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Part I.—Original Articles.

MELANCHOLIA: A HISTORICAL REVIEW.

By AUBREY J. LEWIS, M.D., M.R.C.P.,
Assistant Medical Officer, The Maudsley Hospital.

PART I.

MELANCHOLIA is one of the great words of psychiatry. Suffering many mutations, at one time the tenacious guardian of outworn schemes or errant theories; presently misused, cavilled at, dispossessed, it has endured into our own times, a part of medical terminology no less than of common speech. It would seem profitable to consider the history of this word, and of the states of fear and distress with which it has from the beginning been associated.

THE ANCIENTS.

The beginning was with Hippocrates (1): "If fear (phobos) or distress (dysthymia) last for a long time it is melancholia," he wrote, and so fixed the word. He insisted on the special temperament and constitution which tend to melancholia. His notion that black bile and phlegm altered the brain in its hotness and humidity, thus darkening the spirit and making melancholy, was to influence much subsequent speculation, and all classification was reared on his divisions—mania, melancholia, paranoia, phrenitis; but it is evident that for Hippocrates the atrabiliar conditions were numerous, and that the term "melancholia" covered diverse states, now otherwise regarded. Furthermore, he considered epilepsy and melancholia to be closely related: "melancholics ordinarily become epileptics, and epileptics, melancholics: of these two states, what determines the preference is the direction the malady takes; if it bears upon the body, epilepsy, if upon the intelligence, melancholy." To the seasons he imputes much influence. However little now remains of these latter beliefs, once current in the School of Cos, there has been in recent times

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fresh interest in the doctrine of temperaments, most active and justified where depression and mania are in question ; there has even been a revival in France of the long-rejected theory that black bile is the source of melancholy.

Aretæus (2) of Cappadocia gives a detailed description of severe melancholia : “ If it (black bile) be determined upwards to the stomach and diaphragm, it forms melancholy, for it produces flatulence and eructations of a fetid and fishy nature, and it sends rumbling wind downwards, and disturbs the understanding. On this account, in former days, these were called melancholic and flatulent persons. And yet, in certain of these cases there is neither flatulence nor black bile, but mere anger and grief, and sad dejection of mind. . . . It is a lowness of spirits from a single phantasy without fever ; and it appears to me that melancholy is the commencement and a part of mania. For in those who are mad, the understanding is turned sometimes to anger and sometimes to joy, but in the melancholics to sorrow and despondency only. But they who are mad are so for the greater part of life, becoming silly, and doing dreadful and disgraceful things ; but those affected with melancholy are not every one of them affected according to one particular form ; but they are either suspicious of poisoning or flee to the desert from misanthropy, or turn superstitious, or contract a hatred of life. Or if at any time a relaxation takes place, in most cases hilarity supervenes, but these persons go mad.”

He points out the recurrent character of the conditions, gives criteria of differential diagnosis, and concludes : “ The characteristic appearances, then, are not obscure ; for the patients are dull or stern, dejected or unreasonably torpid, without any manifest cause : such is the commencement of melancholy. And they also become peevish, dispirited, sleepless, and start up from a disturbed sleep. Unreasonable fear also seizes them, if the disease tend to increase, when their dreams are true, terrifying and clear ; for whatever, when awake, they have an aversion to, as being an evil, rushes upon their visions in sleep. They are prone to change their mind readily ; to become base, mean-spirited, illiberal, and in a little time, perhaps, simple, extravagant, munificent, not from any virtue of the soul, but from the changeableness of the disease. But if the illness become more urgent, hatred, avoidance of the haunts of men, vain lamentations ; they complain of life and desire to die. In many, the understanding so leads to insensibility and fatuousness, that they become ignorant of all things or forgetful of themselves, and live the life of the inferior animals.”

Melancholia, like mania, Aretæus would localize in the hypochondrium, and he would have it the fundamental form, from which other psychotic varieties develop—a doctrine that lasted until the end of the nineteenth century.

Asclepiades and his follower, Cælius Aurelianus (3), though important in the general history of psychiatry for their advocacy of rational therapy, have little to say about melancholia ; the latter of them points out the distinction between the mood-disorders of mania and of melancholia. Celsus (4), another of that period, and greatly productive, includes many depressive states under

the heading "phrenitis"; he classifies partly according to duration, and speaks of "another kind of madness which continues a longer time and goes no further than a sadness", and of a "third kind of insanity, the longest of all, inasmuch as it does not shorten life. There are two species of this. In some the deception arises from false images. . . . If imaginations mislead, first of all it must be observed whether they be melancholy or merry". He classes melancholia among the partial deliria (general delirium being mania). His treatment is a curious mixture of very good and very bad.

Galen (5), living in the second century, developed the humoral pathology. Hippocrates (1) had insisted on the importance of the brain: "Men ought to know," he wrote, "that from the brain, and from the brain only, arise our pleasures, joys, laughter and jests, as well as our sorrows, pains, griefs and tears. . . . It is the same thing which makes us mad or delirious, inspires us with dread or fear. . . . The corruption of the brain is caused not only by phlegm, but by bile. You may distinguish them thus. Those who are mad through phlegm are quiet and neither shout nor make a disturbance; those maddened through bile are noisy, evil-doers and restless, always doing something inopportune." Galen agrees with this in general—"if we were well acquainted with the physiology of the brain, we should assuredly find in its pathological condition both the place and nature of the remedy"—but when he comes to speak about the humours and the part they play, he expresses not hopes and apodemes, but assured opinions. Melancholia depends on a superfluity of black bile "in the very substance of the brain"; the melancholy humour is a condition of the blood, "thickened and more like black bile, which, exhaling to the brain, causes melancholy symptoms to affect the mind". He attacks Erasistratus for denying this. Under the designation "melancholia" he describes indubitable schizophrenic pictures, and he agrees with Hippocrates as to the relation between epilepsy and melancholia.

There is in Plutarch an admirable description of one afflicted with religious melancholy, but it is proposed to abstain here from those citations out of non-medical writers and discussions about the madness of famous personages, from Hercules onwards, which are common in articles of this kind, but belong less to the history of psychiatry than to its *belles-lettres*.

THE MIDDLE AGES AND AFTER.

From the time of Galen there is a long blank in occidental psychiatry. The influence of the Church was unfavourable. Demonology became the speculative foundation of thought about mental disorders. Exorcists continued through the Middle Ages the tradition of priestly intervention, long known among the peoples of antiquity. Religious value was placed on many of the signs of mental disturbance. In the East, and especially in Turkey, matters were better, but in Christendom, apart from a Greek survivor like Paulus

Ægineta (6) and an occasional later voice like that of Jean le Charlier (7), belief in demoniacal possession, incubi and succubi, witchcraft, lycanthropy and such like usurp the place of medicine in this field. With the sixteenth century there is a gradual revival of empirical medicine in the study of insanity, characterized in part by a reversion to the teachings of Hippocrates and Galen, and by attempts at classification and a recognition of natural causes associated with the names of Paracelsus, Weyer and Plater.

In their views on melancholia, the majority of the writers of the first half of the sixteenth century repeat what Galen had said. Thus, Vallesius (8), in his *Tractatus Medicinalis* and his *Methodus Medendi* (1559–1589), compares and judges previous views about melancholia and gives as his own opinion “melancholia morbus non fit sine melancholia succo, genito aut in ipso cerebro, si est affectus proprius; aut alibi si est per consensum . . . intemperies facit succum nigrum, nigrities obscurat spiritum, obscuratio spiritus facit metum et moestitiam” (“The disease ‘melancholia’ does not occur unless there be a melancholic tumour generated either in the brain itself (if it is primarily affected) or elsewhere (if it is affected consensually) . . . the disturbance causes black juices; these obscure the spirits, and hence come fear and sadness”). This is said with more to the same purpose also by Montanus (9), Cappivacci (10), Nicolas Piso (11), Walter Bruel (12), Gregory Horst (13) and others of note in their time, whose works the laborious Laehr has collected. Rondelet of Montpellier (14) (1507–1566) said that melancholia arose from a mere defect of the brain, or consensually from suffering of the whole body, or, finally, from the stomach as melancholia hypochondriaca, thus recalling Galen’s (5) view, akin to that of Diocles of Carystus, that there is a melancholy that arises from the stomach. Similarly, Hieronymus Mercurialis (15) (1530–1606) emphasized the occurrence of disorders of digestion in all cases of melancholy, and said that there was also affection of the heart in them, which accounted for their special fears—a view developed forty years later by Daniel Sennert (16). Among these writers, elimination of melancholic humours by purgation, clysters, blood-letting and baths, the use of hellebore, the specific from Anticyra, application of aromatic poultices, vesicants, leeches around the anus, cautery to the skull with long-maintained suppuration and finally working on the patient’s imagination are the weapons for combating the *frigida intemperies cerebri, affectio tenebricosa*.

