunts her. Her dreams are filled with painful visions of children having their throats slit. Her anxiety increases, and one fine day she tells herself that she must have had an abortion, that this miscarriage is a very bad thing. She is therefore a criminal; it must be cut into pieces, etc.

If, at these times, a visual hallucination occurs, it will be related to the patient's delusional preoccupations. He will see the guillotine ready to operate, he will hear the toll announcing his death. Then his agitation will be extreme. He**[178]** begs to be saved; he laments, begs for forgiveness.

The nature of the delusion also varies with the education, level of education and social condition of the patient. At the same time as he very loudly manifests his melancholic delusion, he is constantly in motion. He roams his room in all directions and, when he is free, he wanders off aimlessly, simply to satisfy this imperative need to change places, to move continually. German authors gave these melancholic wanderers the name of melancholia errabunda.

In moments of great anxiety the patient pulls his fingers, tears his hair, scratches his forehead, cheeks, neck, chest, tears his clothes. Sometimes there is a sort of explosion of fury against himself or others. During these melancholic paroxysms he is capable of committing the most dangerous acts: ransacking the furniture, setting fires, tearing out his eyes, ears, genitals, destroying himself, hitting and even killing the first person who comes along his scope. He commits all these acts in a disorderly and impulsive manner.

The anxious melancholic often presents himself, even outside of these attacks, with a red, swollen face. His contracted features express strong irritation, great discontent. The eyes are bright; they are mobile because of the**[179]** permanent worry in which the patient lives (obs. 13). Speech is rapid, broken; the tone of the voice plaintive, but much louder

than in the passive melancholic. The patient often has traces of scratches and bruises on his face, neck, hands, and other parts of his body. We have already insisted on his general attitude and noted the impossibility**[180]** in which he is to remain still for a moment.

Let us recall in a few lines the main physical characteristics that we noted in the previous chapter among anxious melancholics. The appetite is very diminished; and the patient sometimes deprives himself of eating in the hope of hastening his death. Constipation is, so to speak, the rule. Breathing is often more frequent than normal, sometimes superficial and then with periodic deep inspirations; we observe, at the time of paroxysms, a sharper, more irregular curve, indicating anxiety. Circulation is often more active, with normal or

Fig. 13 — Anxious melancholia.

slightly above average temperature during periods of excitement; the pulse is more or less rapid, sometimes simply normal. Apart from paroxysms, the sick can present, like the stuporous, functional disorders rather by default.

During the paroxysms of which we have spoken the patient resembles an excited maniac, and from this point of view there are many diagnostic errors made by doctors with little experience. The act of the maniac is the consequence of a need to expend a continuous excess of strength, while the act of the melancholic is the reaction to an excessively painful state of consciousness, it is, for example, a paroxysm which from time to time comes to cut the monotony of the illness. Between these**[181]** explosions of anxiety, patients present a calm which is only apparent and which one must be wary of. Let us not forget that their mental activity, while manifesting itself in a very limited circle of ideas, can be quite great. From one moment to the next they can, under the influence of some delusional conception, move from idea to action.

The duration of anxious melancholia is longer than that of depressive melancholia; healing is possible, although more difficult to obtain. Another ending which is not rare, especially among old people, is the secondary weakening of the mental faculties.

You should know that anxious people can fall into a state of stupor and vice versa. On the other hand, anxious people in a state of paroxysms are very different from how they are in a calm phase. The combination of all these elements makes the clinical facts very complex and explains the apparent contradiction that one can encounter, in the same subjects, in the research of physical phenomena as variable as those of respiration and pulse.

This is an example of anxious melancholia with multiple delusions.

OBS. VI. — - *Hereditary anxious melancholia with multiple delusions.*

Mme Col..., Augustine, 34 years old, florist, entered the Ste-Anne asylum on February 15, 1894 (service of Mr. Joffroy).

[182] Father died at sixty-eight of pneumonia. Living mother, aged seventy-three years; she was an excessively nervous woman, prone to violent anger and without serious motives. Sister died at nine months of convulsions. Brother died at nine years of meningitis. Sister aged thirty-seven, very emotional, subject to loss of consciousness. Brother aged forty-one, suffering from strabismus, following convulsions.

Born full term. Has always been very emotional. At eighteen, following setbacks in her business affairs, she had an attack of melancholic depression. She was sad, “her head seemed disturbed”; she

experienced the sensation of “being sunk in a hole”. This first attack lasted three months. Around the age of twenty-five, she presented a similar attack. At the age of twenty-seven she had an abortion by a midwife; the reality of this fact is confirmed by the information provided by the patient's sister.

The psychological symptoms began in 1892 with a long period of abulia. During this period, it seemed to her that she no longer knew anything, that her hands were working, but that her mind “was no longer there”. Everything seemed funny to her; she could no longer talk. Then towards the end of November 1893, this state of abulia was complicated by symptoms of melancholia.

On December 2, she was placed in a nursing home, where we noted phenomena of visceral anesthesia (she no longer had "organization" in her head), ideas of negation (she no longer had a heart, she no longer felt any emotions), phenomena of abulia which she expressed thus: “I would like to, I can't”, very strong anxiety especially in the morning, refusal of food, attempts at strangulation, ideas of guilt, etc.

On February 15, 1894, she entered the asylum where her condition remained stable for a long time.

Ideas of negation : “I have a false head,” she said, “I no longer have a head, no heart, no stomach. " **[183]** She answers all the questions asked in the negative.

Ideas of immortality: “I will no longer die because I do not have my soul; my head is dead, that is why I cannot die.”

Ideas of guilt: “I had an abortion. I am a wretch; I murdered, I deserve to die for everything I did. I am a disgusting being; I must be made to pay dearly for my abortion/miscarriage. My head must be cut off.” She blames herself for no longer loving her parents, for no longer having feelings, for completely lacking affection.

Hypochondriacal Ideas: She is completely clogged. Her head is blocked. She continually asks to have her head opened to see what's inside. We will see that her head contains only thoughts of food, food, sausages.

Suicidal ideation and attempts : She always tries to strangle herself, pinches her neck, makes her fingers bleed. She continually scratches the skin on her face.

Ideas of humility : She would like to leave the asylum to go dig the earth. To atone for her fault, she asks to do difficult work. “From a woman,” she said, “I have fallen to the state of a beast. I'm not worth taking care of anymore. I will drag the wheelbarrows, I will serve as a servant. I will never say that I am tired.”

Ideas of persecution : M. X...did experiments on her, he made her fake tears, he put sausages in her head.

With this, she is aware of her morbid mental state. “The more I go, the crazier I get. I don't know which way to go anymore, because my head is lost.” On several occasions she tried to jump the walls of the asylum to carry out her thoughts of suicide.

For a long time her sleep has been almost nil; she wakes up often and has a tendency to get up and walk around the dorm. At first she had constipation, now she has a fairly good bowel movement. The appetite is very capricious. Touch sensitivity is**[184]** diminished on both sides; very marked analgesia at the beginning. Pharyngeal reflex diminished. Slight alternating divergent strabismus. No narrowing of the visual field. Normal hearing. Breathing often accelerated, sobbing. Pulse usually accelerated at the time of paroxysms. The face, and especially the forehead and the lip, bear nail blows with which she tears her skin.

The following observation is a case of anxious melancholy in a hereditary woman.

OBS. VII — *Anxious hereditary melancholia in a woman.*

Mrs. Er... Henriette, thirty-seven years old, entered the Ste-Anne asylum on April 29, 1894 (service of Mr. Joffroy).

Her maternal grandmother had a very limited intelligence. Father interned and died in the Vaucluse asylum at the age of sixty-four; he was an alcoholic who had fallen into dementia. Mother with congenital kyphosis; very frail woman, having given birth nine times, and having had eight miscarriages; brother died of meningitis; a daughter of our patient suffers from hydrocephalus with blisters.

At the age of five the patient had chronic coryza with ozaena (scrofulosis). Great difficulty learning to read and write. Headaches and stomach aches from a young age. Dark character, touchy, impressionable, but no real nervous crises. At nineteen years old, trauma to the left leg, which was accompanied by suppuration; recovery only occurred after three months. Married at twenty-eight, her husband barely earned a living. Two childbirths without accidents, the last occurring in 1889. Since then, one or two miscarriages (??).

The onset of psychological symptoms began in August 1894, with a physical weakening (weight loss, pallor, sadness). Ideas of death manifested themselves; she said that everyone was mad at her, that**[185]** her parents had abandoned her, that her husband wanted to poison her. She refused to eat. For two weeks, from August 10 to 25, we tried to treat her at home; but on August 26, the situation became more serious. She had been accusing herself for some time of having harmed her parents, and that day she had an attack of anxious agitation. She kept saying she wanted to leave. At one point, taking advantage of her parents' absence, she approached the window, opened it and leaned down to jump from the third floor. The guard who entered at that moment was able to detain her in time.

When she arrived at the asylum, she seemed anxious, she sighed continually. Every moment she moves towards the window or the door, trying to escape (or commit suicide). Mutism. At times, when we insist a lot, we see her making an effort to respond, we see her mouth parting, her lips moving, but she doesn't say a single word.

Physical examination : Pronounced weight loss. Skin sensitivity retained. The pupils are moderately dilated and respond well to light. The patellar reflexes are not exaggerated; the plantar reflex is normal. Her appetite has been good since the last days of October; previously the anorexia has been severe enough to require tube feeding. Her breath is foul, and the constipation stubborn. Auscultation allows you to hear the prolonged expiration at the level of the left vertex. Nothing in the heart. The pulse is often accelerated. The urine is very colored, dense, and contains neither albumin nor sugar.

B. Melancholia divided according to the presence or absence of delusions and hallucinations. — *a. Melancholia without delusion.* — In *melancholia without delusion*, which is partly confused with simple depressive melancholia, everything is limited to coenesthetic disorders**[186]** and some degree of abulia. The ability to associate ideas becomes more or less difficult. No hallucinations or delusional conceptions are observed. This form of melancholia is found especially among the city's clientele; it is very close to simple depressive melancholia, which we described in the first place, and certain authors combine the two. It very often escapes the attention of people unfamiliar with mental pathology, especially since patients are self-possessed enough to hide their psychological state under a mask of relative tranquility.

It is true to say that melancholic people without delusions sometimes surprise those around them with a very gloomy facial expression, with a completely unhealthy irritability, with a sad state of mind and a complete change in their way of reasoning and feeling. But, instead of considering all these manifestations as pathological in nature, parents and friends look for explanations on the side. Moreover, the sick themselves allege all sorts of fallacious reasons to excuse their laziness of mind and body, their negligence, their thoughtlessness. Because the melancholic without delusion, while being aware of his state, wants above all not to appear ill. But there comes a time when the affection

makes great progress, the patient exasperated by his mental pain**[187]** increasing number commits some act of violence. Then those around them realize that they are in the presence of a truly insane person.

It sometimes happens that an inexperienced doctor, called to see a patient in this category, is not at all affected by the mental syndrome, and that his diagnosis speaks of all sorts of things (anemia, chlorosis, neurasthenia, etc.) , except for the main fact, the melancholic state. It is certain that the observation of the somatic terrain, on which this mental affection evolves, has considerable importance, but we must not forget the mental affection itself, which is the result of all the physical disorders of the body.

b. Delusional melancholia.— Next to melancholia without delusion we must place delusional melancholia (fig. 14). Here the disorder is deeper and the very content of the ideas is more or less altered. In a word, in the variety that we are going to quickly study a new element is introduced: the delusional conception.

How is it born? Most often, it is the consequence of a greater intensity of psychological disorders of the previous variety. It represents on the part of the patient an attempt to explain everything painful he experiences. We have seen in what vicious circle the melancholic turns: his mental pain, primitive at first,**[188]** is then maintained by the difficulty of feeling, thinking, acting, a difficulty of which the patient is perfectly aware. Clinically, this state, having reached the highest stage of its development, manifests itself by deep depression, by hesitation in making the most insignificant decisions, and finally by delusional ideas. The melancholic then tells himself that he is ruined, that he is reduced to begging, that he is unworthy of living, that he is incapable; he accuses himself, he declares himself guilty towards God and towards men; he is damned, everyone despises him and does him a thousand insults. Added to this is the fear of punishment, hell, torture, and also ideas of negation, immortality, etc.

We already know that all impressions from the outside world arrive in the patient's consciousness profoundly altered; this psychological dysesthesia, as the German authors say, gives all impressions a dark, painful color. This is the source of all the ideas relating to the imaginary dangers which threaten the melancholic and to the equally imaginary persecutions of which he is the victim.

The resignation which the melancholic manifests in such a striking manner is the result of the profound conviction of his impotence. Psychic anesthesia comes next, and thanks to it, sensory perceptions and mental representations lose all pleasant or painful meaning. The**[189]** melancholic becomes incapable of manifesting a feeling of friendship, an aesthetic impression, a religious idea. As he is perfectly aware of this change occurring in him, he comes to the conclusion that he is no longer a human being, that he is a beast, that God has abandoned him, that he is damned, etc.

When psychological anesthesia is at its maximum**[190]** intensity, the patient imagines that everything around him has disappeared and that he himself is dead. The delusional conception relating to imminent danger, the delusion of expectation, often has its origin in the very frequent and very intense precordial anxiety among melancholics belonging to this category. Under the influence of this anxiety they imagine that they are going to be pursued, ruined, guillotined. Secondarily, and as explanations for these latter conceptions, they declare that they are great criminals and that they have deserved all these punishments.

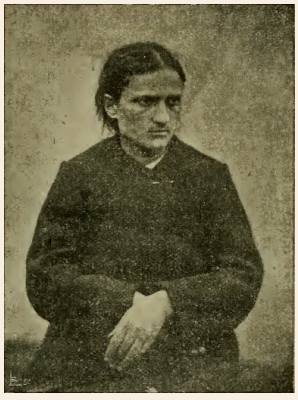

Fig. 14 — Delusional melancholia.

If the patient has committed an action in his previous life that seems contrary to morality, he immediately interprets this fact as justifying all the punishments he must suffer. Finally, disorders of skin sensitivity, neuralgia, anesthesia, modifications in the special senses can in turn, by being interpreted, transform into delusional conceptions.

c. Hypochondriac melancholia.— Certain melancholics, in seeking the cause of their mental pain, find it not in the impressions they receive from the outside world, but in those which result from disorders of their general or visceral sensitivity. The gastrointestinal tract and the genitals in particular give them all sorts of painful sensations, which become the starting point for real conceptions **[191]** of delusional and hypochondriac melancholics.

The sick are sad, depressed. At first, they cannot give any explanation for their discomfort. But soon, they said they were worried about their health. They feel fatigue, weariness, a sort of general stiffness which prevents them from engaging in their usual activities. Some time later, these still vague sensations become clearer: it's the stomach, it's the gut, it's the chest or even the head that hurts. The most careful medical examination does not allow the discovery of any objective sign in the incriminated organs, and yet the complaints are more and more serious, more and more pressing. We acquire the conviction that suffering, however subjective (?) it may be, is in no way simulated; because under their influence the patient soon abandons his most important affairs, sometimes goes to bed and urgently demands care.

The melancholic hypochondriac, having reached the period of state, becomes an unbearable tyrant for those around him. He demands the presence of his relatives or guardians day and night. The slightest of his whims must be satisfied immediately; otherwise he moans, cries, even becomes aggressive. His doctor is naturally one of his first victims. Every day he tires him out for hours by describing to him in detail**[192]** everything he has experienced since the day before, the new symptoms he has discovered, the medications he has taken; he speaks to him in great detail about his sputum, his urine, his excrement.

Finally, he himself is in perpetual anxiety: he feels his stomach, looks in a mirror, searches through medical books, consults pharmacists' advertisements, takes a quantity of drugs; and the idea of incurability obsessed him. This is how he behaves during bouts of anxiety. Then he falls back into depression and stays in bed. In some cases, Krafft-Ebing[179], Kovalevsky[180], Schüle[181], Pohl[182], noted hallucinations of general sensitivity.

Among the physical symptoms, the state of the digestive tract should especially be noted. The tongue is often saburral [like coarse sand]; there is little appetite and stubborn constipation. The patient suffers from persistent insomnia. In the vast majority of cases, patients present with vasomotor disorders which are manifested by sudden redness and paleness of the face; their integuments are usually discolored and anemic. Weight loss is sometimes very pronounced.

[193] Among the sub-varieties of hypochondriac melancholia, the most frequent are, according to Krafft-Ebing[183], syphilidophobic melancholia and hydrophobic melancholia. The first can occur not only in individuals free from any venereal disease, but also in proven syphilitics. It is probable that, in these latter cases, the organism suffered a profound weakening, either mainly due to the syphilis itself, or due to the anemia caused by too vigorous an administration of mercury and iodide. The idea of syphilitic infection with all its worst consequences takes root in the consciousness of these patients like a real obsession.

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[179] Krafft-Ebing, Lehrbuch f. Psychiatrie, 1890, p. 434.
[180] Kovalevsky, Psychiatrie (in Russian), 1890, t. II, p. 32.
[181] Schüle, Handbuch f. Psychiatrie, 1885, p. 407.
[182] Pohl, Die melancholy, Prag., 1852, p. 36
[183] Krafft-Ebing, works cited, p. 434.Obs n. 20.

The development of hypochondriac melancholia is often an alternation of bouts of anxiety and periods of depression. The duration is usually long (several months and even several years). The ending is very variable, in relation to the etiological conditions, and in particular to the terrain. According to M. Kovalevsky,[184] healing would be observed in a third of cases; another third would pass into a state of chronic hypochondriac melancholia; finally, the last third would slide into dementia.

Sometimes, hypochondriac delusion is accompanied**[194] by** ideas of negation, as well as in the following case.

OBS VIII. — - *Melancholia with hypochondriac ideas and negation.*

Mrs. Na... Augustine, thirty-four years old. (Service of Mr. Joffroy, in Ste-Anne.)

Father died of a paralysis attack at sixty-six years old. Mother died of heart disease (?) at sixty-seven years old. Seems like an intellectual moron.

The patient denies any excess alcohol. Her mother, moreover, agrees on this point. As a pathological antecedent, we find, according to the patient, a chest inflammation (?) which occurred in early childhood. She also complains of having suffered with her stomach all her life. Last August (1895), she said she felt a lot of grief at the death of her godson to whom she had become very attached; but we do not know the exact part that must be attributed to this fact in the pathogenesis of her mental disorders.

The psychological symptoms appeared in September 1895. She began by imagining that someone had "pushed up the nerves in her stomach". As she had recently gone to Montmartre to consult *a man curing all diseases* "for swelling in her legs which had gone up into her ears", she accused the latter of having displaced her nerves. She even cites the name of the operator, who would have produced this effect by means of spiritualism. He put his hand all over her; then the nerves in her head cracked and broke. Since that time, she has been convinced that she can no longer die, an idea that will be further corroborated by her failure to make the suicide attempts which we will discuss later.

She also has some ideas of persecution: people followed her in the street, people said unpleasant things to her, even insults. Everyone made fun of her when she passed by. Currently she is still**[193]** very suspicious; also, seeing that we are taking notes while she speaks, she asks for what purpose we are doing it. When asked about her hearing acuity, she replied: "I hear well and I should not be made deaf." She has difficulty deciding to speak. She did not recognize the people following her and could not repeat what they said to her; she does not know for what purpose they were behind her. One day she tells us that, to pursue her, people known to her change their clothes and even their faces.

To escape this persecution, she wanted to kill herself. She chose the moment when no one was with her, climbed over the window sill, held her hands on the bars and let herself go. She felt nothing when she fell to the ground: the pain only came a few hours after her fall. After this suicide attempt she was interned.

What we first notice, upon her arrival at the asylum (November), are the hypochondriac ideas. "The blood is boiling in her head, she feels shifting pains, tremors in her hands. With her left eye she sees a ring of hair. She's breathing too well and it's hurting her. She often has pain in her ear. She never feels well, the nerves in her body are tense; on the contrary those of her head have gone down, so that she no longer has her nerves. This is even the cause which prevents her from dying; because she can only die if her neck and waist are cut and her stomach is cut open." These are indeed ideas of negation linked to the hypochondriac state of the disease. They are not the only ones; because she still says that "even if she eats, she always feels her stomach empty". Sometimes she thinks she realizes that her heart is stopping.

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[184] Kovalevsky, works cited, p. 34.

Her ideas of persecution still persist: “they always want to harm her, they prevent her from resuming her work.” If we ask her to specify which are those who are hostile to her, she answers: “a little bit of everyone”. She was never able to recognize them. When**[196]** we followed her in the street, she looked: she was dealing with strangers. She cannot give the slightest description for the face or the clothes. These men never spoke to her.

But the dominant idea in her and relating to the delusion of negations is that she cannot die because her nerves have been displaced, and yet she wants to die. This idea of suicide is not, moreover, motivated, because the patient's other hypochondriac ideas have so little consistency, her ideas of persecution so little clarity, her hallucinations so vague that we must recognize their little importance in the patient's determinations.

On December 11, 1895, at two o'clock, the patient, lost sight of for a few minutes and taking advantage of the opening of a window, threw herself into the garden, absolutely repeating her first suicide attempt. As soon as she was raised, it was noted that she only had a few small erosions on the front part of her left knee. The next day the swelling of the joint was evident, and the functional impotence of the limb was complete. On December 20, when moving the kneecap, we noticed a crepitation which we attribute to the detachment of the articular cartilages and which persisted for a long time, even when the patient was able to walk.

She later explained that her ideas of immortality inspired her for the second time to commit suicide, because there was no other way for her to end life. Now, as hanging and asphyxiation by coal did not inspire any confidence in her, she decided to throw herself out of the window.

Now that she sees this method of suicide not succeeding any more than the others, she is discouraged, but she in no way abandons her ideas of killing herself, and she must be closely monitored.

Melancholia with delusion of negations.— The delusion of negations therefore sometimes mixes with the hypochondriac delusion;**[197]** these are also the two trunks coming from the same somatic stem. It's Cotard[185] who first described this morbid species, which several authors[186] and in particular Mr. Séglas[187] have studied in recent times. These are usually sad, worried individuals with a marked melancholic tendency. They anxiously fear ruin, condemnation, and the death of those who are most dear to them. They accuse each other of all kinds of misdeeds; they are damned, possessed. At this point, they are driven to suicide and often attempt to mutilate themselves. Then the ideas of negation appear: they no longer have a heart, no more stomach, no more blood, no more brain; they no longer think, they no longer have affectionate feelings, they no longer have a will. Sometimes, these negative tendencies extend to the external world and even to the metaphysical domain: the sick deny the soul, God, justice, etc. Hallucinations of hearing and sight are often added to the delusional conceptions. From a physical point of view, the melancholic denier usually presents analgesia.

The evolution of this variety of melancholia is**[198]** remarkable for its tendency towards chronicity and for the appearance of ideas of grandeur in reverse. The negating lypemaniac becomes a very important personality, but in evil: he is Satan, he is immortal so that he can suffer eternally; he does not urinate for fear of causing a new flood; he refuses all food, because if he eats he will starve the whole world. The delusion of negations then becomes a real delusion of enormity.[188] Healing is possible. Sometimes remissions are observed, sometimes the progress is continuous. The delusion of negations can also turn into dementia: it all depends on the terrain on which it is grafted.

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185 Cotard, Du délire hypocondriaque dans une forme grave de la mélancolie anxieuse, 1880, Étude sur les maladies du délire des négations, works cited, p. 307.

186 Ed. Toulouse, Le délire des négations, Gaz. des hôpit., 1893, p. 301.

187 Séglas, Le délire des négations, Encyclopedia of memory aids.

188 Cotard, Le délire d'énormité, 1888, in Études...,works cited, p. 374.

When the ideas of negation have become very extensive and strongly systematized, the patient's physiognomy is truly characteristic. His conversation is monotonous and always presents negative tendencies which cut short the questions asked of him. Besides, he is generally anxious. Melancholic deniers often make suicide attempts, but these are rarely successful due to lack of willpower. Sometimes they refuse to eat, because they are no longer alive and they have no mouth. When the negative trend becomes generalized, we have what Guislain called the *opposition madness***[199]**. If we want to put the sick to bed, get them up, sit them down, walk them around, they don't want to and they oppose all attempts to direct them with absolute refusal.

Mental vision may be impaired in melancholic deniers. Cotard's works[189] have proven it, not only for the anxious, but for the melancholic in general. They have difficulty representing visual forms, the faces of the people they have known and the streets they have often crossed. It seems that mental hearing is also affected.[190]

In summary, there are the following six characteristics in this variety of melancholia:

1° Melancholic anxiety;

2° Idea of damnation or possession;

3° Propensity for suicide and voluntary mutilation;

4° Analgesia;

5° Hypochondriac ideas of non-existence or destruction of various organs, of the entire body, of the soul, of God, etc. ;

6° Idea of never being able to die.

Let us examine these various characters. Melancholic anxiety is the background on which the other morbid elements are usually grafted. The ideas of**[200]** damnation and possession are quite frequently associated with melancholic delusion and by themselves have no precise meaning. The propensity to suicide is one of the most frequent impulses of melancholia; similarly, analgesia is a common symptom of lypemanic states. What remains — as a more or less special fact — are the ideas of negation strictly speaking, which sometimes relate to the psychological or physical person of the patient (they no longer have thought, energy, brain, heart, stomach, legs) or on the outside world (nothing exists, there are no houses, trees around them). Oddly enough, these deniers of their own existence often declare that they are immortal. The two ideas are not irreconcilable. “This idea of the negation of death is generally the corollary of the idea of the negation of life. The sick say that they no longer live, just as they claim that they no longer have bones, flesh, or blood; and yet, they know that they are not dead, in the materialist sense of the word. They continue to suffer, but the consciousness of this new existence is so different from those they had before, that this survival is for them a kind of death. And their pessimistic tendencies make them believe that it will not end. They are therefore immortal to endure their evils eternally.[191]”

[201] For us, the delusion of negations is a syndrome which requires, to be produced, certain conditions, the main ones of which are alterations of coenesthesia. Melancholia often realizes these conditions; It is also frequently observed in this disease. Does this delusion have a meaning of particular gravity, of incurability, as Cotard believed? It seems risky to assert this. What is true is that it only develops in certain anxious melancholia whose alterations in sensitivity would probably be significant. But we can encounter the delusion of negations elsewhere than in melancholia, and generally in all illnesses where there is dysesthesia, notably in alcoholism, general paralysis, etc. However, it is, in these affections, less systematized than in melancholic states.

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[189] Cotard, Perte de la vision mentale dans la mélancolie anxieuse, Arch. de neurol., 1884, t. VII, p. 289.

[190] Ed. Toulouse, Le délire des négations, works cited.

[191] Ed. Toulouse, Le délire des négations, Gaz. des hôp., 1893, p. 306.

**Here, summarized, is the observation of a case of systematized delusion of negation, published elsewhere by one of us.[192]

OBS. IX. — *Systematized delusion of negations.*

Mrs. Ne..., thirty-six years old, entered the Saint-Yon asylum in August 1892.