Felix Plater (17) (1536–1614), the Basle professor, is justly eminent for his attempt to build up an empirical psychiatry by classifying the diseases according to their nature and setting up empirically recognized varieties. Of his four divisions of insanity, the third, “*mentis alienatio*”, includes melancholy and hypochondriasis among its subdivisions.

For the rest of the sixteenth and the seventeenth centuries there are Prosper Alpinus (18) (1553–1616), who gives a good description of melancholia and recommends warm baths for it, Riverius of Montpellier (19) (1589–1655), who

says that there is a proximate cause, a poison generated in the body, which can be taken up and developed best in the atrabiliar constitution, Waldschmidt (20) (1644-1687), of the chemical school, who thinks melancholia arises from abnormal fermentation in the organism, Tozzi (21) (1638-1717), who reverts to Hippocrates' definition, Bellini (22) (1643-1704), who gives a good description, especially of the aboulia and psychic inhibition, and Hoffman (23) (1662), who, like the Englishman, Sir George Ent (24) (1667) and others of the time, advised blood transfusion in melancholia, as in mental disorders generally. Of other Englishmen may be mentioned J. Johnston (25) (1603-1675), who follows Aretæus in his views on melancholy, Sydenham (26) (who appears as an ardent phlebotomist, a Sangrado of the gloomy), and the illustrious Thomas Willis (27). Willis has been described as the father of modern cerebral physiology; he regarded the "animal spirits" as the principle of sensation and movement—they are separated out in the brain from its blood; he sought to find the channels through which these animal spirits flowed during mental activity, and to defect or spoiling of them he attributed such disorders as melancholia. Sydenham appears to have adopted these views.

THE EIGHTEENTH CENTURY.

A fresh period, in which the interaction of physical and mental factors is discussed and psychology brought nearer to practical medicine, begins with the influence of G. E. Stahl (28) (1660-1734), exercised through his animistic doctrine. Paracelsus (29) and, after him, van Helmont (30), had said that mental disorders sprang from anger, fright and other effects of the mystical Archæus, the life-principle, *anima sensitiva*, the seat of which is in the stomach, and which builds up the organism and dominates all vital phenomena. Stahl, equally a vitalist, pointed to the influence of the psychic life on organic phenomena; these processes are united into one whole in the living organism by the *motus tonico-vitalis*; thereby all the single functions and organs express themselves in one animal economy as instinct in the healthy state, in morbid conditions as *vis medicatrix nature*; mental disorders are an abnormal relationship of the soul, inhibited in its regular working by a strange motive (*idea*), which arises either from the senses, or from other bodily functions, or from the mood. It is not appropriate here to deal further with his views, essentially dualistic, on the genesis of mental disorder; they were carried into a later period by Zückert (31) (1737-1778) and Unzer (32) (1727-1799). The former described patients with strong "imagination" in whom all other senses and feelings are suppressed, thinking only of the subject which makes the imagination so lively; if this state be conjoined with lasting sadness, that is melancholia. Other currents in medical thought towards the end of this period are recalled with the names of Mesmer, Gall and Spurzheim, and Lavater, but they have no particular bearing on melancholia. The main

features of European writings on psychiatry during this period (presently to be described, so far as they concern melancholia, under national headings) are new classifications, search after bodily changes, especially in the brain, and crude attempts to apply psychological principles in treatment. There is also a large sediment of Galenical teaching in Friedrich Hoffman (33) (1660–1743), who considers the proximate cause of melancholia to consist in a rush of thick blood to the brain, its stagnation there and impeded return.

It will not be amiss to consider first the place of melancholia in the general nosological systems, more varied than in the last period. Vogel (34) (1724–1774) divides the *morbi mentis* into six : *mania*, *melancholia*, *fatuitas*, *stupiditas*, *amentia* and *oblivio*. Boissier de Sauvages (35) (1706–1767) divides insanity into three orders. The first order is *morbi deliri*, and includes mania and melancholia ; the cause of them is a material one, located in the brain, the sense-organs or the arrangement of the nerve-fibres. Melancholia is “ *chronicum sine febre medietabundum paucis objectis affixum delirium* ” (“ a chronic afebrile, brooding delirium fixed on a small number of objects ”). Among his second order, the *morbi imaginarii*, is hypochondriasis ; the third order is *morbi morosi*. This is followed by Michael de Valenzi (36), in whose system the influence of Linnæus may be discerned ; Linnæus had divided mental disorders on formal grounds into ideal, imaginary and pathetic, melancholy being one of the pathetic. Valenzi classes all the forms as *vesaniæ*. Metzger (37), writing in 1793, separates feeble-mindedness (*mentis imbecillitas*) from insanity. True insanity is either febrile or chronic ; if chronic, it is often ushered in by melancholia—a state of the mind in which it is occupied with sad pictures and thoughts. Sooner or later melancholia passes over into chronic insanity—a view that culminated long after in Kahlbaum’s *vesania typica*. Kurt Sprengel (38), the medical historian, divides disorders of mood into melancholia, mania and fatuity. The essence of melancholy lies in an obstinate fixation of attention on one object and in mistaken judgment about it ; from this one-sided activity result the feelings of inactivity and the sad mood ; as proximate cause he assumes such an irregularity in the use of the brain’s energy, that it becomes active only with one definite idea, all other having a weakened effect. Dreyssig’s (39) classification (1770–1809) shows well the changes of meaning that the term “ melancholia ” was undergoing. He collects all mental disorders into three forms—mania, melancholia, imbecility ; melancholia is a partial insanity, or a partial failure of judgment and reasoning capacity, limited to one or a few subjects ; it may be true or false ; true melancholia is bound up with a lasting sad mood, false melancholia with indifference or cheerfulness ; raging melancholy as the highest form approaches mania. This is clearly a very important distinction between “ true ” and “ false ” melancholia. The proximate cause of melancholia he took to be a disturbed balance between the power of judgment and the power of imagination. It is distinguished from hypochondria and hysteria on the ground that in the

latter, irritability is specially increased in the abdominal viscera. As to the relation between mania and melancholia, just alluded to, the famous aphorisms of Herman Boerhaave (40) contain a similar opinion. Boerhaave regarded mania as a higher form of melancholia: "si melancholia eousque increscit ut tanta accedat agitatio liquidi cerebrosi qua in furorem agantur sævum, mania vocatur" ("if melancholia go so far that the agitation of the cerebral fluid causes the patients to go raving mad, it is called mania"); he syncretized the prevailing nosological conception of melancholia in his definition of it as "ille morbus in quo æger delirat diu et pertinaciter, sine febre, eidem fere et uni cogitationi semper affixus" ("that disease in which the patient is long and obstinately delirious (deluded), nearly always dwelling on one and the same thought, but without having any fever")—almost identical with the earlier one of Johnston. The relation of mania and melancholia had been considered by Boerhaave; Morgagni (41), more akin to later writers, denied in his *De sedibus et causis Morborum* (1761) any complete distinction between the two: "Melancholiæ autem mania ut Willisii utar verbis in volumine eodem prolatis in tantum affinis est ut hi affectus sæpe vices commutent et alter uter in alterum transeat; quin sæpius dubitantes medicos videas hinc taciturnitate et metu, hinc loquacitate et audacia in eodem ægro subinde alternatis, melancholicum an maniacum pronuntiare" ("Mania, to use the words of Willis, is in so far akin to melancholia that these disorders often change from the one into the other, and so you may see physicians doubting whether they should call a patient melancholic or maniac who alternates between talkative boldness and frightened silence. This sounds a little like a reference to catatonic excitement, rather than mania. The Dutchman, Schim (42) (1779), went a step further and described periodic outbursts, and Philippe Pinel (43) described periodic insanity in more detail in 1798, concluding that the periodicity had no connection with the nature of the causes, and that the original site of this malady was in the region of the stomach, whence the attacks radiated. Fifty years later came Falret and Baillarger.

Before concluding these general considerations, a brief note on the therapy of melancholia as advocated by most writers of the eighteenth century may be added. Drugs were of all sorts, the most favourable being anagallis, arsenic, belladonna, datura stramonium, phosphorus, tartar and other emetics and purges. Electricity was occasionally employed. Asses' blood was highly recommended, even regarded as a specific (Cardilucci (44); Boenneken (45)). Boerhaave (40) recommended hydro-therapy: "præcipitatio in mare, submersio in eo continuata, quamdiu ferri potest, princeps remedium est". ("Plunging into the sea, immersion for as long as it can be borne, is the chief remedy"). Likewise John Ferriar (46) (1763-1815), who in his *Medical Histories and Reflections* advised warm baths to soothe mania, cold baths for melancholia. Some used immersion as a punitive or minatory remedy. Music was recommended as treatment for melancholia by French writers

(Col de Villars (47), 1737, Buchoz (48), 1769) ; was there not King Saul in Holy Writ to attest its efficacy? Not all measures were so gentle. The barbarous methods of general management, including the whirling chair which Avicenna (49) long before had advised in melancholia to direct the blood into the proper parts, need no further mention here.