Her maternal grandfather was an alcoholic. He was locked up in the Caen asylum, where he died. At one point in her life, her grandmother manifested melancholic ideas which, however, did not require her**[202]** internment. Although the patient's father was an illegitimate child and never knew his close or distant relatives, Mme Ne... 's maternal ancestors and collaterals represented a very extensive family tree. Her maternal grandfather was the brother of nine children, and this prolific faculty does not diminish in the descendants of all these people, for at a family reunion held in recent times, the members present numbered 64 (?). This abnormal fertility, which we wanted to make a characteristic of neuropathic families, is therefore worthy of note.

Three pregnancies, only one of which came to term and again to give rise to the birth of a dead child. No traces of syphilis. Menarche at the ordinary age, around thirteen; menstruation always capricious, delaying or advancing. Without being very robust, she has always enjoyed good health. Her character was rather cheerful, and she does not seem to have previously had any bizarre ideas, any irresistible impulses, in short any of the manifestations of an insane mental organization. Married at twenty to a man she loved. She helped her husband in his business, was hardworking and satisfied with her position.

No strong sorrow, no powerful mental annoyance, no serious apparent illness had come to trouble her when, in June 1892, she felt dejected, incapable of taking an interest in her ordinary occupations. She then suffered from pain in her lower abdomen, for which she went to see a doctor who spoke to her about a possible operation. When she returned from this visit she went to bed. It is from this moment that, for those around her, dates the beginning of her mental disorders.

At first the patient behaved like an anxious melancholic. She was desolate, crying, declaring that she was going to die. At night she was very restless and did not sleep. On different occasions she refused to eat, always under the pretext that her end was near. However, at the same time she had thoughts of suicide. But it doesn't seem like she tried hard**[203]** seriously to put her plans into execution; because when she hid a knife under her mattress, she immediately warned her husband so that he would prevent her from using it. She beat her head against the walls or hammered it with her fists, without injuring herself; or she stuck her finger in her nose to cause a fatal hemorrhage. She also tried to swallow harmless substances, such as wool, in order to poison herself. So if thoughts of suicide existed, the will to carry them out was lacking. This fact has been observed in similar cases of anxious deniers. It seems that in the state of psychological fatigue in which these patients find themselves, they are incapable of finding the energy necessary to take their own lives.

She was interned in August 1892. The doctor who saw her before her confinement noted that she was a melancholic with thoughts of suicide, that she complained of having an illness in the brain that could not be resolved or taken away from her, and that she did not appear to be hallucinating. Note that from this moment, this idea of incurability, which is in some way the prodrome of the idea of immortality, was expressed by the patient.

In the asylum she was considered an anxious melancholic. She complained of headaches and not being able to sleep, and often declared that her illness would not be cured. Finally, in recent times, one morning she expressed ideas of negation. We questioned her carefully and we were surprised to find that her negative conceptions were very extensive, stable and perfectly systematized.

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[192] Ed. Toulouse, Délire de négation à début précoce chez une mélancolique, Bulletin de la Soc. de méd. ment, de Belgique, 1893, p. 25.

The ideas of negation are (1893) easier to observe with her, although they are not very extensive. She first declares that her head has been removed, that the one she has is no longer the same as the one she once had. It is the Lord who carried out this transformation for the purpose of punishment, because she is damned. So she no longer has her former face. Even if the new one was well organized! But this borrowed head is a ball**[204]** bone or wood where there is nothing. If we removed her scalp, we would find no brain, no nerves, no flesh or anything that gives thought. So she can no longer think, feel, or want. Her eyes also changed. Previously they were too light, which made her suffer. Her ears are falling off, they're crumbling like plaster. Her nose remains, but it has the skeletal protrusion, it no longer serves any purpose. Her teeth are no longer made of ivory; They are made of iron, so they could not be torn off. The hair no longer has the appearance or strength it once did, it seems to have withdrawn into itself.

Her neck is no longer straight. She cannot raise it; so her head always tilts. Her throat is not like everyone else's. And she insists that her throat be examined, and explains that the two parts which hold the throat (probably the veils of the palate) have been torn and no longer exist. Her heart has stopped, it no longer beats. You could prick all her veins and not a drop of blood would come out. She no longer has flesh; she prints her nails on his skin, and cries: “You see, it remains, it is no longer flesh.”

This patient's ideas of negation relate to her physical and psychological constitution, mainly to the first and, in the latter, more particularly to the organs contained in the head. They are not always formulated in grammatically negative sentences. But when she says, for example, that her ears are going away, it is clear that she is seeing an organ destruction which is not yet complete, but which is in the process of taking place. These ideas of physical negation are associated with ideas of transformation of the same order.

Feeling transformed and reduced to the state of a "skeleton", Madame Ne... declares herself immortal. This idea is extremely negative; it is the logical conclusion of the others relating to its different organs. The patient is therefore immortal, but in a certain way. This **[205]** is not an idea of grandeur, as we encounter among certain persecuted people, who are also sometimes immortal because they have found the means to live eternally or because they have a quasi-divine nature. They pride themselves on this supra-terrestrial faculty. Quite unlike them, Madame Ne... is immortal because she is damned, because she is an unworthy person who did not pray to God, and on whom God inflicted a terrible punishment. Because this immortality from which she suffers is a terrible suffering and pain. Far from being proud of it, she deplores it, she moans about it all day long. This is therefore indeed an idea of magnitudes in reverse, such as Cotard differentiated it from other ambitious conceptions.

There is one more remark to be made about this idea of immortality that Madame Ne has... She is immortal and at the same time she is dead. She no longer thinks, she no longer has flesh, she is reduced to the state of a skeleton, and that is why she no longer lives, or at least why she no longer lives as before and the same way as the others. But at the same time she is aware of this state, which borrows its sufferings from life and its eternal duration from death.

“I am immortal,” said Madame Ne..., “because I am a skeleton, that is to say because I am what is immortal in us.” She feels very well that she is not living, since her head is empty, her heart no longer beats, but she also feels that she is not completely dead, since she still has the appearance of life, the suffering and the ability to get up, walk, eat.

Mrs. Ne... is absolutely convinced that she is physically dead. So she smiled when recounting her previous suicide attempts. Why would she try to kill herself? A revolver bullet would ricochet in her head like in a cupboard, no poison could kill her. However, as we listed to her all the processes by

which we can destroy ourselves, she replied that if we burned her and reduced her to ashes she would**[206]** no longer suffer, and there would be nothing left of her empty forms, of her appearances of being alive.

Madame Ne...'s mental faculties are not at all weakened. Her memory is good. She does not (?) have any fading or loss of mental vision, a symptom which seems to have some connection with ideas of negation. She reasons well about everything that does not touch on the matters of her hypochondriac delusion. She has no hallucinations or sensory illusions.

But she feels transformed. The outside world does not seem the same to her as before. And yet she distinguishes everything and is perfectly aware of the things around her. She cannot explain her new sensations, which no words could convey. She also feels a profound reduction in her physical and mental energy.

We looked for lesions in the sensory functions that could be the provocative agents of these delusional ideas. Sensitivity is mainly affected in the posterior part of the body. Let us recall in this regard that Mrs. Ne... 's ideas of negation mainly concern the organs and regions located in this zone. The upper limb, neck and head show a decrease in all three forms of sensitivity, to touch, to temperature and to pain. This anesthesia would be deep and would affect the skin, muscles and even bones. However, it is good to be on guard against the tendencies of deniers to formulate answers in relation to their delusions, when they are questioned about the functioning of their organs; this makes their examination excessively difficult. So we give Mrs. Ne... the dynamometer and ask her to tighten. She does it sluggishly and barely moves the needle and says: “I have no strength”; and yet the next day she reached the number 28 on her right hand, but only the number 8 on her left hand.

The muscular sense also seems affected. Reflexes are preserved; those of the forearm (anesthesia) even seem exaggerated.

[207] Let us say here that apart from this anesthesia there are no hysterical symptoms. The patient has never had nervous attacks or other symptoms of this neurosis. Moreover, the vision in both eyes is normal, both in terms of the extent of the visual field and the acuity of vision as well as for the recognition of colors. The same goes for hearing, smell and taste.

From a physical point of view, the patient does not present any significant organic lesions. The skin is neither dry, nor dull, nor purplish as in melancholic people. There is a certain degree of overweight. The tongue is good. Digestion is good, appetite is satisfactory.

N. B. — Mrs. Ne... died presenting the same delusion during the year 1893, following typhoid bouts.

We can observe ideas of negation in other melancholic states and for example in those symptomatic of a general paralysis as the following fact shows.

[OBS. X...]

[208] ....

We will end our description of the varieties of melancholic-psychoses there. By developing somewhat the main delusional ideas, which were reviewed in the previous chapter, we could have created even more numerous forms, but without any benefit.

[209] C. Melancholias divided according to the degree of cohesion of the delusion. — *Systematized melancholic delusions.*[193] Delusional conceptions and sensory disturbances, specific to certain systematized delusions, can be observed in the syndrome of melancholia just as the symptoms of melancholia can enter as epiphenomena in the clinical

[193] We will not describe here the non-systematized melancholic delusions, banal morbid forms, which we have studied under other labels.

picture of paranoia. This point of the question was recently addressed by M. Schloss.[194] He rightly points out that there are certain cases which are challenging and whose diagnosis will be, according to some: melancholia, and according to others: systematized delusion. Both seem to be right, because the assessment of the phenomena observed is entirely subjective in a question of this order. Moreover, it must be admitted that the clinic does not always realize our artificial divisions: it often places melancholia side by side with a systematized delusion or it makes one derive from the other in the most disconcerting way for our current classifications.

Religious melancholia, which can be cited as an example of systematized melancholic delusion, generally appears in individuals**[210]** whose education was very pious. Under the influence of melancholic depression, they very naturally seek consolation in prayers and devotion, but they soon realize that nothing can relieve or console them. They have lost the ability to feel the ordinary benefits that they attribute to their religious practices. Psychological anesthesia, this common symptom of melancholia, is the main cause.

When these sick people clearly see the impossibility of finding psychological calm in prayer, they become desperate. Soon they are miserable sinners abandoned by God. Thanks to the resignation which lies at the bottom of every melancholic state, they interpret the misfortune that befalls them as a just punishment from heaven for some imaginary fault: “they deserved all this, because they did not pray enough.” Often things don't stop there. They have lost divine grace. God is angry with them, and to punish them worthily, condemns them to the eternal torments of hell. It is in this way that religious melancholics very often fall into *demonomaniacal melancholia.*

It is worth adding that this transformation is not always observed. It is subordinate to the particular terrain on which religious melancholia evolves. This is how in hysterics, presenting numerous sensory and motor disorders, this**[211]** evolution very frequently occurs thanks to the delusional interpretations they make of their morbid disorders. For example, a hysteric suffering from religious melancholia will have intercostal neuralgia; immediately she will declare that the demon is trying to tear out her heart. A convulsive attack will be given as proof of possession by the same demon. The hysterical mind itself will serve as an explanation for the incontestable presence of Satan in the body of the patient.

Often hallucinations of general sensitivity (burning in the throat or on the skin), of sight (devil), of hearing (voices from heaven or hell), of smell (sulphur) come to bring their pathogenic elements in this clinical picture: under their influence patients have real melancholic raptus with impulses to suicide and self-mutilation. According to Krafft-Ebing, who cites several observations of this variety of melancholia, its ending is generally favorable.[195] Melancholic demonomaniacs recover gradually; their delusion retrocedes and often returns to the religious melancholia which marked the first phase of the affection and which then disappears in its turn in a progressive manner. In these cases, as in**[212]** all the others, the terrain is a most important prognostic element.

D. Melancholia-psychoses divided according to their course. —*a. Continuous melancholia.*— Its history is confused with the varieties previously described.

b. Intermittent melancholia. — As a phase of intermittent insanity, this variety is essentially a bout of mental illness which can occur several times in the same patient. In the intervals between bouts the disease seems to have completely disappeared. The bouts appear at regular intervals and present an almost complete resemblance to each other. The patient manifests exactly the same delusional conceptions, the same degree of resignation and abulia. The beginning can be as abrupt as the ending.

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[194] Schloss, Melancholia und Paranoïa, Jahrb. für und Neurol., 1895.

[195] Krafft-Ebing, Handbuch für Psychiatrie, 1890, p. 429. — Meynert, Die primären Formn der Irreseius. Oesterreicher Zeitschrift für practische Heilkunde, 1871, 44-47. — Id., Psychiatrie, 1885, t. 1, p. 39. —- Frese, Allgemeine Zeitschrift für Psychiatrie, 28 p. 487.

The history of these intermittent melancholias is intimately linked to the history of intermittent madness (periodic, circular, double form)[196]. So we cannot address it here. During one of their periods these illnesses produce a typical melancholic state. From this point of view they are very instructive.

[213] We used a lot in our work the observation of a circular melancholic, who presented for twelve days a state of excitement without loss of consciousness or delusion and which for another fifteen days remained in a state of melancholic depression. We were therefore able to easily study the somatic conditions of cheerfulness and sadness in this patient who thus carried out an excellent laboratory experiment.

Here is his observation.

OBS. XI.[197] — Circular-form melancholia.

Mme So..., Marie, thirty-three years old, entered June 19, 1895 at the Asile Ste-Anne (service of M. Joffroy).

Father still living, aged sixty; takes brandy in the morning on an empty stomach. Mother, fifty-five years old, violent, hotheaded, also using brandy. Sister, twenty-seven years old, married; At the age of three, she had convulsions which resulted in strabismus. Another sixteen-year-old sister, in good health.

Measles at around three years old. Whooping cough around the age of four. Frequent bronchitis and tonsillitis. Menstruated at thirteen years. Married at twenty. At twenty-one her first child was born, the only one still alive, very frail at birth, very intelligent, but very sensitive in character. At twenty-six years old, she gave birth to two twins who both died, one at the seventh, the other at the eighth **[214]** day. A few months after their death, first internment in the Clermont asylum; she stayed there for five years. Released, she only stayed outside for six months and was interned in the Villejuif asylum, where she spent six months, during which she gave birth to a little girl, who died at seven months of meningitis. Then transferred to the Clermont asylum, where she remained for ten months. Released in November 1894.

On June 19, 1895, her husband took her to the Sainte-Anne asylum and gave the following information. She is of mediocre intelligence and weak character; she in no way possessed the qualities of a housewife. But she only showed signs of mental disturbance starting in November 1887. Seven months after the death of her twin children, she began to lose complete interest in household affairs and remained in an apathetic state. However, in the past she was taken for some time by the mania of going out and walking without anything being able to keep her at home. (Further observation will reveal the meaning of this need for movement alternating with periods of prostration and complete despondency.)

A few weeks after the onset of her mental illness, she attracted a young man, her neighbor, to her home and demanded that he be with her continuously. Her husband, observing the worsening of her condition every day, sent her, on the doctor's advice, to the countryside, to be with her father. But it was not a small charge for this one. Thus, when the patient was seized one evening around half past nine with one of these irresistible desires to go out, the father was forced, to prevent her, to tie her to her bed. The husband, informed of this fact, decided to have her interned in Clermont. The main reasons specified are: “Erotic madness, manic excitement, hallucinations. Refusal of food.” We can say that the character of the illness, we mean these regular alternations of excitement and depression, however already marked, was little known. She left the Clermont asylum in 1891.

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[196] Ritti, Traité clinique de la folie à double forme, 1883. — Magnan, De la folie intermittente, Recherches sur les centres nerveux, 2nd series, 1893, p. 497.

[197] This very interesting observation, which M. Joffroy allowed us to collect in his department, was used for numerous researches. M. Dumas published some of them in the Revue Philosophique, 1896 and 1897. Despite the numerous details that we give here on this patient, the observation is not complete. It will one day be published in its entirety by M. Joffroy, who continues to study the patient.

[215] In December 1892, she was pregnant when her mental disorders required a second internment in Villejuif. There she gave birth to a daughter who died at eight months of diphtheria. Her entry certificate signed by Dr. Legras bears the following mention: “Mental debility with melancholic depression, hallucinations of hearing and sight, intermittent excitement, violence towards her child, voluntary muteness, refusal of food. Imaginary terrors. Hasty flight to escape the enemies she believes she has. Five months pregnant. Hears a voice from above telling her to do good.” In this second certificate we must note the following two observations: melancholic depression and bouts of excitement. We only have to bring these two states together and note their alternation in successive periods to characterize the patient's intermittent madness.

After staying six months in Villejuif, she was transferred to Clermont, where she was kept for ten months. In the meantime, her husband tried to take her back, but was forced to return her to the asylum three months later. Leaving Clermont for good in December 1894, she returned to her father. She was then unable to take care of anything. In January her husband took her back with him. She no longer has the hallucinations she suffered from before.

At this time her morbid state is clearly understood and observed by the husband and becomes clearer. For eight to ten days, this woman was in a state of absolute despondency: she remained lying like an inert mass, or, if she got up, it was to sit on a chair and remain there without movement or speech throughout the day, refusing to eat and even have a bowel movement. Then, also for eight or ten days, she would go out all day and only come back in the evening; outside she accosted passers-by, sometimes prostituted herself and returned from her expeditions with her pockets stuffed with objects of all kinds. During this period, she was even restless at night to the point of not being able to sleep; her appetite was exaggerated. These two successive cycles**[216]** lasted about a month, they were renewed like this for four to five months. Her periods generally coincided with her period of agitation, except in April 1895, when it appeared while the patient was in bed. From this moment the menstruation no longer reappeared, the patient being pregnant.

On June 3, 1895, during one of her days of excitement, she suddenly left home and set off on foot somewhat randomly in the direction of her country. She begged to live, and slept at night under the stars. One evening when she wanted to stay near a brickyard, she was seen by the workers, who all had her successively. She admits, moreover, that she lent herself to this violence without defending herself too much. But it was the only time such a thing would have happened to her during her escapade. She thus arrived at T..., very tired, without shoes on her feet, still a beggar. The mayor of the town wrote to the husband, who went to take her back. Her journey had lasted fifteen days.

From the above it is easy to conclude that this was a circular madness consisting of alternating periods of excitement and melancholia.

The patient, entering the asylum, had a miscarriage on July 20, 1895 and expelled a three and a half month old fetus. All parts of the egg sack came out completely, and the hemorrhage was profuse. Following this accident, the patient gained weight and presented very clearly to our observation the alternations of excitement and depression.

Nothing is more different than the physiognomy, attitude and manners of Mme So..., in the period of excitement and in the period of depression. In the first, she is "all out there", her face happy, cheerful, loquacious, tiring those around her with her incessant verbiage, tearing her clothes, acting like a busybody, eating a lot, becoming licentious and sometimes showing some ideas of persecution towards her mother-in-law in her remarks**[217]** and her gestures. In the second, she sits all day, her features sagging, presenting the mask of sadness, incapable of doing nothing, indifferent to everything that happens, speaking little and in a low voice, sometimes refusing food, having dirty

tongue, yellow hands, and behaving entirely like a melancholic.

It is not the aspect alone that changes, but all the physiological processes; and we can study in each of the two periods the somatic conditions of joy or those of sadness. Generally speaking, we can say that everything (temperature, number of pulses and respirations, blood pressure, quantity of urine, body weight, dynamometric force) rises during the period of excitation and falls during the period of of depression, as can be seen in the following table (fig. 15).

But let's take a closer look at each thing.

Body weight increases in excitement and decreases in depression. This is a result of other variations, and in particular parallel modifications of appetite. Weight variations are 3 kilos on average from one period to the next. In a year, they have not exceeded the maximum of 6 kilos (60 to 66 kilos). The weight usually drops at the beginning of the depression, rises again when excitement comes and continues this upward movement until the end of this last period, so that the graphic line of the weight describes a curve with greater concavity whose two ends correspond to the beginning**[218]** of depression and at the end of excitement and the middle at the junction of the two periods.

[219] *Temperature* undergoes modifications which could be represented by the same graphic curve. There is only one degree of difference at most between the two temperatures; the average variations are even only a few tenths around 37°.

The composition of blood appears to undergo equally important modifications according to the still unpublished research of M. Dumas, who noted the following facts: At the beginning of the period of excitation there is a strong (apparent) reduction in globules because of the vasodilation. At the beginning of the period of depression, there is a large (apparent) increase in blood cells, due to vasoconstriction. In the course of periods on the contrary: in excitement, there is continuous growth (and probably real) and, in depression, continuous decline (and probably also real).[198]

The muscular strength also changes in each of the two periods. The differences are 15 kilos on average; they range between 10 and 30 kilos.

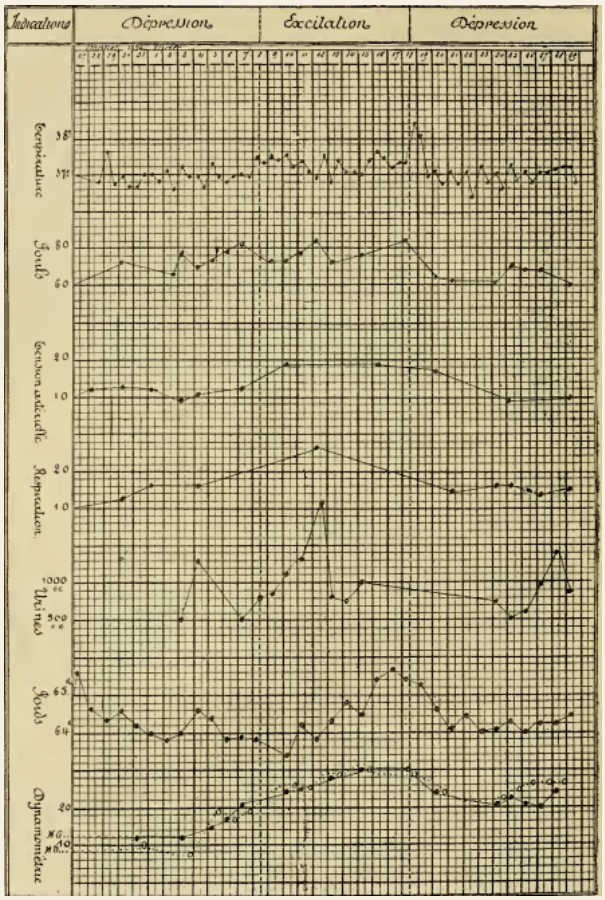

Fig. 15 — Variations in circular melancholia.

Pulse also changes; the number of pulsations oscillates between 60 and 80, the blood pressure between 10 and 20. The shape of the pulsation is ample in excitation (fig. 16) and contracted in depression (fig. 17).

Capillary pulse, taken with the Hallion and Comte plethysmograph, is ample in excitation (fig. 18).

[220] In depression it does not exist, or at least it is so weak, even after warming the hands, that it cannot be recorded.

198 G. Dumas, Revue philosophique, 1897, n° 6, p. 626 and following.

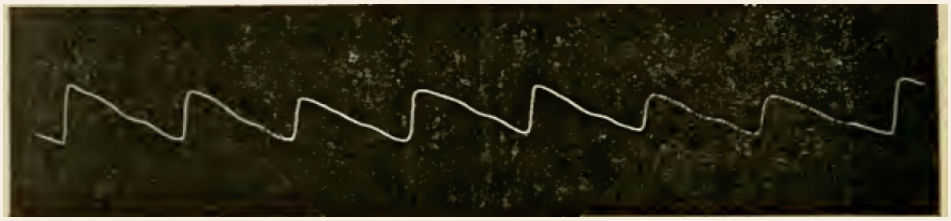

Fig. 15 — Variations in circular melancholia.

The number of respiratory movements oscillates between 10 and 20. Breathing is ample in excitement (fig. 19) and superficial in depression (fig. 20).

Fig. 17 — Pulse in circular melancholia (depression).

Fig. 18 — Capillary pulse in circular melancholia (excitation). 10".

The urine volumes oscillate from 500 to 2000 c.c. The elements also vary. In the period of excitement, the urinary elements are in ordinary quantity, except the chlorides, which are, as well as the density, ... **[221]**

Fig. 19 — Respiration in circular melancholia (excitation). Eighteen seconds.

Fig. 20 — Respiration in circular melancholia (depression) Eighteen seconds.

[222] slightly diminished. In the period of depression, density becomes normal, urea decreases, uric acid increases as well as phosphoric acid (undernutrition of nervous elements). These results are recorded in the following table:[199]

Variations of elements in the urine in circular melancholia.

ÉLÉMENTS	MOYENNE chez la femme.	CHEZ SO...	
		En excitation.	En dépression.
Densité.....	1018 à 1020	1015	1021,6
Acide urique.....	0,30 à 0,40	0,30	0,62
Urée.....	20 à 28 gr.	28	18,20
Ph O^5 total	1/10	1/11	1/6
Ph O^5 Rapport à l'urée.....	2 gr. 30	2,40	3,12
Chlorures.....	8 à 10 gr.	6,50	7,40
Indican.....	Proportion minime.	Proportion minime.	Proportion élevée.

[199] The urine analyzes were carried out by Mr. Tiffenau, intern at the Sainte-Anne asylum; the figures given are averages.

The *mental state* also changes considerably, as we have said. To study something measurable, we took the reaction times in the two opposite states (excitation and depression) and in an intermediate state that is rarely observable and can be considered as the normal state, however closer to excitation **[223]** than depression. These experiments were carried out with the enlightened assistance of M. Vaschide, from the physiological psychology laboratory at the School of Hautes Études directed by M. Binet, and have already been the subject of a communication at the Société de Biologie.[200]

The experiments took place between ten a.m. and noon. Reaction times were taken with d'Arsonval's chronometer, using a new device designed by M. A. Binet[201] and consisting of placing a screen between the experimenter and the subject, in order to prevent the subconscious visual perceptions, which play such a large role in these states of sustained attention. We had explained to the patient how she should react, and we only began the experiment after a few attempts. First we took the simple reactions, and, following a ten-minute rest, the choice reactions.

Simple reactions. The subject must react immediately after hearing the sound of a signal being struck on the table. We performed 30 trials each time, averaging an interval of 10 seconds between each auditory stimulus. It should be noted that the patient had only one anticipated reaction in all three**[224]** sessions and only when she was in the normal state (between the 12th and 13th second). Apart from this case, she always reacted well and seemed, especially when she was excited, to put a lot of self-esteem into doing what was best. In this state, she had difficulty keeping her eyes closed, and she burst out laughing wildly with joy when she thought she had reacted well. In the depressed state this ambition was less visible although from time to time a slight smile of satisfaction appeared on the melancholic mask of the face. We made no sign of approval or disapproval of the subject.

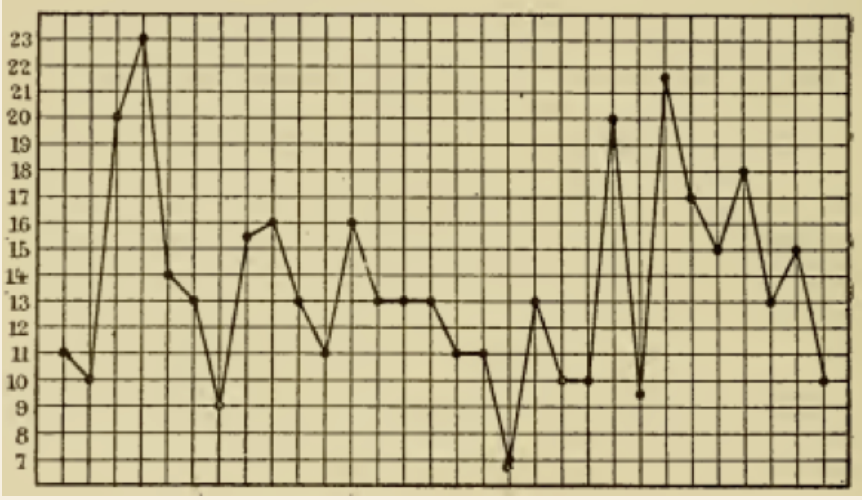

Fig. 21. — Simple reaction time in circular melancholia (excitation).