ENGLISH WRITERS OF THE PERIOD.

It is convenient to consider separately and in some detail the contributions of English physicians of the eighteenth century to this subject of melancholy. The "spleen", for long agreed to be a disorder peculiarly incident on the English—"maladie Anglaise"—was explored by Burton, by the essayists of the *Spectator* and Boswell's *Hypochondriac* with curious and familiar concern. Doctors were not behind in this. Cheyne (50) wrote a book, *The English Malady, or a Treatise of Nervous Diseases of all kinds, as Spleen, Vapours, Lowness of Spirits, Hypochondriacal and Hysterical Distempers* (1733), and he discussed the great frequency of suicide among the English. Montesquieu, it may be mentioned here, was corrected by Philippe Pinel (43) for falling into this error of regarding suicide without evident motive as a malady peculiar to the English, though Pinel himself believed sufficient in the national gloominess to write: "On doit peut-être admirer la heureuse fécondité des Anglais en expressions énergiques et propres à exprimer les perplexités extrêmes, l'abattement et le désespoir des mélancoliques, dans leurs ouvrages de médecine, et indépendamment de leurs romans et de leur poésie" ("One ought to admire perhaps the unfortunate richness of the English in vigorous expressions for the extreme perplexity, dejection and despair of the melancholic in their medical works, quite apart from their novels and poetry"). Benjamin Fawcett (51), though probably without medical training, published at Shrewsbury in 1780 his *Observations on the Nature, Causes and Cure of Melancholy; especially of that which is commonly called Religious Melancholy*; he regarded it as a bodily illness, working on the mind, and he recommended, *inter alia*, rubbing the skin with a brush.

A more notable name is that of William Cullen (52), described by Kornfeld as "the creator and founder of the theory and practice of psychiatry in England". He classed *vesaniæ* or "lesions of the judging faculty" as one of the orders of neurosis, excluding from this order the hallucinations and the morositates—"the morositates, or erroneous passions, that accompany *vesania*, which as consequences of a false judgment, must be considered as arising from the same causes, and as symptoms only of the more general affection". The *vesaniæ* he subdivided into delirium (erroneous judgment, the meaning it still bears in France) and fatuity (weakness or imperfection of judgment). The nervous power or cerebral activity "is, at different times, in different degrees of mobility and force. To these different states I beg leave to apply the terms

of excitement and collapse. . . . To that state in which the mobility and force are not sufficient for the ordinary exercise of the functions, or when they are diminished from the state in which they had been before, I give the name of collapse". He deplored the present incapacity to distinguish the several species of insanity according as they depend upon "the different state and circumstances of the brain", and deprecated "the ingenious Dr. Arnold's" distinction of varieties: "these varieties appear to me to be often combined together, and to be often changed into one another, in the same person: in whom we must therefore suppose a general cause of the disease . . ." Mania he believed to occur "most frequently in persons of a melancholic or atrabilarian temperament" as well as in the sanguine. The genus melancholia he described as a partial insanity, but speedily pointed out his doubts as to the justice of this: "I am inclined to conclude that the limits between general and partial insanity cannot always be so exactly assigned . . ." He considered it improper to distinguish melancholia by the character of partial insanity alone: "If I mistake not, it must be chiefly distinguished by its occurring in persons of a melancholic temperament, and by its being always attended with some seemingly groundless, but very anxious fears." He gave the differential points between it and hypochondriasis, which is one of the "adynamiaë".

Another important figure is John Brown (53) (1735–1788), who declared insanity to be a disease, not of a single part, but of the whole body, mostly caused by excessive exertions of the mind—violent passions. His views on excitement, the sthenic and asthenic states, which reverted to the doctrine of Haller, had a considerable influence upon psychiatry in England and elsewhere, especially as to therapy; in this regard it was a most unhappy influence. He strove to excite the opposite passion in the patient to that which was evident and operative; thus he would rouse a melancholic from his torpor by the cruellest alarms.

Thomas Arnold (54), in his *Observations on Insanity*, published at Leicester in 1782 and 1786, shows himself an inveterate drawer up of schemes and categories, applied also to the analysis of melancholia, its forms, ætiology and prophylaxis. Linnæus is his pattern. Richard Temple (55) (1792) defines melancholy as chronic disorder of the understanding in certain things, with sadness and rumination, the proximate cause being too great a dryness of the brain substance. W. Perfect (56) (1740–1789) was one of those who used electricity in treating melancholia; he gave careful descriptions of the somatic symptoms in his *Select Cases* (1787), and laid emphasis on inheritance. A Harper (57), who confidently wrote *A Treatise on the Real Cause and Cure of Insanity, in which the Nature and Distinctions of the Disease are Fully Explained, and the Treatment Established on New Principles* (1789), considered there were two sorts of mental disorder besides insanity—melancholia and hypochondriá. His bold claims as to treatment are not unjustified; he would have the body

looked to as well as the mind ; phlebotomy, diaphoretics, purges, diuretics, camphor, quinine, exercise, change of air, warm baths, music, sleep and moderate copulation shall be accompanied by the avoidance of all irritation and unnecessary restraint ; isolation he declares especially harmful. One should try to discover the cause of distress, then remove it, give way to every sensible idea, avoid all exhausting activity of the mind, and prevent all unpleasant ideas and overstrung impressions. If these rules could be carried into practice early in the disorder, it would become exhausted and its progress stayed, he held. This was indeed admirable doctrine for the times. Faulkner (58), in his *Observations, etc.* (1790), is all for psychic treatment of the condition, and against the custom of immediately putting the patient into an asylum, since the sudden change of place and removal from all acquaintances may be harmful. Pargeter (59), writing in 1792, describes some cerebral changes in melancholia, but refrains from drawing any conclusion, remarking that it is uncertain whether these are cause or effect of the disease—a dilemma not unknown in later times. Among other remedies he liked snuff, which clears out unclean lymph from the respiratory passages and sinuses, and, especially in melancholia, shakes up the whole body through sneezing, and stimulates the nervous system. He recommended rubbing the belly with flannel for half an hour morning and evening—not unlike Fawcett, who used a brush instead of flannel. Pargeter, it may be mentioned, denied any influence of the moon in lunacy.

Better known than these is J. Haslam (60), one-time Apothecary to Bethlem Hospital. In his *Observations, etc.* (1798), he discussed the relationship of mania and melancholia : “ As the terms, mania and melancholia, are in general use, and serve to distinguish the forms under which insanity is exhibited, there can be no objection to retain them ; but I would strongly oppose their being considered as opposite diseases. In both, the association of ideas is equally incorrect, and they appear to differ only from the different passions which accompany them.” He objects to Ferriar’s insistence on “ intensity of idea ” in melancholia, and writes of the alternation of (schizophrenic) excitement and depression, “ when the furious state is succeeded by melancholy, and after this shall have continued a short time, the violent paroxysm returns, the hope of recovery is very slight. Indeed, whenever these states of the disease frequently change, such alternation may be considered as unfavourable ”. For melancholia he recommends blood-letting, but has little use for the other measures, such as emetics, camphor, opium, blisters to the head, and setons, then customary. Alexander Crichton’s (61) *Inquiry, etc.* (1798), contains a psycho-pathological system unlike anyone else’s, depending on a division of excitable parts, occasionally reminding one of Broussais’ (62) *De l’Irritation*. The passions, according to Crichton, work on the nerves by means of the blood-vessels, and melancholia is the outcome of inhibition of vascular activity in the nervous system. Less fanciful and more intellectualistic were the views

of James Sims (63) (1799), who considered melancholia to be a condition where imaginations of unpleasant experiences were mixed with correct recollections, the sufferer arriving from such faulty premises at formally correct conclusions. This was largely a restatement of John Locke's (64) view.

Of these English physicians, Philippe Pinel (43) wrote with severity: "Un examen sévère et impartial n'y fait découvrir qu'une manière vague de disserter, des compilations répétées, des formes scolastiques, et quelques faits épars qui servent de temps en temps de points de ralliement, sans offrir un corps régulier de doctrine fondée sur les observations les plus multipliées" ("Severe and impartial examination discloses in them only a vague style of disquisition, repeated compilations, scholastic forms and some scattered facts which occasionally serve to hold the thing together, but do not make up a regular body of doctrine founded on many observations"). He is here talking of Arnold, Harper, Pargeter and Ferriar. For Perfect's *Annals of Insanity* he has high praise so far as it contains curious and valuable observations on different varieties of insanity, but he exclaims: "Qu'il y a loin de ce recueil à un corps régulier de doctrine, à un traité général et approfondi sur l'aliénation mentale!" ("What a long way this collection is from being a regular body of doctrine, a general and thorough treatise on mental disorder!").