The reaction times were, in excitation of 13.67,[202] a figure which is lower than the corresponding one**[225]** to the general average, estimated at around 15. These times are extended in the normal state (17.77) and even more in the state of depression (25.55).

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200 E. Toulouse et Vaschide, Temps de réaction dans les deux périodes d'une mélancolie circulaire, Soc. de Biologie, 1897.

201 For the details of this method we refer to a volume by M. Binet, in preparation, the Psychologie individuelle.

202 Hundredth of a second.

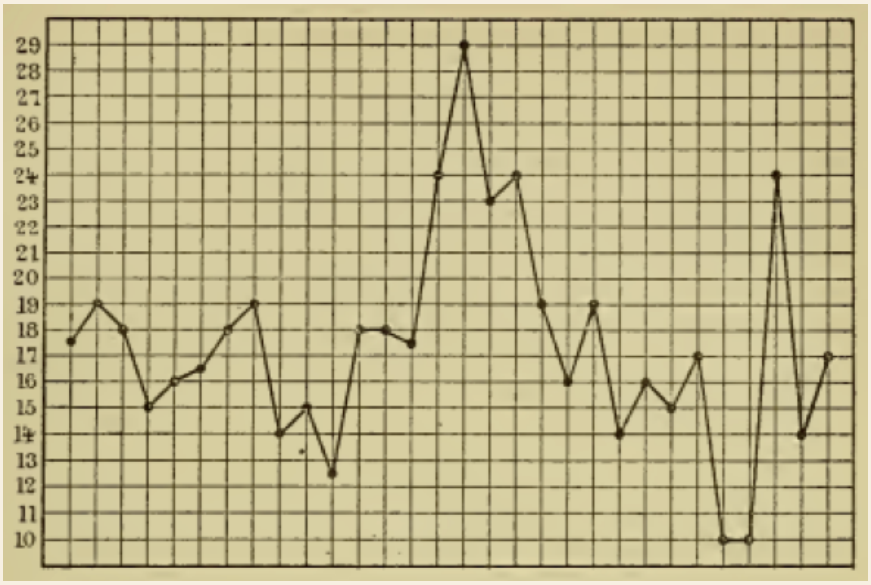

Fig. 22. — Simple reaction time in circular melancholia (normal state).

Simple reactions.

	MOYENNE arithmétique.	VARIATION de la moyenne.
Excitation.....	13,67	3,07
État normal.....	17,77	3,23
Dépression.....	25,55	8,14

The average variations were generally large and above average (2), while**[226]** retaining the same relationship with the average reaction time, as shown in the previous table (p. 221). For the construction of the averages we did not make any eliminations, no figure being very far from the average.

Reactions of choice. It was understood that the subject would react when she heard signal noise on**[227]** the table and would not react when the signal was struck on a box whose delivered sound was completely different from the other. We put an average interval of 10 seconds between each trial. We stopped the experiment when we had obtained 30 correct reactions, that is to say 30 reactions responding to the agreed signals. The following table shows the results of the experiments, in terms of averages and variations.

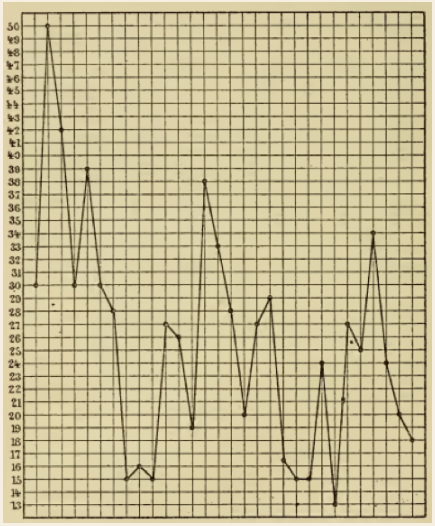

Fig. 23. — Simple reaction time in circular melancholia (depression).

Reactions of choice.

	MOYENNE arithmétique.	VARIATION de la moyenne.
Dépression.....	27,18	3,01
Excitation.....	24,25	0,72
État normal.....	29,52	0,65

To obtain the arithmetic averages and variations, we had to eliminate, as being very far apart, a few figures (60 for the normal state; 70 and two 50s for depression; 240 and two 50s for excitation). The 0s, that is to say the reactions in which the patient had not responded to the false signal, as had been agreed, were not counted in the averages. There were 7 in the normal state, 10 in the excited state and 19 in the depressed state.

It will be noted that the average times are **[228]** slightly longer than the general average (around 20). The figures obtained further show the decrease in attention in the three states and even more in the periods of normal state and depression. The average variations presented by the patient are related to the oscillations of attention; and the latter are very great in depression. In this state, the patient seemed to get tired from time to time and then gave very slow reactions. If we set aside these periods of distraction, we would realize that the arithmetic average is short and the variations not great.

On the other hand, incorrect reactions were more numerous in excitement (15) than in the normal state (11), and very rare in depression (3). The incorrect reactions were relatively short. The three for depression were 23, 26 and 70 (hence the median value (Scripture)[203] was 26); those in the normal state had a median value of 24 and those in the excited state had a median value of 20.

The patient lent herself well to experiments and in doing so showed a lot of self-esteem, especially excitement. As soon as she had a false reaction she seemed to wake up from a temporary numbness. So after this enormous reaction of 240 she rubbed her eyes and said: “Oh! I had forgotten, I thought it must not be held.”

[229] She seemed to react automatically, especially in her incorrect choice reactions, which were faster than the good ones. As soon as she was accustomed to one of two sounds, after two or three for example, we were sure to deceive her by changing the signal.

These experiments on reaction times show, if we only want to consider the two extreme periods, how, in this patient, excitement and depression are different. Excitation is characterized by greater speed of simple processes and by much less speed of complex processes; by more sustained attention and by more errors (bad reactions). Excitation represents pure automatism with its acceleration and absence of thought. In depression, intelligence is slower, attention tires easily (some very long reactions), but errors are much rarer.

The patient's letters also testify to the change in mental state in the two opposing periods. Here first is a letter written to her husband in excitement and which is remarkable for its abundance and its ideas of satisfaction.

My Dear A...,

“I am very concerned that I have not heard from you since October 29, which is a long time of three and a half months. What has happened to you since this time which really seemed so long to me? A serious indisposition to our mother, to you or to our dear great Paul. I do not**[230]** know what to think anymore

[203] Psychological year, 1896, p. 764.

and haven't for many weeks. As for an illness, I always assumed that you would have written to me, either at the beginning or during the period of improvement, or to one or other of the three of you. May the Lord now remove from our family the great misfortunes, especially the illnesses and the death of those whom we have always loved and whom we will love all our lives; because in almost fourteen years we have lost people very dear to our hearts, and our beloved children who would already be so grown up and so kind and would perhaps give us so much satisfaction. The will of the Almighty has been otherwise for us; we must resign ourselves and always hope to see better days ahead.

"I have some very good news to tell you about myself. First I will tell you about my health; It has been excellent for almost two months, except for aches, or rather, headaches that are quite violent and therefore of short duration, fortunately for me, right? On this occasion lack of appetite often occurs, only my mood is gloomy, I cannot engage in any serious work, nor in any distraction other than a good reading of a newspaper which interests me, such as the *Petit Journal* and its supplement which is lent to me by a companion quite often, which gives me great pleasure. Time passes much faster and more pleasantly when working on sewing or other no less pleasant tasks. In a few days, I hope to have this satisfaction.

"Please, dear friend, answer me immediately to reassure me or come see me next Thursday or Sunday; I await you with legitimate impatience.

"I also dare to hope that all our parents are doing well, for such long months on both sides without any news, I must put an end to this state of affairs, because my torment is very great on this side.

"I am happy to tell you that for the past two weeks, I have spent almost the entire day in the infirmary where you have come to see me several times. I help our two nurses**[231]** from 5:15 a.m. each morning until 5:00 p.m. Finally I help as much as I can and walk a lot, in bed at 8 o'clock in the evening. I tell you the good rest I'm taking; tired of walking as I do and on the polished floor, it is precisely a lot of exercise that the Chief Doctor recommended me to take to heal myself quickly. I almost forgot something very essential for all of us. A great joy for me is that an 8-day leave of absence has been granted to me by M...., this good Chief Doctor. All you have to do is come Monday or Friday morning from 9 to 10 a.m. or write to him and to the Director. Dear Augustin, I leave you not without kissing you from afar from the depths of my heart, as well as our dear son, our Paul who is kind, I hope, as well as obedient; I also send my best and kindest affectionate kisses to mother Bet... as well as to our beloved sister Hortense whom I will be so happy to see again soon."

Now here is another letter, written in depression, and which is remarkable for its laconicism and also its feeling of sadness.

"My Dear Husband,

"I have been a little ill for some time; If you had come to see me earlier the boredom would not have returned to me.

"I hope your health is good as well as that of our Paul and even mother Bet...

"I end by wishing you good health."

A few words about the periods and their succession. Excitement lasts less (12 days on average) than depression (15 days on average). The two periods have an average duration of 27 days, that is to say one lunar month. There does not appear to be any connection between the sequence of periods and....
[232]

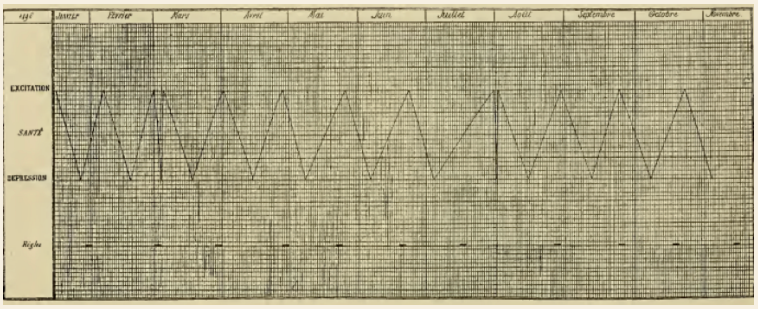

Fig. 24. — Circular melancholia; succession of periods. (By a vicious graphic arrangement, the angles, which were to represent the moment of greatest excitement or greatest depression, correspond to the changes of periods. The ascending lines indicate the duration of depressions, and the descending lines that of excitations.)

[233] ...the succession of phases of the moon. This is how each of the periods coincided, during the year 1896, with different districts.

The transition from depression to excitement usually occurs abruptly, overnight, from one hour to the next, and sometimes at noon. The same goes for the reverse passage. Rarely does one have time to observe an intermediate period between excitement and depression, which would constitute a normal state. Sometimes the period of excitation is interrupted by an excitation of short duration, which tends to lengthen its total duration.

Periods don't always come at regular intervals. They are usually observed at the end of the period of depression or at the beginning of the period of excitement, as can be seen, as well as the details listed above, in the table opposite (fig. 24). . The moon does not seem to have any action on the periods.

c. Remitting melancholia. —It only differs from the previous one in that instead of intervals of perfect health the patient presents simple remissions.

1. SYMPTOMATIC MELANCOLIAS

In the previous chapter we tried to describe the main clinical forms of melancholia.**[234]** Although the varieties with stupor, anxiety or hypochondriac delusion can present themselves as more or less pathogenetically linked with somatic states (intoxications, infectious diseases) and that, from this point of view, they would be amenable to the epithet of symptomatic, we mainly considered them in our description as pure psychoses. It therefore remains to study melancholia in its clinical modalities in relation to their more or less apparent causes, that is to say the clearly symptomatic melancholic states of which we will try to indicate – if necessary – the particularities of appearance and of evolution linked to pathogenesis.

Symptomatic melancholias are, for example, those which develop on a degenerative basis, those of alcoholic origin, those which develop in general paralytics. This means that, to analyze them, it is necessary to review the entire etiology of pure or symptomatic melancholia: the insane predisposition, hereditary, congenital or acquired, the outcome of which is degeneration, and the direct, social causes, biological, physiological, pathological, etc. Regarding each cause we will indicate – when necessary – the special morbid forms which they are likely to determine.

Mental illnesses can be accompanied by a melancholic state, which is associated with them. But**[235]** in cases of this kind, how can we establish that a particular group of symptoms forms a coexisting morbid species? Often – Guislain always said – mental illnesses begin with a stage of depression; like persecutory delusions. But should we see there an illness – melancholia – which leads to another? It is more logical to admit that the period of onset of the persecutory delusions is a period of a state of melancholic depression. Sometimes, however, there seems to be a real association of melancholic delusion and persecutory delusions, as emerges from an observation by Mr. Magnan.[204]

[204] Magnan, De la coexistence de plusieurs délires de nature différente chez le même aliéné, Recherches sur les centres nerveux, 1893, p. 413.

[236] CHAPTER V

ETIOLOGY

In this chapter we will have in view the study of the causes of all melancholic states, both those which we call pure psychoses and those which we call symptomatic delusions. If we acted otherwise, we would have to do two chapters on etiology. And as very often the same causes can produce psychopathic states which, for certain authors, have all the characteristics of essential mental disorders and which, for others, represent vague mental disorders, incapable of constituting morbid entities, we should repeat ourselves. However, we will gradually indicate those causes which are more particularly productive of melancholia-psychoses and those which are more particularly productive of symptomatic melancholia. Is it necessary to point out that the etiological factors are **[237]** much more numerous for the latter? Indeed we represent — at least this is currently the current opinion — the so-called true melancholias as essential illnesses whose causes are most often ignored or far removed as well as hereditary tendencies, or even simply occasional as well as the exterior pathologic influences and others. On the contrary, each time an etiological factor (alcohol, typhoid fever, general paralysis) is very apparent and seems to have great force, we are inclined to see in the psychopathic product only a symptomatic disorder. We will say in the course of this chapter what ideas the attentive study of the facts has allowed us to form on this subject.

It is natural to divide this etiological study into two large paragraphs: the predisposition that we seek to find at the origin of any mental illness and the causes that we can call
direct. For the presentation of this chapter we will follow the work plan of one of us,[205] where we will draw, by summarizing them, the facts which interest us here.

1. PREDISPOSITION.

An individual is said to be predisposed to a disease when, placed apparently under the same conditions **[238]** as other individuals, he is more apt than the latter to fall ill.

This predisposition, which is a general fact in all pathology, can be bequeathed by the ancestors or be acquired by the individual during his intrauterine development or later during his life outside the maternal womb. This means that this predisposition has hereditary or congenital factors or that it can be acquired.

Heredity. — In biology, we call heredity "the transmission of natural or acquired properties or qualities from ascendants to descendants through sexual generation.".[206]

While most naturalists[207] today are inclined to admit that acquired characteristics are not inherited or only in an exceptional way, and although on the other hand the disease is a character acquired by the individual, doctors firmly believe in the transmission of diseases of ascendants to descendants. We distinguish similar heredity — that is to say the transmission of the same pathological accident – from dissimilar heredity, which is on the contrary the transmission of a morbid element **[239]** transformed. The father bequeathing his cancer to his son is the first case; the epileptic engendering an insane person is the second. However, in pathology and especially in mental pathology, similar heredity is uncommon.

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[205] Ed. Toulouse, Les causes de la folie, Prophylaxie et assistance, 1896.

[206] Sanson, L'hérédité normale et pathologique, 1893, p.

[207] Weissmann, Essai sur l'hérédité, trad. H. de Varigny, 1892. — Wallace, Le darwinisme, trad. H. de Varigny (Bibliothèque évolutionniste).

Melancholia, for example, is rarely transmitted in nature; and it is relatively uncommon to encounter it in the ancestors and descendants of lypemaniacs. It does not appear that the descendants of melancholic people who themselves become insane are more often affected by lyeamania than by another variety of mental alienation.

However, the hereditary transmission of impulses to suicide, which is often linked to a variety of melancholia, has struck observers from Gall to our contemporaries.[208] Some families have been devastated, in the exact sense of the word, by suicide, which could cause up to six deaths in fifty years in a family (Le Roy).[209] Maccabruni's[210] observation is also very instructive in this regard. It has been noted that in family suicides, **[240]** means used were often the same.[211] It is still at the same age that individuals kill themselves or are seized with the desire to do so.[212] The same place is chosen.[213] But to what extent can we blame heredity for such similarities? Whether we accept the transmission of a certain organization and a certain character with a sad tendency, the idea can be supported with some plausibility. But if individuals use the same weapons, choose the same places, and this at the same age as their ancestors, it is mainly because they are pushed to imitate in an identical way the actions of their parents who greatly impressed upon them. Mark[214] said it very well: "In almost unanimous cases this hereditary disposition only degenerates into suicide by example."

In any case, it is not exceptional to find, among the ancestors of suicides, people who voluntarily killed themselves. But are these cases common? It should be noted that we have not looked for the facts – perhaps more numerous – of suicides generating subjects who do not manifest the same impulses. Ultimately we must accept that family suicides are exceptional events.

[241] As for melancholic states, we have said that nothing could lead us to admit that they are ordinarily transmitted in their form from ascendants to descendants. What is more ordinary is to see melancholic subjects, sons of other alienated people. "All forms of madness," said Marcé,[215] mania, melancholia, partial delusion, engender each other reciprocally and in an indistinct manner." Morel,[216] Griesinger[217] thought the same. Among the ancestors of melancholics we can therefore find all types of psychopaths. The work of M. Doutrebente[218] and M. Legrain[219] are very interesting in this regard.

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208 Esquirol, works cited, I, p. 580 and following. — P. Falret, De l'hypochondrie et du suicide, p. 5 and following. — Moreau (de Tours), Psychologie morbide, 1859, p. 170 and following — Cazauvieilh, Du suicide, de l'aliénation mentale et du crime contre les personnes, 1840. — Marc, De la folie considérée dans ses rapports avec les questions médico-judiciaires, 1840, t. II, p. 420 and following.

209 Le Roy, Étude sur le suicide et les maladies mentales dans le département de Seine-et-Oise, 1870, p. 199.

210 Déjerine, works cited, p. 66.

211 Hammond, in Feré, La famille névropathique, 1894, p. 29.

212 Esquirol, works cited, p. 580 et 581.

213 Mabilie, Trois cas de suicide survenant en trois ans chez trois sœurs, Ann. méd-psych., 1891, t. XIV, p. 228.

214 Marc, works cited, t. II, p. 420.

215 Marcé, works cited, p. 107.

216 Morel, Traité des maladies mentales, 1860, p. 115.

217 Griesinger, Traité pratique.... works cited, p. 186.

218 Doutrebente, Étude généalogique..., p. 197 et 368.

219 Legrain, Du délire chez les dégénérés, th. Paris, 1886.

But we don't only find insane people; we also meet neuropaths, because both are first cousins — as the first alienists had noticed (Guislain,[220] Griesinger,[221] Moreau (of Tours)[222]). This is how we find, either among the ascendants of melancholics, or among their descendants — because the descendants prove heredity as much as the ascendants **[242]** — hysterics,[223] epileptics,[224] of Basedowiens,[225] choreics,[226] subjects suffering from paralysis agitans [Parkinson's],[227] especially tabes.[228] Finally we can say that it is not a nervous disease,[229] neurasthenia, tics, multiple sclerosis, labio-glosso-laryngeal paralysis, progressive muscular atrophy, infantile paralysis, primary myopathy, diffuse myelitis, migraine, facial paralysis, senile tremor and hereditary essential tremor, which is not associated in the same families with melancholic states.

General paralysis is sometimes found in the ascendants of melancholic people or even in their descendants; and in cases where paralytics [243] belong to a disordered strain, we wanted to see a difference in the clinical appearance and the evolution of the patient.

Alcoholics are also very frequently encountered either as ascendants or descendants of melancholics. In everyday clinic it is easy to find examples of this heredity. Here is one:

OBS XII. – *Hereditary melancholia.*

T... Jean, accountant, thirty years old, entered the Ste-Anne asylum. (Service of Mr. Joffroy.)

The father, aged sixty, used to drink a lot of absinthe. It was only recently, after nervous accidents, such as sudden jolts and violent nightmares, that he began to drink less. The mother, aged fifty, had hysteria attacks when she was young and even five or six years ago. A maternal uncle is an excessively irritable and violent man, usually a drunkard.

The patient was born at full term. He was raised on a bottle, far from his mother. "Cradle cap" during childhood. Infantile convulsions during teething, and also during conflict. Croup at five years old. At school, not a very bright and undisciplined student; however he was able to pass his baccalaureate around the age of twenty-five.

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220 Guislain, works cited, t. I, p.437.
221 Griesinger, works cited, p. 182.
222 Moreau (de Tours), Psychologie morbide, works cited, p. 177.
223 Briquet, works cited, 1859. — Déjerine, works cited —Roubinovitch, Hystérie mâle et dégénérescence. Paris, 1890.
224 Bouchet et Cazauvieilh, De l'épilepsie considérée dans ses rapports avec l'aliénation mentale , Arch. génér. de méd., déc. 1825. — Herpin, Du pronostic et du traitement curatif de l'épilepsie, 1852, p. 325 et suiv. — Moreau (de Tours), De l'étiologie de l'épilepsie, Mém. Acad. de méd., t. XVlll, 1854, p. 55.
225 Raymond et Sérieux, Goitre exophtalmique et dégénérescence. Revue de médecine, 1892, p. 961 et suiv. — Joffroy, Nature et traitement du goitre exophtalmique, Progrès médical, 1894, p. 61.
226 Breton, État mental dans la chorée, th. Paris, 1893, p. 101. — Huet, De la chorée chronique, th. Paris, 1889.
227 Déjerine, works cited, p. 142.
228 Ballet et Landouzy, Du rôle de l'hérédité nerveuse dans la genèse de l'ataxie locomotrice progressive, Ann. méd.-psych., 1884, t. XI, p. 29.
229 Féré, La famille névropathique, Arch. de neurol., 1884, t. YII. — Id., La famille névropathique, 1894.

At the age of twenty-eight, he managed to find a place as a tutor at the Pontoise middle school; but, finding the service too difficult, he only remained there ten months. It was after leaving this middle school that he fell into a real bout of melancholia (intense mental pain with a feeling of deep discouragement and a desire to die). However, the weakening of will, so common among patients in this category who "do not know how to want", was such that having bought a revolver to **[244]** kill himself, he never had the courage to put his idea into action. It was a typical case of depressive melancholia with the two basic symptoms: mental pain and the slowing down of all psychological functions. This bout of depressive melancholia lasted a month. Recovered, he placed himself as a tutor at the middle school of Vitry-le-François, where he remained for only six months. At the end of this period of time a new attack, this time in a more active form. In a fit of mental pain, he wanted to cut his foreskin with scissors.

Today (1896) the patient presents with a depressed face. He speaks in a very low voice, and, from the start of the interrogation, complains of a psychological weakness consisting in the impossibility of associating ideas. He is perfectly aware of his state, which is characterized above all by a sort of psychological impotence. “I am incapable of doing anything,” he repeats every moment... “I wish I were dead.” No real delusional conceptions. No hallucinations.

The extremities are slightly bluish and cold, almost no appetite, constipation, saburral tongue, dry mouth; dynamometer: right hand. 11; left hand, 8.

But there are not only insane and nervous people in the ascendants of melancholics; there are also arthritic people[230], scrofulous and tuberculosis patients.

We must therefore arrive at this conception that the disordered predisposition and in particular the predisposition to melancholia are given by any ascendant who, insane, nervous, intoxicated, arthritic **[245]** or cachectic, is in a state of hypo-vitality. It is possible that the disordered defects of the ascendants are more frequently observed than the others; but the fact is only probable, because up to now we have barely been concerned with bringing the former to light.

In summary, we must provisionally accept that any individual, finding themselves in a poor state of nutrition, has a chance — especially if it is the mother (Baillarger) — of giving birth to a being who is poorly gifted biologically and a candidate for psychopathies, consequently for melancholic states.

Congenital factors. — We know that maternal illnesses are more easily transmitted to children than paternal illnesses; and we understand in fact that, as a result of placental exchanges, intoxications, infections, nutritional disorders and even the emotions which can produce the latter, are capable of disturbing the normal development of the fetus and consequently determining in him a state of degeneration. This is how we understand the physical and mental debility of the children of drunkards, of women affected during childbirth by serious illnesses. Children born in troubled times[231] are often degenerates, because of the physical and psychological miseries which have exhausted their **[246]** mothers. On the other hand we know that monstrosities are more frequent in the working classes where pregnant women work hard; and the experiences of Dareste[232] and M. Féré[233] account for the influence of physical and chemical agents on the abnormal development of embryos.

All observers (Esquirol, Lucas, Morel) noticed that children conceived during drunkenness were candidates for madness; and some of them become melancholic. It should be admitted that alcohol immediately alters the sperm or egg to the point of hindering their subsequent normal development.

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230 Charpentier, De la valeur des hémorroïdes et de quelques autres signes en aliénation mentale, Ann. méd.-psych., 1887, p. 283 and following.

231 Esquirol, works cited, t. 1, p. 67. — Féré, Les enfants du siège, Progrès médical, 1884, p. 243.

232 Dareste, Production artificielle des monstruosités, 2e édit., 1891.

233 Féré, C. R, Society of Biology, 1894.

In the case of acquired predisposition, it is the individual who, upon leaving the maternal womb, found poor external conditions, which prevented his perfect psycho-physical development. Alcoholism plays a large part in these events. We understand that, in the long run, this intoxication can, through the nutritional disorders it causes, reduce resistance to morbid causes and in some way degenerate the individual. Sometimes alcoholism dates from childhood; it is all the more pernicious. Finally we could see the alcoholism **[247]** of the wet nurse affecting the health of children.[234]

But cerebral diseases, especially meningitis, nervous diseases which strike the marrow, serious eruptive fevers, typhoid fever, these are commonplace and powerful causes of degeneration. Trauma, poverty with its deprivations and poor hygiene, finally all illnesses, which we will review shortly as direct causes of melancholia, can cause a more or less complete state of degeneration, i.e. that is to say a state of disordered aptitude.

We understand that the most powerful causes of degeneration will be those which can most easily hinder the normal development of the individual. This is why causes subsequent to birth are less active as they act on the already formed individual. Deafness makes a child of three years deaf and mute and greatly compromises his intellectual development, whereas, in a man of forty, educated and in full intellectual strength, the consequences of this accident will be less serious. Likewise, congenital causes are even more powerful, since they hinder the development of the embryo. **[248]** Finally, we understand that a hereditary cause, whose action is exerted from fertilization, can have equally harmful effects.

Here are briefly listed the three main factors of disordered predisposition, that is to say degeneration. All the causes examined above have the effect of making the individual, whom they reach directly or indirectly, more likely to become alienated under the influence of an illness or even a physical or mental shock. It should first be noted that these causes are so numerous that they can be found in almost every family.