As to other countries, French and German writers are to be considered; the Italians are represented by Chiarugi (65), who supposes in melancholia a pre-occupation with one idea, presented by phantasy, the whole state being a product of sad passions; the patients should have their attention distracted.

PINEL AND OTHERS.

In France there are Lorry (66) (1762), for whom "melancholia" covers almost the whole range of mental disorders, including hysteria and epileptic convulsions, Le Camus (67), who denies psychic causes, J. F. Dufour (68) (1770), who follows Boerhaave's teaching, and the illustrious Philippe Pinel. In his *Traité Médico-philosophique sur l'Aliénation Mentale*, Pinel says: "J'ai conservé le nom de délire mélancolique à celui qui était dirigé exclusivement sur un objet ou une série particulière d'objets, avec abattement, morosité, et plus ou moins de penchant au désespoir, surtout lorsqu'il est porté au point de devenir incompatible avec les devoirs de la société" ("I have kept the name 'melancholic delirium' for the variety that was directed exclusively upon one object or particular series of objects, with dejection, gloom and more or less tendency to despair, especially when it goes so far as to become incompatible with one's duties in society"). In the section of "mélancolie ou délire exclusif" he speaks first of melancholy as a habitual temperament (using it in the sense of Napoleon's remark, "cependant sans cette maudite bile on ne gagne pas de grandes batailles"); he then describes melancholy considered as a mental disorder, and includes quite exalted states (chiefly paranoiac) as

well as depressive ones. He speaks of melancholia "degenerating" into mania, but his illustrative case is of a paranoid schizophrenic. He treats of the melancholy that leads to suicide and gives some vivid case-histories. He points out the danger of sending patients home too soon.

In Germany one picks out the names of Philipp Fischer (69) (1790), who asserts that to understand these causes properly one must get chronological data to permit of studying the whole psychological state of the patient—what is nowadays called "the longitudinal section" of the case; and of M. A. Weickard (70), who makes the division of mental disorders into "Geisteskrankheiten" and "Gemütskrankheiten". In the mood-diseases one will find lively affective qualities of mood or slow depressed retiring ones; among these latter are sleepiness, fatigue, sadness, depression, envy, shame, fearfulness, anxiety, despair, suicide. Simple depression and simple mania he thus regards as disorders of mood; while depression and excitement with delusions are included among the "Geisteskrankheiten", subsection "Wahnsinn, Insania". Where the patient is confused and deluded through preoccupation, sadness or other passion, it is melancholia; if he is raging, it is mania. The philosopher, Immanuel Kant (71), expressed general views about insanity in his *Anthropologie* (1798); he divided the "Gemütskrankheiten" into mania and hypochondria. Melancholia is not quite a disorder of mood for him, but can lead to that; like hypochondria it may be a mere delusion of misery. J. G. Langerman (72), a follower of Stahl, advised that in diagnosis one should take carefully into consideration the somatic constitution and individual psychic character, with especial emphasis on the tendency to phantasy. Finally, there is an interesting anonymous paper (73), *Beobachtungen und Erfahrungen über Melancholische*, by a gaol chaplain, in which melancholy is said to be that state of mood in which dark and confused ideas and sad and apprehensive feelings prevail.

ESQUIROL TO GRIESINGER.

The next period starts with Esquirol (75) at the beginning of the century, and ends with Griesinger, half-way through it. There is great preoccupation with methods of classifying the forms of insanity, and interest in their course and relations; description becomes more detailed.

Esquirol (75), following Pinel, assumed four varieties of mental disorder: mania, monomania or fixed delusion, dementia and idiocy. For depressive states, once called melancholic, he introduced the term "lypemia", and instead of "melancholia" in its current sense at that time, he substituted "monomania". The meaning of the word "melancholia" had been much perverted and extended—the "*angor animi*" of Aretæus had become insignificant, while the "*in una cogitationi defixus atque inhærens*" of his definition was all important. The blame for this shift has been laid at the

door of Reil and Hoffman, but it was much older ; it is to be found in Daniel Sennert, and very plainly in Boerhaave. By Esquirol's time it was the parent of confusion. Prichard (74), defending it, pointed out that in ordinary Greek writings, in Aristophanes, for example, *μελαγχολᾶν* meant simply to be mad, to be out of one's mind, without any lowness of spirits ; but there was the special medical significance, given first by Hippocrates, and for long generally preserved, a usage firmly established, moreover, in popular speech. Esquirol did not get rid of the word, but through his criticism it was purged of accretions and returned to its proper use. Of lypemania Esquirol wrote : " nous la croyons bien définie en disant que la mélancholie avec délire, ou la lypémanie, est une maladie cérébrale caractérisée par le délire partiel, chronique, sans fièvre, entretenu par une passion triste, débilitante ou oppressive " (" we believe that this is a good definition : melancholia with delirium, or lypemania, is a chronic afebrile cerebral malady, with partial delirium, kept up by a sad debilitating or oppressive emotion "). He separates it from " the habitual state of sadness in some individuals " and from monomania : " (Celle-ci) ne saurait être confondue avec la monomanie qui a pour caractère les idées exclusives avec une passion expansive et gaie " (" It should not be confused with monomania, which is characterized by exclusive ideas with an expansive or cheerful emotion "). He also separated lypemania from dementia, and, with much emphasis, from hypochondria. As to the relation to mania, he wrote : " La lypémanie passe quelquefois à la manie ; c'est sans doute celle transformation qui a fait confondre la mélancholie avec la manie " (" Lypemania sometimes passes into mania ; it is doubtless this change that has caused melancholia and mania to be confused "). In his lively description of the condition he surpasses his predecessors in accuracy and completeness. His influence upon English psychiatrists, as will presently be seen, was considerable. Prichard, for example, dedicated his treatise to Monsieur Esquirol, " the most distinguished writer of his age on the subjects which I have endeavoured to investigate ".

Another writer in French was the Belgian, Joseph Guislain (76) (1797-1860), who assumed that every mental disorder was preceded by a more or less pronounced stage of depression—a view very generally adopted and later turned to the purposes of the *Einheitspsychose*. Among many opinions having a modern ring, Guislain advocated bed-treatment for melancholia.

English psychiatrists of this period devoted much attention to asylum arrangements and humanitarian principles in treatment ; in theoretical psychiatry, discussions of classification and of pathological changes in the brain were in the forefront.

In his sober and admirable *Description of the Retreat* (1813), Samuel Tuke (77), though no doctor, gives a " statement of cases and remarks " in which " the cases are arranged under three classes, *viz.*, dementia, melancholia and mania. . . . Under the class melancholia, all cases are included

in which the disorder is chiefly marked by depression of mind, whether it is, or is not, attended by general false notions”.

In Philadelphia, on the other hand, Benjamin Rush (78) was advocating the opposed view. There are partial insanity and general insanity; melancholia is partial insanity in which the delusions apply to external objects. The melancholic patient may be sad or cheerful; so there are two varieties, tristimania (Esquirol's lypemania), and amenomania (monomania, paranoia).

Burrows (79), the maligned director of the Clapham Retreat, concluded, with Haslam, that “mania and melancholia have one common physical origin, and are one and the same disease. All classification of mental disorders consequently appears to me worse than useless”. He discusses grief as a “frequent moral cause of melancholia—often owing to an hereditary predisposition, or the person is of the melancholic temperament”. Schizophrenia and paranoia contribute to his array of the symptoms of melancholia, as with so many other writers. He follows Esquirol in the main, but disagrees with his substitution of monomania for melancholia.

Prichard (74), famous for his *Moral Insanity*—a term that has undergone a considerable change of meaning, but which, as he used it, included all affective disorders without delusions—says in *A Treatise on Insanity* (1835): “A considerable proportion amongst the most striking instances of moral insanity are those in which a tendency to gloom or sorrow is the predominant feature,” and he gives a good clinical description of simple depressive states. Under the section “Of Monomania” he explains how this term is synonymous with the “melancholia” of earlier writers, and says, “mental dejection or melancholy which extinguishes hope and gives the mind up to fear and the anticipation of evils, lays the foundation for many kinds or varieties of monomania”, and he includes hypochondriasis as a form of monomania associated with fear and despondency.

M. Allen (80), in his apologia-born *Essay on Classification* (1837), regards mania and melancholia as “effects of the same power being overactive in different directions”, likely to be followed by “a third stage, of exhaustion”. Neville (81) (1836) regards melancholy as a partial affective insanity; his views are manifestly coloured by phrenology, but do not otherwise differ from those of his contemporaries. Conolly (82), of Hanwell, the champion of “no restraint”, describes mania and melancholia as “the two principal forms of mental malady” in his Croonian Lectures of 1849, but he casually differentiates apathy (? of early schizophrenia) from true melancholy in the following passage: “Young persons not infrequently fall into a state somewhat resembling melancholia, without any discoverable cause of sorrow, and certainly without any specific grief; they become indolent, or pursue their usual occupations or recreations mechanically and without interest; the intellect, the affections, the passions, all seem inactive or deadened, and the patients become utterly apathetic; but the true melancholic patient is not apathetic. The mind sinks

under some imaginary fault . . .” These are the chief writers early in the century. The thread of English psychiatry will be resumed with Maudsley.