It cannot be denied, however, that there are some who are more flawed than others. However, we do not know to what extent the defects, large or small, mental, nervous, arthritic, tuberculous or other that we find in most families, are dangerous. Even if we only consider clearly neuropathic defects, our ignorance is no less great. It would be necessary to identify a few families scattered over a territory, and calculate how many of these members there are cases of mental and nervous illnesses. We would have the average index of neuropathic defects widespread in the family groups of a country; because it must be admitted that the vast majority of families are more or less affected rather than completely unscathed. When, in a given family, **[249]** we would find an index higher than this, we would be authorized to say that it is more defective than the average. Otherwise – and this is what happens today – the investigation is carried out on an unlimited number of members of a family group, on the most distant ancestors and collaterals, and if, on a very high number of In individuals, we encounter two or three cases of neuropathic defects, it is said that the family is very defective. However, it could be that at this rate the defect is still — given the number of subjects targeted — equal to or even below what we observe in the majority of cases. Research of this kind is very difficult to pursue; Ball and Regis[235] tried them and did not arrive at very precise results.

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[234] Charpentier, De l'influence de l'alcool, de la nourrice sur les convulsions du nourrisson, Bull, de la Soc. protectr. de l'enf., 1873. — Ed. Toulouse, Gaz. des hôpitaux, 1891, p. 914. — Vallin, Académie de médecine (20 oct. 1896).

[235] Bail et Régis, Les familles des aliénés au point de vue biologique, Encéphale, 1883.

What statistics did not do, the clinic attempted. But it must be admitted that preconceived ideas greatly guide the observer's research. This is how negative cases, in the study of morbid transmissions, are neglected. Now if two out of ten offspring of the insane are neuropaths or madmen, we are authorized to say that morbid transmission occurred twice out of ten cases, but also — which is not usually said — that it was not carried out eight times out of ten cases, a higher proportion than the other. On the other hand, the defects of **[250]** ascendants are not all equivalent. Those which strike the father are much less serious for the descendants than those which affect the mother, who feeds the child for nine months and can during this time transmit to him an infectious disease or cause him to adopt habits of vicious nutrition. On the other hand, is old syphilis, which is hardly in the blood of the ascendant except in a vaccine state, comparable to recent syphilis or even to chronic alcoholism, where all the tissues of the generating organism are soaked in poison permanently? Great circumspection must therefore be exercised when examining hereditary defects,[236] and only admit as truly dangerous those in activity. Deep intoxication, a serious dystrophic illness in progress, mental alienation at the time of pregnancy or fertilization, these are defects which are likely to have an unfortunate influence on the psycho-physical development of the embryo.

In other words, a defect in the ascendants is information that must be examined closely. Often it has no chance of impacting the offspring. Also any individual who has a hereditary neuropathic history should not, because of this, be considered a degenerate. Likewise we **[251]** will not say that a son of a syphilitic has by the *very fact* hereditary syphilis. We must study the subject, examine him, question him, and find out if, in his physical conformation or in his psychological organization, there are not defects proving that he is really poorly gifted and incapable of adapting without clashing with the necessities of the external environment where he lives.

This is, in short, how those who have been concerned with the study of degeneration have understood the question. Morel[237] and later Mr. Magnan[238] who continued his work by expanding and completing it, sought the signs capable of detecting degeneration, that is to say the physical and psychological stigmata. These are too well known for us to describe them here. Let us just say that we must, in the crowd of stigmata described in recent times, make a judicious choice and retain only the most serious, those which endanger the proper functioning of the organ in which we observe them.

Certainly, such a choice is not easy to make, and that is why the theory of degeneration oscillates a little. Some tend to circumscribe the latter, others to broaden it. M. Joffroy[239] **[252]** thinks that, to be insane, one must be more or less unbalanced and that madness only develops among degenerates in one capacity or another. But that does not prevent the fact that there are, among these, some more degenerate than the others. From this point of view, M. Magnan's types represent the most poorly gifted subjects, the most incapable of adapting to their environment, the most predisposed in short to madness. With them the predisposition is at its maximum; also the action of direct causes can be at a minimum and still cause serious psychopathic disorders, which will betray the character of the subject much more than the etiological element which activated them. When the predisposition is so strong, the slightest shock brings delusion; but it is clear that this delusion cannot reflect much on the cause (alcohol, infection) which simply provoked it. It will detect the mental character of the individual. But what is it? The basis is debility to any degree, mobility, inconsistency. As a result, the delusion will rarely stay on the same track. He will go from one subject to another; ideas of persecution will mix with ideas of grandeur, mystical ideas with hypochondriac ideas. It will be a polymorphous delusion. It

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236 Ed. Toulouse, Les causes de la folie, 1896, p. 323.

237 Morel, Traité des dégénérescences physiques, intellectuelles et morales de l'espèce humaine, 1837.

238 Magnan et Legrain, Les dégénérés, collection Charcot Debove.

239 Joffroy, De la folie choréique, Semaine médicale, 1893, p. 91. — Id., Congrès des médecins aliénistes et neurologistes (Session de Clermont-Ferrand, 1894).

will be born suddenly, since the individual is still sub-delusional, and it may disappear in the same way. Finally, agitation will quickly lead, through rapid exhaustion, to a correlative depression; also long periods of mania **[253]** frank will rarely be observed in these degenerates. This is how we can understand and justify M. Magnan's theories.

What is true of delusion in general is true of melancholia. The melancholic states of the seriously degenerate are above all characterized by this abruptness of appearance and disappearance, this delusional polymorphism and this irregularity in the evolution which are the result of the mental character of the deficient, of unbalanced. We will find cases of this in several works and in particular in the thesis of Mr. Legrain.[240] Here is one:

OBS XIII - *Depressive melancholia in a feebleminded person.*

Mme Hé...., twenty-eight years old, entered Ste-Anne (Service of Mr. Joffroy.)

Father died at sixty-two from chest inflammation; lively and quick-tempered, but a good husband and father; didn't drink. Mother aged sixty-five; of sad character, but very gentle; not nervous. Three brothers and three sisters who are all healthy and normal; Among the sisters, one has melancholic tendencies.

She had scarlet fever around seven years old. She learned quite well; she knows German and French. Very cheerful in her childhood, she was very fond of games. This cheerfulness persisted until the age of twenty-three; and the patient even says that she did not know a young girl happier than her, nor in a more joyful mood until she was twenty-three. Menstruated around thirteen; well adjusted since that time. She left school at thirteen and remained at home until fifteen, taking care of the household. At that time she came to Paris with her mother and, almost **[254]** immediately, as her lack of attention prevented her from learning a trade, she placed herself as a servant. She stayed in the same place for nine years and was quite happy there, although she had to work a lot. However, she had some small troubles because of her irritable character and her combative spirit.

At twenty-three, she completely changes her character; from exuberant cheerfulness up until then, she becomes sad and concentrated. She explains this metamorphosis by family troubles, and in particular that of seeing her brothers and sisters settle down, marry, have children, while she remained single and a domestic. She left her place on impulse, but only stayed two weeks with her mother, moved back and spent four years in the same house. Then she was seized with the desire to learn the trade of seamstress so that she could work for her mother, as the trade of a servant displeased her more and more each day. She became even more sad, discouraged, depressed. She lost sleep, imagining that she was facing persecution. Soon she felt incapable of any work and had to return to her mother. She was very unwell there for a long time, then recovered a little. However, she was not completely cured; work at home was only possible intermittently. Very often, it happened to her that she was unable to do anything, the very idea of work being very painful to her. On those days she felt a need to go out and walk which she could not resist. So she would leave her mother and go wandering at random, sometimes for a whole day, preferably looking for solitary places. These ideas sometimes even took hold of her at night in her bed; she had to exert extreme violence on herself not to give in, thinking of her mother's pain if she noticed her nocturnal escapes. Ordinarily her sleep was very poor, which caused her annoyance. In addition, she said, she was subject to violent itching all over her body without the slightest eruption. It was at this moment that she decided to commit suicide. One

[240] Legrain, Du délire chez les dégénérés, th. Paris, 1886.

morning, her **[255]** mother had not spoken to her as friendly as usual; she had also noticed that visits from her brothers and sisters had become rarer for some time. So she left her house and wanted to go and jump into the water. Her mother, having suspected something, followed her and brought her back. A little later, the patient made another suicide attempt with laudanum, which caused her to be interned.

When she entered the asylum, it was difficult to obtain information from her. The patient speaks in a somewhat incoherent manner, says meaningless words in an important manner, appears to have a pronounced mental weakening. She moves from one idea to another abruptly and without any transition. Her thoughts of suicide have no substance: she invokes futile reasons to explain them. Besides, she only decided with great hesitation to put them into action, spending a whole day on the water's edge without throwing herself in, preferring poisons, because this method requires less courage. But this second attempt also aborted, the laudanum having only produced repeated vomiting in her. She also has some ideas of negation: often in fact it occurs to her that her blood is not circulating.

Among the physical symptoms, it should be noted that the tickling reflex is abolished in the palms of the hands; patellar reflexes are reduced especially on the left; hands and feet are cooled. Sensitivity is normal.

On February 15, 1896, the patient was much improved; she speaks effortlessly and sensibly; she became much more cheerful and laughed easily. She explains her suicide attempt in a more reasonable way, saying that she wanted to end her life because she did not want to cause her mother any more grief with her eccentricities and inexplicable outings. She admits that she no longer has the slightest idea of suicide.

[256] But below these degenerate types of M. Magnan, there is a whole hierarchy of individuals who are getting closer and closer to a normal psychological state. For these, the direct causes must be, in order to act, more powerful; and, as they will have had time to practice for longer, they will make their stamp on the psychopathic form.

So the predisposition has degrees. When it is at its maximum, it can be activated by the slightest causes which above all reveal the original debility of the subject and are therefore called occasional; when it is at a minimum, it requires a greater shaking of the organism, and then we can more easily establish an etiological link between the morbid form and the effective cause. But let us not forget that, hereditary or acquired, the predisposition by itself cannot create anything. It is a vague force, which requires it to be activated by something. And this something is poisoning, brain damage, diathetic disease. These are the direct causes, whose importance has been too diminished in recent times in a current of opinion against which one of us has tried to react[241]; we will study them in their relationship with melancholia.

[257] 2. DIRECT CAUSES.

Some of the causes that we will review in this chapter could just as easily be classified with the predisposing causes. Age and sex, for example, can only act by disposing the being to resist more or less well the attack of a morbid agent. This is true in a sense; but on the other hand, isn't senility, which is one of the almost usual consequences of age, a clearly defined pathological state, with precise lesions? In this case it is more than a disposition to delusion, it is an immediate, direct cause.

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[241] Ed. Toulouse, Les causes de la folie, 1896.

On the other hand, the most efficient causes, alcoholism in particular, sometimes act by unbalancing the individual, making him less able to withstand the action of other morbid agents which then lead to delusional disorders. We will therefore keep our classification; because all this only proves one thing that, like all the others, it can only serve for the convenience of description.

a. Social causes. — Civilization has been accused of increasing the number of cases of madness. This increase, which is more apparent than real and which follows the increase in population as well as the extension of public assistance, is mainly caused by alcoholism and general paralysis. **[258]** Psychoses, and among them melancholia, do not appear to be much more numerous at present than at the beginning of the century. It must also be said that the statistics are no longer comparable, because the alienists who developed them do not have the same ideas and therefore did not use the same labels as our[242] contemporaries.

Major political or social upheavals often cause a perhaps exaggerated increase in cases of madness. The events of 1870-71, which caused many cerebral victims, caused melancholic states with stupor and thoughts of suicide, but in fewer numbers than exuberant psychoses (Lunier[243]). These concussions have been accused of disturbing especially the predisposed (Belhomme,[244] Lunier[245]). However Lunier had noted, among the insane people of 1870-71, a proportion of hereditaries less than half that which is usually observed in the antecedents of psychopaths.

Exaggerated religious ideas sometimes develop into melancholic states with mystical ideas. **[259]** Demonopathy epidemics[246] were common in the Middle Ages; Along with mystical ideas, erotic ideas often arise.

Marital status does not seem to have a very obvious influence on the production of melancholia. If we consider suicide as a manifestation of the latter, we notice that it is single adults who kill themselves the most, then come widowers without children and lastly married men with children. Men commit suicide more than women, when single or widowed, and a little less than them when married (Socquet[247]).

We can also assess professions in their relationship with suicide. According to M. Socquet, the populations where there would be proportionally the most suicides would be those of people without confession, liberal professions, and those where there would be the least would be agricultural professions.

There has been much discussion about whether the prison regime can cause insanity. It must be noted first of all that many delinquents are degenerates and therefore more apt than others to become delusional; on the other hand it happens quite often that the insane are misunderstood and condemned (Legrand du Saulle, Pactet, Joffroy, Garnier, **[260]** Magnan, H. Monod). They did not go crazy in the prisons because they already were. For others the anti-hygienic, anti-moral and anti-physical regime of imprisonment can cause madness. A depressive state with hallucinations and ideas of persecution has even been described, which are said to be common among imprisoned criminals.[248] On his side, Nacke[249] found no melancholic out of 53 insane inmates.

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242 For example the statistic of Esquirol, Traité des maladies mentales, works cited, t. II, p. 687, and that of M. P. Garnier, La folie à Paris, 1890, p. 24.

243 Lunier, De l'influence des grandes commotions politiques et sociales sur le développement des maladies mentales, Ann. méd.-psych., 1872, 1873, 1874.

244 Belhomme, Influence des événements et des commotions politiques sur le développement de la folie, 1849.

245 Lunier, De l'influence, works cited, 1873, t. IX, p. 245.

246 Calmeil, De la folie, etc., 1845

247 Socquet, Étude statistique sur le suicide en France de 1827 à 1880, Ann. méd.-psych., 1889 and 1890.

248 Semal, Coup d'œil sur les folies pénitentiaires, Congrès international de méd. ment., Session de Paris, 1889.

249 Nacke, Crime et folie chez la femme, All. zeits. f. psych., 1893, t. 94, p. 396.

b. Biological causes. — The age of manifestation for madness seems to be adulthood. This period of life produces the most insane people, compared to youth and old age. Childhood is in fact more spared from madness; but it is not the same with old age. And if we look at how many become insane out of the same number of individuals aged twenty, twenty-five, thirty and so on up to the extreme age of life, we see that the more one advances towards old age, the proportionately more insane there are.[250] In old age the proportion of the insane relative to the number of existing individuals becomes enormous. The same observation was made for suicide (Socquet).

Melancholia can appear at all ages, **[261]** in children, adults and the elderly. Puberty sometimes causes psychopathic states of which we have wanted to make special morbid varieties;[251] among the forms observed, melancholic states are not rare. We understand the pathogenesis if we consider that these psychopathic causes, acting at this biological moment, are of a depressive nature. The body of certain poorly gifted subjects cannot bear the cost of sexual evolution, of the transformation of the child into an adult, and this deficit results in a melancholic state. Likewise early dementia[252] and also general paralysis[253] occur quite easily in certain degenerate adolescents.

Old people, especially those who have inherited madness[254] can present melancholic states in all respects analogous to those seen in adults. But we also observe melancholia among them which takes on special characteristics from the background of psychological weakening, which goes hand in hand with senility. The latter is more or less late and does not always follow age. When it occurs in **[262]** an individual, it manifests itself by well-known phenomena of atrophy (Charcot) and atheroma. Psychoses, and in particular melancholic states, which evolve in this area, present a certain dementing tendency, and are sometimes only a mental aspect of senile dementia.[255] Delusions are rare and monotonous; the reaction phenomena are not very noisy.

Sex is not an indifferent element in the etiology of melancholia. We know that insane women are more numerous than men, although female admissions to asylums are slightly fewer than male admissions.[256] This is because men are more often affected by alcoholism and general paralysis, curable or fatal illnesses, which through discharges or deaths reduce the number of the population of insane people present in hospital establishments. Fewer women, on the contrary, enter asylums, but they stay there longer. They suffer from psychoses more frequently than men. M. Garnier's statistical research[257] show that, out of 1000 female admissions, there are 150 attributable to **[263]** melancholia, and, out of 1000 male admissions, there are only 37. Why this difference? We must remember, to explain the frequency of melancholic states among women, that they find themselves in an inferior social situation. Material misery is more common and heavier among women; domestic sorrows too. Finally, pregnancy is a source of fatigue exclusively for women. All these depressive causes put the body in a state somatic very favorable to the development of melancholia.

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250 Esquirol, works cited, t. II, p. 674 and following, and pl. XXVI.

251 Mairet, Folie de la puberté, Ann. méd-psych., 1888, t. VIII, p. 337; 1889, t. IX, p. 34, 209 et 353.

252 Roubinovitch, Démence juvénile avec athétose double, C. R. du Congrès des aliénistes et neurologistes (Session de Bordeaux, 1895).

253 Ed. Toulouse, La paralysie générale juvénile, Gaz. des hop., 1893, p. 909.

254 Pécharman, Essai sur les psychoses de la vieillesse, th. Paris, 1893.

255 Ed. Toulouse, Étude clinique sur la mélancolie sénile chez la femme, th. Paris, 1891.

256 Constans, Lunier and Dumesnil, Rapport à M. le Ministre de l'Intérieur sur le service des aliénés en 1874, Paris, 1875.

257 P. Garnier, La folie à Paris, 1890, p. 25.

c. Physiological causes. — Both the excess and the lack of exercise of physiological functions lead to a more or less profound disturbance in the mental state. Excess in the intellectual or physical sphere causes fatigue[258], that is to say a state of nervous exhaustion to which is added auto-intoxication caused by the exaggerated production of elimination products; and this state manifests itself by a psychological laziness, a nervous breakdown comparable, in small ways, to the stupor of melancholic people. This is how serious illnesses, such as typhoid fever, which leave enormous fatigue in their wake, must act. It has also been said that hysteria is comparable, through its mental state of distraction, to a **[264]** chronic fatigue[259]. Overwork is one of the elements of civilization; it especially affects those who are poorly gifted from a mental point of view.

But lack of exercise often causes depressive states. Many hypochondriacs maintain their delusional ideas in an inactivity calculated to make organic sensations more vivid. The transition from an active life to a life of rest has always been considered dangerous and capable of causing melancholia (military, industrial, etc.). This is how Legrand du Saulle noted that soldiers and civil servants died in greater numbers in the first year of their retirement, that is to say in the transition period. It seems that an individual's nerve cells are accustomed to sensations coming from the external environment as well as to the excitement of poisons (morphine, tobacco). The suppression of these sensations causes cravings and sometimes a nervous breakdown.

Starvation is, with its hyperthermia, a somatic condition favorable to depressive delusions. After prolonged fevers (typhoid fever), this is sometimes the real cause of the mental disorders that we observe.

The absence of physiological activity can also be due to the congenital or surgical absence of a **[265]** organs.

We know that when the thyroid gland is missing, we have myxedematous idiocy, the main characteristic of which is physical and psychological arrest. Likewise, castration in men and women can cause depressive delusions, partly by suppressing the internal secretions of these glands which seem to have general tonic properties.

The abuse of venereal pleasures, even more than their deficiency, sometimes causes states of depression. We must also remember that “no one goes to excess” and that those who do are frequently unbalanced. Masturbation has often been accused of causing melancholia. It does not seem more tiring than coitus; but it is especially practiced untimely by unbalanced people, in whom the resulting depression is always greater.

Sleep deprivation is a nervous fatigue that is frequently encountered at the origin of melancholia. But sometimes it is only the prodrome of mental illness. Dreams often betray delusion, even before it appears during the day[260]. Melancholic people usually have very painful dreams.

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[258] Mosso, La fatigue, trad. Langlois, 1894.

[259] Féré, La pathologie des émotions, 1892, p. 158 and following.

[260] Faure, Étude sur les rêves morbides, Arch. génér. de méd., 1876, p. 558.

The disorders of *menstrual functions*[261] are **[266]** frequently noted in the etiology of melancholia. Sometimes it is the establishment of the period that is called into question; other times, neuropathic disorders or suicidal impulses[262] appear at the time of menstruation and then disappear after them. Other times, on the contrary, it is their absence which seems to provoke them. But amenorrhea is so frequently associated with madness that it can be said that it is often only the symptom. When menses reappear, they sometimes exaggerate the anxiety of melancholic people. And in certain cases their return without improvement of the mental state can be considered as having a serious prognosis (Esquirol).[263]

It is difficult to explain all these seemingly contradictory cases. Often menstrual disorders, amenorrhea for example, are, like mental phenomena, symptoms of a general disorder of the organism. There is only a relationship of coexistence between melancholia and amenorrhea and not of cause and effect. Other times we can imagine that menstrual disorders lead, through abundant bleeding, pain, self-intoxication or even, through the absence or reduction in the secretion of ovarian fluid, to a state of melancholic depression.

[267] The puerperium[264] has connections with melancholia. Pregnancy can cause, especially among mentally ill, melancholic states where obsessions are not rare. Auto-intoxication, caused by functional insufficiency of the liver and kidney, and the fatigue caused by the development of the fetus explain the outbreak of these psychopathic disorders. Childbirth often causes delusions which take on the mask of melancholia, but which are in fact mental confusion caused by an infectious element;[265] but it also causes melancholic states. Lactation, through the fatigue it imposes on the woman, sometimes creates the somatic conditions specific to the development of a melancholic state. It is generally admitted (Magnan, Joffroy) that the puerperium is not the effective cause of the psychoses that we observe. For some mentally ill, it would only be an opportunity to go crazy. We think **[268]** there is a question of form. In certain cases, somatic disorders are such that they almost inevitably awaken psychopathies. And on the other hand, each of the puerperal processes tends to put its personal stamp on mental disorders; it was based on these facts that one of us said that there were no etiological psychoses, but that there were pathogenic psychoses.[266]

d. Psychological causes. — They are the most common[267] causes of madness and especially melancholia. They are observed more often in women than in men (Marcé). According to Parchappe[268] they would not be the same in both sexes. The same must be said for the ages (Esquirol). All depressing emotions, the main ones of which cannot be listed here, and especially domestic sorrows which occur every day, can gradually create a state of melancholic depression. This is a cause of lypemania, even of the so-called essential variety. Thwarted love sometimes causes melancholic states which have been seen to end in death (Morel). But often the real cause of delusion is not love sorrow, but rather regret of the position **[269]** lost with the breakdown of the marriage. The union of young girls with old men or immoral beings, unjust accusations are sometimes noted. Remorse[269] have also been reported, as in the following fact:

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261 Icard, Contribution à l'étude de l'état psychique de la femme pendant la période menstruelle, Paris, 1889.

262 Brierre de Boismont, Du suicide et de la folie, 1865, p. 206.

263 Esquirol, works cited, t. I, p. 364.

264 Esquirol, works cited, t. I, p. 230 and following. — Marcé, Traité de la folie des femmes enceintes, 1858. — De Gorsky, Considérations sur la folie puerpérale et sa nature, th. Paris, 1888. — Lallier, De la folie puerpérale dans ses rapports avec l'éclampsie et les accidents infectieux des suites de couches, th. Paris, 1892. — Ballet, Les psychoses puerpérales, Médecine moderne, oct. et nov. 1892. — Ed. Toulouse, Étiologie et formes cliniques des psychoses puerpérales, Gaz. des hôpit., 1893, p. 1057.

265 Ballet and Roubinovitch, Contribution à l'étude des auto- intoxications dans les maladies mentales. — C. R. du Congrès des neurologistes et aliénistes. La Rochelle, 1893. — Ed. Toulouse, Délire infectieux de la période post-puerpérale, Tribune méd., 1893, p. 686.

266 Ed. Toulouse, Les psychoses puerpérales, works cited.

267 Esquirol, works cited, t. I, p. 62. — Griesinger, works cited, p. 196. — Guislain, works cited, t. I, p. 399.

268 Parchappe, Art. Aliénation, Diction. encycl. des sc. méd., 1st s., III, 1865.

269 Morel, Traité..., p. 229 et 230.

OBS XIV. — - *Melancholic delusion; ethical cause.*

Mme Ta..., Pauline, thirty-seven years old, baker, entered the St-Yon asylum, June 15, 1893.

Mentally ill uncle, sister prone to nervous attacks.

Measles at age eleven; would have always had a "stomach ache" (?). Menstruated at approximately fourteen years; has always been well regulated, two pregnancies (two girls aged ten and twelve, in good health). No seizures. Gentle character, but quite mobile.

She cheated on her husband with her brother-in-law in March. This lasted for a short time, after which she pushed her brother-in-law away. She had remorse which made her cry, she hardly ate anymore; At night she did not sleep. It seemed to her that everyone knew it, that people were looking at her; she heard voices accusing her. She even thought she read allusions to her fault in the newspapers. One evening, pressed with questions by her husband who questioned her about her condition, she confessed to her action. Besides, she would have told everyone at that moment; She had to confess to those around her to make amends. This is how she confessed it to another woman who advised her not to tell her husband; she also wanted to entrust him one day to one of her uncles. Her husband forgave her and, seeing her ill, had her interned.

When she first arrived at the asylum, she was very sorry, she cried for part of the day. Sometimes she seemed devastated. Other times, she agitated as if in fits of despair. She **[270]** saw the asylum in flames and voices told her that she was going to burn in the fire. One night, she broke windows to escape. Another time she tried, in a panophobic paroxysm, to strangle the patient who was near her; but she was prevented from doing so. Ordinarily, during the day and at night, she heard the police commissioner coming to arrest her husband. It seemed to her that the latter was handcuffed when he came to see her. She wanted to go to prison with him. But the fires often returned before her eyes, even outside of sleep and while awake.

Nostalgia,[270] which is a sad and prolonged emotion, especially affects young people and particularly men who leave their country more often than women. It is more common among rural inhabitants who come to the city, among the illiterate and also in certain races (Bretons, Corsicans, French). It is mainly characterized by a state of melancholic depression, where impulses to suicide are common.

It is especially sad emotions that cause melancholic states, as do other mental alienations.[271] In cases where joy appears to be involved, there is often hidden pain. A man becomes hypomanic upon learning of his appointment to an important position; now the real cause of his illness was having, to take possession of his post, to leave **[271]** his mistress (Esquirol). However, undeniably cheerful emotions could have caused melancholia and, above all, stupor. Pinel[272] recounts the case of an artilleryman who had submitted the project for a new cannon to the Committee of Public Safety; a favorable letter from Robespierre moved him to such an extent that when he read it he was struck with amazement.

Violent emotions often cause stupor: the sight of a fire[273] the death of a loved one, the spectacle of war, rape, etc.; sad and renewed emotions rather provoke depressive and anxious melancholy.

How do emotions work? Like too intense nervous excitement. They depress either suddenly or over time. The effects of emotions, which themselves have somatic conditions, are therefore to the highest degree physical.

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270 Benoist de la Grandière, De la nostalgie ou mal du pays, 1873.

271 Esquirol, works cited, t. I, p. 59.

272 Pinel, Medical-philosophical treatise on mental alienation, p. 184.

273 Morel, Études cliniques, t. I, p. 295.

Melancholic ideas are sometimes transmitted from one subject to another: this is then a question of mental contagion. We can classify these facts with emotions, because sometimes delusional ideas seem to be communicated because of the impression they cause[274]. This is how suicides are often epidemic[275] ; it is the same **[272]** way that melancholic states appear contagious, while ideas of persecution, which are transmitted very easily (J. Falret and Lasègue), rather take the mode of slow suggestion.

[274] Pronier, Étude sur la contagion de la folie, Genève, 1892.
[275] Paul Moreau (de Tours), De la contagion du suicide à propos de l'épidémie actuelle, th. Paris, 1875.


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