In Germany the psychiatrists were especially concerned with general questions concerning the nature and causes of insanity, with systematic divisions, for example, according to the affection of will, mood, thought (Neumann (83)), or ideation, sensation, instinct (Hagen (84)), and predominantly with the question of psychic *versus* somatic, which was the great question for the first four decades of the century. The philosophical foundations of psychiatry were speculated on at length, and if it were not for the interest and enthusiasm of which these writings were indicative, one would find much pertinence in Burrows' (79) dictum: “The best rule, however, for everybody to observe when attempting a judgment on any particular case of insanity is to take care and preserve his own faculties clear, and as free from the mysticism of speculative philosophy as from the trammels of nosology.” Of the numerous writers before Griesinger there are few who possess interest in the present connection; the different schools became known to English readers especially through the Sydenham Society's translation of Feuchtersleben's (85) *Medical Psychology*. Feuchtersleben included melancholy (lypemia, parathymia), in the restricted sense, in the general division “fixed delusion”, the monomania of Esquirol.

Flemming (86) divided the *vesaniæ* into dysthymia (affective disorders), *anæsia* (where there are delusions with dysthymic phenomena that are of secondary significance) and mania. Zeller put forward an interesting division into two great groups; one characterized by the morbid origin, dominance and persistence of affective states with consequent modification of the whole psychic life; and another, where there are disorders of ideation and will, deriving not from dominance of an affective state, but representing an independent false thinking and willing without deeper excitation of mood, mostly with the character of psychic weakness. If the first of these groups be called affective disorders, and the second schizophrenia, with an allusion to Berze's (89) view about insufficiency of psychic activity in the latter, the differentiation seems modern. In Zeller's (87) *Berichte über die Irrenanstalt Winnenthal*, 1840, however, it is held that the states contained in the first group, in the majority of cases, precede the states of the second group; further, there is within the first group a certain definite succession of individual kinds of affective state, and so we come to regard insanity as showing in its different forms different stages of one disease process which may be modified, interrupted, changed by all sorts of intercurrent pathological happenings, but which, on the whole, keeps to a steady successive course which can go on to complete disintegration of psychic life—the *Einheitspsychose*.

The most important name in nineteenth century psychiatry, if one except Kraepelin, is that of Griesinger (88) (1817–1868). The general importance of Griesinger in the development of scientific psychiatry cannot be gone into here.

As far as melancholia was concerned, he accepted Zeller's (87) view of "two grand groups or fundamental states of mental anomalies, which represent the two most essential varieties of insanity"; he pointed out that in the first group were all the recoverable conditions: semeiology, psychological analysis and investigation of morbid anatomy all point towards recovery in these primitive affective mental anomalies. In this group are contained depression (Schwermut), mania, and delusional insanity. Among the forms of Schwermut are hypochondria, simple melancholia, melancholia with stupor (in which the schizophrenic form, regarded by Esquirol as dementia, is discussed also), melancholia with destructive tendencies (suicidal or homicidal), and melancholia with persistent excitement of the will (*folie raisonnante*, moral insanity, psychopathic character). Schizophrenia in its earlier stages was regarded by him as one of the affective disorders: "Observation shows that in the great majority of cases those conditions which form the first leading group (emotions and emotional states) precede those of the second group; that the latter generally appear only as consequences and terminations of the first, when the cerebral affection has not been cured." He agrees with Guislain (76) that most mental diseases commence with depression, and says he has no hesitation in speaking of the *stadium melancholicum* as the initiatory period of mental disease.

MAUDSLEY.

The influence of Griesinger gradually made itself felt in England. His book was translated for the New Sydenham Society in 1867. In 1863 Dr. Skae (90), of Morningside, had propounded a scheme of classification with ætiological bias, containing twenty-five separate diseases, of which Blandford (91) wrote in 1871, "The merits of this division are so great, and its superiority over all preceding so manifest, that it requires little or no comment". It received, however, a great deal of comment, some of it critical, was modified by Batty Tuke (92), widely approved, and, with Bucknill's elaborate divisions, marks the height of classifying activity in England. But in 1868 one finds Henry Maudsley (94) putting forward a simpler view. The main changes of opinion in England during the rest of the century can in large measure be followed in the successive editions of his book, *The Pathology of Mind*. To trace these changes in some detail is at once relevant and pious in one who is writing from the Maudsley Hospital.

Following in the steps of Prichard (74), and influenced by Esquirol (75), Maudsley gives, in the edition of 1868, a symptomatological grouping into affective and ideational insanity which, in some of its implications, recalls Griesinger: "If a broad division were made of insanity into two classes, namely, insanity without positive delusion and insanity with delusion—in other words, into affective insanity and ideational insanity; and if the subdivision of these into varieties were subsequently made—would not the

classification, general as it may appear, and provisional as it should certainly be deemed, be for the present preferable to one which by postulating an exactness that does not exist, is a positive hindrance to an advance in knowledge?" "The affective disorder is the fundamental fact; in the great majority of cases it precedes intellectual disorder; it co-exists with the latter during its course; and it frequently persists for a time after this has disappeared." "A third objection to an adherence to the present artificial classification is that it has unquestionably fettered observation, and hindered the faithful study of the natural history of insanity. The different forms of affective insanity have not been properly recognized and exactly studied because they did not fall under the time-honoured divisions; and the real manner of commencement of intellectual insanity in a disturbance of the affective life has frequently been overlooked." He recalls Guislain's and Griesinger's observation that depression is often an initial stage in mental disorder, and adds that "maniacal perversion of the affective life" may be equally a precursory stage. In his working out of this scheme, however, he is hampered by relics from the earlier writers. His affective insanity includes mania without delusions, melancholic depression without delusions, "mental alienation proper" (moral insanity), and the insane temperament (*neurosis spasmodica*). Obsessions, compulsive disorders generally, phobias, etc., are included in it. As forms of ideational insanity there are acute and chronic mania and melancholia (which are called general forms), monomania and melancholia (partial forms), dementia, general paralysis of the insane, and idiocy. The significance of the relation of the delusions to the affective state, pointed out by Griesinger, is overlooked, hence the overlapping and the inclusion, in the clinical descriptions, of schizophrenic and true melancholic patients in the same grouping. Depressive states are actually described almost entirely under the heading "ideational insanity". There are adumbrations of a later adoption of Griesinger's view that there is but one disease, insanity: "The different forms of insanity are not actual pathological entities, but different degrees or kinds of the degeneration of the mental organization—in other words, of deviation from healthy mental life."

The third edition (95) of Maudsley's book appeared in 1879. Of this there is an interleaved copy, with his manuscript annotations, in the library of the Maudsley Hospital. There is here recognition of the occasional independence of the manifest affective state and the delusions. In regard to mania and melancholia with "partial" delusions (monomania and lypomania) he writes: "While the intellectual disorder is limited to a few ideas, the same thing can seldom, if ever, be said truly of the feelings; they are more deeply and generally affected, and yield a constant nourishment to the delusion which is rooted in and fed by them. Were our observer to reside long enough in the asylum to watch the course which these mental disorders went through, he would notice that there took place in some instances a gradually increasing failure of mental

power with an increasing incoherence of ideas, the feeling that inspired the delusions waning in force, while the delusions themselves persisted and perhaps became more in number and more extravagant in character." He puts forward the view that where there are delusions not explicable as arising out of the affective disturbance, strong hereditary predisposition may be assumed; this is summed up in a manuscript note, "So calm and yet so deluded, he could never have developed that alone"; and in another such note he writes: "Delusions not, as it were, the logical outcome of a predominant mood and coherent development, but independent, abrupt, of spontaneous outcome, as it were, have got themselves to be explained. The fact is, I take it, that it is with them as in dreaming, the supreme centres show their natural tendency to fashion or create, and to create according to their inbred form." The pragmatic inadequacy of his grouping of mental disorders is explicitly admitted, but not on just grounds: "when we have to think how a particular case has been caused, what course it will run, how it will end, and what sort of treatment should be used, we do not so much consider whether the symptoms are mania or melancholia as we do what constitutional diathesis underlies, or what bodily disturbance accompanies the derangement. It is certain that we get more help generally from the exact observation and appreciation of such bodily states than we do from the mental symptoms alone; for example, whether a mental disorder is maniacal or melancholic is not of much moment, but the recognition of a gouty disposition, of a syphilitic infection, of a commencing paralysis, of a puerperal cause, and the like, will help us much." The clinical description of melancholia is full and admirable; though it is still included under "ideational insanity", the essential unimportance of the mere presence of delusions is plainly stated: "at the beginning of melancholia in most cases, and throughout the disease in some cases, there is no definite delusion, the person is simply morbidly melancholic"; the painful delusion "has been precipitated, as it were, out of the vague feeling of unspeakable misery which is the medium in which its gestation or incubation has taken place; and it takes different forms according to the person's culture and habits of thought, and according to the prevailing social and religious opinions of the time". In one place he describes the alternation of hypomania and mild depression as an example of moral insanity; elsewhere he alludes to Falret's "*folie circulaire*" as the succession of true mania upon true melancholia.

In the last edition (96), of 1895, classification is scarcely mentioned (though in this it was not wholly representative; the influence of Skae and the earlier classifiers was still working in Clouston and others). The emphasis is now all on the individual, his inheritance and make-up—an evidence of French influences. The physician "will reflect if he is wise, that there is no such disease as insanity, that there are really so many insane individuals to be treated in the concrete"; in involuntional melancholia "here, as always, the right question is not whether the disease is one likely to end in recovery, but

whether the particular sufferer from it, being what she is, is likely to recover". The manuscript notes in the earlier edition are elaborated and polished. "Moral or affective insanity" is thrown overboard; the importance of constitution (tintured by Morel's (109) views on degeneracy) is underlined with fatalism; it is "the inborn structure of the individual mind which determines whether disorder shall deepen into disorganization or shall pass away. . . . In this relation it is proper to remember and reflect that bad foundations of mental structure are laid, not by positive madness only in the parental stock, but by such wrong and unwholesome mental development in it. . . . Not that every degree and sort of neuropathic inheritance is fraught with so serious a risk. It is a question of kind and degree of degeneracy. . . . The heritage may amount to no more than an unstable equilibrium, prone to be overthrown suddenly and perhaps as suddenly restored. This is especially the case where there was an external cause of mental disturbance in some physical or moral shock, some stress or strain, not apparently adequate in itself, but adequate in the case, and where the disorder was acute." He is speaking here of mania, but has similar views as to melancholia and the alternating recurrent form, "Janus-faced". All depressive states, including hypochondriacal melancholy, are described together, with more stylistic effort and less detail than in the earlier books; the general features of the disorder replace or subsume the catalogue of individual symptoms. There is a striking account of the selfish and exacting claims which many melancholics, professing lowliness, make upon their relatives or nurses—an observation made again by Sigmund Freud. Maudsley, interpreting it, introduces speculations from neurology: "But is all this self-indulgence the selfishness which it looks? It is the indulgence of a partial, maimed and morbid self. . . . The probable pathological condition of things is an exorbitant and predominant, almost exclusive, activity of certain brain-tracts charged with sad feeling . . . entailing a molecular sluggishness and, according to its degree, a lessened or suspended function of other tracts." Hughlings Jackson (97) had speculated in a more tentative and unprecise way about the nature and factors of insanity (1894), but this audacious playing with unsuitable physiological and neurological conceptions, an aberration in Maudsley, was a dominant vice in other English psychiatrists and, more soberly applied, was the characteristic in Germany of Wernicke (98) and his school.

OTHER NINETEENTH CENTURY WRITERS. •

After this detailed examination of the manner in which Henry Maudsley considered the problem, there is little need to write further at length on English psychiatrists during the latter half of the nineteenth century. The influence of Prichard (74) and Skae (90), and less immediately of Esquirol (75) and Griesinger (88), was considerable among the earlier of them, such as Blandford

(91), Bucknill and Tuke (92), and Dickson (99); then come Sankey (100) and Savage (101), the latter notably simple in his classification and clear in his pictures of types of disorder; he describes simple melancholia, active and passive melancholia, and melancholia with stupor; he notices the relationships of melancholy with periods of life and with bodily disorders, such as gout, cardiac and renal disease. He speculates very little, and remarks in one place that "wise men investigate while fools explain". Bevan Lewis (102) devotes nearly half of his work on *Mental Disorders* to anatomy and structural pathology; in his clinical description of states of depression there is much psychologizing. He insists, however, as did Falret *père* (104), on the indivisibility of the mind; speaking of "purely emotional or affective insanity" he remarks: "So interblended are all the mental faculties in their mutual co-operation, that no such division can be drawn, in a strictly scientific sense, between the purely emotional and the intellectual states. When we speak of emotional states, we must ever bear in mind that the term connotes more or less of the intellectual element of mind . . . feeling, memory, reason, volition; or rather that these are but different aspects of the same state". The section (by Rayner (103)) on Melancholia in Allbutt's *System of Medicine* covers no new ground and abounds in technical terms.

In France Jean Pierre Falret (104), in 1851, drew attention to the differences between ordinary melancholia and the periodic variety. Then, in 1854, Baillarger (105) described to the Academy of Medicine his "folie à double forme"; there was a brief controversy as to priority, and Falret at the following session read his paper, *De la Folie Circulaire*. In this he points out the frequency and intensity of remissions and paroxysms in the course of mental disorder, and says that many grave errors have been the consequence of not considering this: "C'est une des causes aussi pour lesquelles, dans l'étude des aliénations partielles, existe et se perpétue la doctrine de l'unité de délire, de la monomanie, doctrine si erronée sous le rapport de la science" ("It is also one of the causes for the persistence in regard to partial insanities of the scientifically erroneous doctrine of the single delusion, of monomania"). Intermittent disorders "ont, le plus généralement, une invasion subite, une marche d'une continuité plus uniforme, moins paroxystique pendant l'accès" ("have most commonly a sudden onset, a more uniformly continuous less paroxysmal course during the attack"). Moreover, it resembles in all points precedent attacks, and, as against the opinion of earlier and of contemporary authors, "la durée de chaque accès peut être et est souvent plus longue, à mesure que la malade avance dans la vie, mais c'est une erreur de croire que la folie intermittente finit toujours par devenir continue. C'est là, au contraire, un fait très exceptionnel" ("The duration of each attack can be and often is longer with advancing years, but it is a mistake to believe that intermittent insanity always ends as continuous insanity. On the contrary, that is very rare"). Most curable in its attacks, it is incurable in its essence, though one

may be able to delay and even abort the attacks. It is intermittent, not periodic. Exciting causes can precipitate an outburst. The intermittency may be prolonged, or brief (eight days to a month). *Folie circulaire* is characterized " par l'évolution successive et régulière de l'état maniaque, de l'état mélancolique et d'un intervalle lucide plus ou moins prolongé " (" by the regular sequence of maniacal state, melancholic state and lucid interval of varying duration "). He considers it " une véritable forme de maladie mentale, parce qu'elle consiste dans un ensemble de symptômes physiques, intellectuels et moraux, toujours identiques à eux-mêmes. . . ." (" a genuine form of mental illness, because it consists in a group of constant physical, intellectual and affective or total behaviour symptoms "). He gives further grounds for regarding it as a natural form ; describes its clinical features : " . . . il n'y a pas lésion restreinte de l'intelligence et prédominance de certains délires bien déterminés comme dans les mélancolies ordinaires, mais dépression physique et morale portée quelquefois jusqu'à la suspension complète des facultés intellectuelles et affectives " (" There is no limited impairment of intelligence and predominance of certain well-defined delusions as in ordinary melancholia, but a physical and mental depression, even to the point sometimes of complete suspension of the intellectual and affective faculties "). He says that it is strongly hereditary, a lot commoner among women than men. And, finally, a classification based on un ensemble de caractères subordonnés les uns aux autres et sur leur marche, c'est à dire sur l'évolution de ces phénomènes, se succédant dans un ordre déterminé " (" a collection of characteristics related together and following a definite course ") is in his judgment most likely to lead to sound prognosis and rational treatment. His reasons for this view and objections to the older classification are expounded with great clarity. His influence on Kraepelin in regard to the manic-depressive psychosis may be safely assumed.

Just as Falret demolished monomania, so Briere de Boismont (106) (1867) showed that *folie raisonnée* was only a symptom of widely different forms of insanity (later Krafft-Ebing (107) designated very chronic and constitutionally conditioned melancholia as " melancholic *folie raisonnée* ") Lasègue (108), in 1852, pointed out that the " *délire de persécution* " was not part of lypemania. Morel (109) (1860), whose insistence on inheritance and the make-up of the individual was of great service, proved less happy in applying his principles to the actual distinction and painting of pictures of mental disorder. Cotard (110) (in 1880) described the syndrome known by his name, in which *délire des négations* is conspicuous ; he recognized its unfavourable prognostic significance, which he took to be invariable.

Magnan (111) (1882), accepting Morel's general group of hereditary insanities, distinguishes true melancholia from melancholic states occurring among these " *dégénérés* ", and he describes as a special group " *folies intermittentes* ". In his general description of them he follows Falret and

Baillarger, but says, " la répétition des accès, *quelle que soit leur forme* (manie ou mélancolie) est le phénomène le plus important au point de vue du pronostic " (" the recurrence of the attacks, whatever their form (melancholia or mania), is the most important phenomenon from the prognostic point of view "), and says that the form of the attack is very variable—" on observe les combinaisons de la manie et de la mélancolie les plus inattendues chez le même malade " (" one finds the most unexpected combinations of mania and melancholia in the same patient ").

It will have been observed that the distinction between psychoses and neuroses (excepting hysteria) was in some measure a product of the nineteenth century ; at first grouped under the " moral or affective insanities ", as by Prichard and Maudsley, more carefully separated by French psychiatrists, beginning with Morel, and regarded as evidences of hereditary alienation or " degeneration ", the disorders in which compulsions or anxiety is the chief clinical feature were gradually delimited, but it was not until the present century that the " neuroses " attained a nosological independence that is nowadays unduly insisted on in some quarters. In the main tide of psychiatry the occurrence of fear, doubt, obtrusive thoughts and more precisely defined " neurotic " symptoms in the course of melancholia has long been clearly recognized. Burrows (79), though in his terminology " neurosis " was the general term for disease of the nervous system, pointed out from the genetic standpoint the close relationship between insanity and certain neuroses in the modern sense. Trélat and Legrand du Saule (112) developed and modified Morel's views on the same matter. Kahlbaum (113), somewhat later, discussed the interrelation between neuroses and psychoses. In the present century Lange (149), Kahn and Abraham (175, 176) have made notable contributions to the subject, so far as melancholia is concerned.

PART II.

With Kahlbaum (113) one stands on the threshold of the modern period in psychiatry. His contributions towards the delimiting of " dementia præcox " have been often stressed. Here it is only necessary to recall that for him general paralysis of the insane (*vesania paralytica*) was the paradigm to which *vesania catatonica* was to be approximated ; mania, melancholia, moria and dementia are " nicht die Formen verschiedener Arten von Geisteskrankheiten . . . sondern die Formen ihrer verschiedenen Stadien, oder noch besser die Formen verschiedener Symptomencomplexe welche sie in verschiedenen Perioden ihres Verlaufs annehmen können " (" not the appearances of different kinds of mental disorder . . . but the appearances of their different stages, or, better still, the appearances of the different symptom-complexes which they can assume at different periods of their course "). Here

he follows Griesinger and Neumann. The difficulties of this, when considered with regard to actual cases, and especially to *folie circulaire*, are acknowledged. In "stable" melancholia, he remarks, all the psychic symptoms can be derived from the morbid affect, not so in "primary dementia". He would reserve "melancholia" as a designation for initial or transitory melancholy, a stage in *vesania typica*, but for stable or definitive melancholy (melancholia in the modern sense) he suggests "dysthymia"—a term already borrowed from Hippocrates by Flemming and Griesinger. This dysthymia he regards as a variety of mental disease (a special, or partial, mental disorder), while the other is only a morbid state. *Folie circulaire* he includes as a modification of *vesania typica*, destined to end in dementia. The relation of melancholia to *vesania typica* is compared by his pupil, Hecker (114), to that between coryza and measles—the former may be an initial stage of the latter, or an independent disorder. Hecker incidentally emphasizes the frequency with which anxiety attacks, often referred to the præcordium (*Præcordialangst*), may occur in "genuine melancholia". Hecker further describes the features of the "melancholia" that usher in *vesania catatonica*—the rigidity, stereotypy, etc.

KRAEPELIN.

With Kraepelin (116, 117), the door of the modern period is opened. Prominent in his work may be recognized the nosological principles of Kahlbaum, the insistence on identity of causal factors (*Entstehungsbedingungen*), course and outcome as the criteria of a mental disease. The *Einheitspsychose* is forsaken. Manic-depressive insanity and dementia præcox take the field; and in the successive editions of his textbook Kraepelin defines more and more clearly the features of the "disease"—*manisch-depressives Irresein*. In the fourth edition the most diverse terminations are ascribed to mania and melancholia, and essentially different states are included as sub-groups of melancholia. In his 1896 edition (116) (the fifth), which he describes as betokening "den letzten entscheidenden Schritt von der symptomatischen zur klinischen Betrachtungsweise des Irreseins" ("the last decisive step from the symptomatic to the clinical approach to insanity"), he divides all insanity into acquired disorders and those arising from morbid predisposition; among the former "melancholia" figures as an insanity of the involution period; among the latter, periodic insanity is given as one of the constitutional mental disorders, and constitutional mood-disorder (*constitutionelle Verstimmung*) as one of the psychopathic conditions (insanity of degeneration). In "periodic insanity" he describes manic, circular and depressive forms.

In the following years controversy centred mainly about the independence of "melancholia" of the period of involution, which Kraepelin had given as a separate disease. Thalbitzer (118) began an attack on the Kraepelinian view in 1902, and in later writings pointed out the grounds on which he would

include this variety of agitated depression within the manic-depressive psychosis, of which it is in clinical form, if not in course, a mixed state. It was only, however, after Dreyfus's (119) monograph in 1907 that Kraepelin ceased to denominate as "melancholia" the depressive anxiety of the presenium, and accepted it as one of his *Mischzustände*. Dreyfus, unlike Thalbitzer, used Kraepelin's own criteria. In spite of Kraepelin's attitude, the point continued to be hotly contested; among Germans, Westphal (120), Ziehen (121, 122), Specht (123), Rehm (124) and Forster (125); among the French, Régis (126), Masselon (127), Ducoste (128), Dény and Camus (129) contributed to the discussion, and in 1910 "*die Melancholiefrage*" was still being debated when Hoche's (131) famous Referat with this title cut the ground from under the feet of the disputants. His pupil Bumke (133) the year before had published a trenchant criticism of the whole Kraepelinian position. Hoche (131), following it up, pointed out that in the eighth edition (1909) Kraepelin had relegated "melancholia" (involuntal depression) from "*Krankheitseinheit*" to a "*Zustandsbild*"—from a disease to a clinical picture—and that it no longer mattered whether there was mania or melancholia, occurrence once in life, or many times, at irregular or at regular intervals, whether late or early, with predominance of these symptoms or those—it was still manic-depressive insanity. This standpoint Hoche attacked on theoretical and practical grounds, and proceeded to his general thesis—that clinically distinguishable *Krankheitseinheiten* do not exist. With incisive sarcasm he derided the systematizing efforts of his contemporaries, "who give the impression of a great number of diligent workmen, most energetically engaged in clarifying a turbid fluid by pouring it busily from one vessel into another". Typical cases are the exception: "Es ist richtig, eine Art von Denkwang, ein logisch, ästhetisches Bedürfnis nötigt uns, nach wohlumgrenzten in sich geschlossenen einheitlichen Krankheitsbildern zu suchen, aber leider ist hier, wie sonst, unser subjektives Bedürfnis noch kein Beweis für die Realität des Ersehnten, für das tatsächliche Vorkommen der reinen Typen in der Wirklichkeit" ("It is here that a kind of thought-compulsion, a logical and æsthetic necessity, insists that we seek for well-defined, self-contained disease-entities, but here as elsewhere, unfortunately, our subjective need is no proof of the reality of that which we desire, no proof that these pure types do, in point of fact, actually occur"). He cited the great variety of clinical pictures seen in structural disease of the brain, toxic disorders, etc., and proposed to substitute for diseases "symptom-complexes" or syndromes: "Ich glaube nun, dass wir weiter kommen werden, wenn wir den Versuch machen würden, Einheiten zweiter Ordnung zu finden, gewisse immer wiederkehrende Symptomverhüppelungen, die wir sehen lernen werden, wenn die Aufmerksamkeit erst darauf eingestellt sein wird" ("Now I believe that we will make more progress if we make an attempt to find entities of a secondary order, certain constantly-recurring accumulations of symptoms which we shall learn to recognize when once our attention is directed to them").

Hypochondria, neurasthenia and hysteria were given as examples of this. He declared that for practical and didactic purposes labelling with names of diseases is unnecessary: "Das wir das Handeln des Kranken voraussehen können, dass wir aus gewissen an sich unbedeutenden Zügen doch in der Regel bald ein Bild des inneren geistigen Geschehens bei einem gegebenen Individuum gewinnen können, beruht sicherlich nicht auf der Existenz von Krankheits-typen, sondern auf viel allgemeineren Erfahrungen, die von der Frage der Etikettierung dieser Zustände ganz unabhängig sind" ("That we can predict the patient's behaviour; that, from certain features, in themselves insignificant, we can yet, as a rule, soon obtain a picture of an individual's inner psychic activity; these facts surely depend, not on the existence of disease-types, but on experiences of a much more general nature, which are quite independent of the question of the labelling of these states"). There are certain regularly recurring symptom-complexes which account for the similarity of utterance and behaviour in countless madmen of all times and countries. Certain of these syndromes lie pre-formed and ready in normal psychic life—the melancholic is one of them. There are in the individual case endless possibilities as to form and course. "Wenn der Name 'manisch-depressiv' die nahe innere Verwandtschaft der beiden Stimmungsgegenpole theoretisch zum Ausdruck bringen wird, so ist dagegen nichts einzuwenden. Als Krankheitseinheit aber und damit als eine diagnostisch und prognostisch brauchbare Bezeichnung ist dieser Name abzulehnen" ("If the term 'manic-depressive' is meant as a theoretical expression of the close internal relationship of the two opposite poles of affectivity, then there are no objections to raise against it. But the name is to be rejected as a disease-entity and consequently as a designation of diagnostic and prognostic value"). "Die Melancholie (erhält) gerade wegen ihrer nahen Verwandtschaft mit dem normalen psychischen Geschehen mehr als andere Seelenstörungen von Alter, Geschlecht und persönlichem Temperament ihr Gepräge, und (weist) somit auch in der Involutionsperiode ganz besondere Züge auf" ("Just because of its close relationship with normal psychic events, melancholia, more than other mental disorders, takes its stamp from the subject's age, sex and personal temperament, and so, too, presents quite special characters when it occurs in the involutionary period").

The influence of these views upon German psychiatry was great, and Kraepelin himself in 1920 made considerable concessions in his *Erscheinungsformen des Irreseins* (117). In this he recognized Bonhoeffer's (145) "*Exogene Reaktionsformen*", and went on to remark how significant it is "dass zahlreiche Äusserungsformen des Irreseins durch vorgebildete Einrichtungen des menschlichen Organismus eins für allemal festgelegt sind und sich daher überall in gleicher Weise abspielen, wo die Vorbedingungen dazu gegeben sind" ("that numerous manifestations of insanity are laid down once and for all by previously established dispositions of the human organism, and therefore run

their course in the same way in all cases, given the same conditions"). We are thus obliged to limit to the utmost the assumption that this or that disorder is characteristic of a definite disease-process (" Krankheitsvorgang").

EARLY TWENTIETH CENTURY.

There has been an independent movement along the same lines in America. Adolf Meyer (134), working at first with the Kraepelinian groupings, gradually between 1902 and 1905 developed out of his dynamic-genetic interpretation a concept of reaction types, clearly expressed in his paper of 1908. These views are given more at length below ; but it may be mentioned here that in 1904, in a discussion (135) on melancholia at the New York Neurological Society, he said that " for practical reasons he would rather favour a different classification. On the whole he was desirous of eliminating the term melancholia, which implied a knowledge of something that we did not possess, and which had been employed in different specific ways by different writers. If, instead of melancholia, we applied the term depression to the whole class, it would designate in an unassuming way exactly what was meant by the common use of the term melancholia ; and nobody would doubt that for medical purposes the term would have to be amplified so as to denote the kind of depression. In the large group of depressions we would naturally distinguish our cases according to ætiology, the symptom-complex, the course of the disease and the results. . . . The distinction had best be made according to the intrinsic nature of the depression. From that point of view we might distinguish the pronounced types from the simple insufficiently differentiated depressions. Besides the manic-depressive depressions, the anxiety psychosis, the depressive deliria and depressive hallucinations, the depressive episodes of dementia præcox, the symptomatic depressions, non-differentiated depressions will occur". The further development of this will be described later.

At about the same time the subject of cyclothymia received much attention, especially in France. Under this name Kahlbaum (113) had collected the mildest forms of circular insanity ; his pupil Hecker (115) treated the subject in a special paper (1898), as did Hoche (132) in 1897 ; Wilmanns (136) pointed out the features which have since come to be associated with " psychogenic " depression, and Römheld (137) wrote on similar lines. Ziehen described periodic menstrual melancholia with depersonalization or excitement, and Kraepelin eventually grouped all these conditions together as " Grundzustände ". In France, Deny (130) and Kahn (138) somewhat earlier (1909) extended the term " cyclothymia " to cover not only mild forms of manic-depressive insanity, but also a special morbid predisposition, highly inheritable—an attitude in keeping with the general trend of French psychiatry.

Friedmann's (139) "neurasthenic melancholia" was regarded in a similar way, though the word "cyclothymia" was eschewed. The importance of the constitutional factors was recognized by Reiss (140) in his paper on "Konstitutionelle Verstimmung"; he found fluid transitions between the various types of depression, genuinely endogenous circular forms at one end of the scale and clear reactions to an environmental situation at the other. Alzheimer (141) wrote a paper on "diagnostic difficulties in psychiatry" which likewise paid due regard to the constitutional factors—still viewed in the light of "degeneration". Other writers dealt at this time with "hysteromelancholia", "pseudomelancholia" and similar newly-named groupings. At the same time psychomological experiments along Wundtian lines were carried out chiefly by Rehm (142), Isserlin (143) and Aschaffenburg (144). Clinical studies were published in great numbers, but were largely occupied with statistics and quarrelling.

NOSOLOGICAL PROBLEMS.

The brilliant work of Bonhoeffer (145) in describing the exogenous types of reaction served to emphasize the difficulties of an ætiological classification. It was clear that the same cause might produce widely different clinical pictures, and the reverse, and that constitutional metabolic, genetic and biological factors generally called for consideration, together with careful analysis of the clinical features, from a phenomenological point of view. Some, presently to be considered, thought that salvation lay rather in minute psychological analysis—a different thing entirely, and open to epistemological objections, as they practised it.

Kraepelin had made concessions to Hoche's view, but it was not surrender. Manic-depressive insanity remained for him, as for his followers, a disease to be differentiated and delimited. He held, as shown above, that the individual brain reacts to the trauma of the disease in the manner determined by its own constitution; among these *Erscheinungsformen* he included delirious, paranoid, emotional, instinctual, schizophrenic, verbal hallucinatory, encephalopathic, oligophrenic and spasmodic kinds. But the fundamental diseases remained. His pupil, Johannes Lange (147), examined in accordance with these principles catatonic phenomena occurring "in the frame" of manic-depressive insanity. The bold claims of Urstein were disposed of. The difficult problem of the interpretation of schizophrenic features occurring in the course of a predominantly affective disorder was gone into by Lange in the light of the exogenous and genetic factors, as well as the time of life. Bonhoeffer (146) showed that periodic confusional states were special variants of manic-depressive insanity, and pointed out the frequency with which compulsive phenomena occur in depressive states—a subject with which Stocker (150) also concerned himself. Lange (148) also made a study of depressive states, following in the

footsteps of Reiss (140), but making more use of the somatic and genetic criteria in accordance with the tenets of Kretschmer (166) and others. The psychogenic forms of depression were dealt with by Kurt Schneider (151), who emphasized the "vital" elements in endogenous depression, in accordance with the philosophic doctrine of Scheler; Westermann (152) followed suit.

Among those who did not support the Kraepelinian views were Rittershaus (153), who, like Hoche (131), saw in manic-depressive insanity only a symptom-complex, and Schröder (154), who would accept pure cases of it as a special disease-group, but would include all the complicated forms (*Mischzustände*, *Grenzzustände*) in a new group, the degeneration-psychoses or metabolic disorders, in which there might also be put impure psychotic pictures, odds and ends from dementia præcox, epilepsy, etc. Kleist (155), the disciple of Wernicke (98) and inheritor of his "motility-psychoses", which he was at first inclined to allot back to the manic-depressive disorder, came to the conclusion that one may delimit the pure manic-depressive psychosis and set alongside it as of equal value motility-psychoses, periodic hallucinoses, periodic paranoid pictures, expansive and depressive autopsychoses, periodic confusional states, etc.—all linked together by their autochthonous development and cyclic course; the whole collection, including mania and melancholia, he denominated "the autochthonous degeneration-psychoses". Later, under the influence of biological tendencies, he separated pure cases of manic-depressive insanity from the degeneration-psychoses, therein agreeing with Schröder (154), and prosecuted his very individual "localizing" method of study. Gaupp and Mauz (156) have arrived at similar conclusions, calling their rubbish-heap "*Mischpsychosen*". A failure to consider the individual and pathoplastic elements in the symptom-picture may be suspected to be the basis of their problem. The word "pathoplastic" was used by Birnbaum (157), in contradistinction to "pathogenetic", when discussing the causal factors in the building-up of a psychosis; its implications as to structural analysis were the same as those of Kretschmer's (166, 167) "pluridimensional diagnosis"—the necessity, in brief, for considering the individual upbringing, experience, environment, setting, when assigning its value to any symptom or group of symptoms. This has been emphasized also by Adolf Meyer (134) and, of course, by those with psycho-analytic convictions or bias.

Ewald (158), in a paper dealing with this subject of degeneration psychoses, expressed the view that, like Thalbitzer (118), he regarded manic-depressive psychoses as endogenous "quantitative diseases", while the other members of the group could be qualified with various combinations of the epithets, "qualitative" and "quantitative", "exogenous" and "endogenous". (It is curious to set alongside his "quantitative" a passage written by Bernard Hart (160) (1912): "In another variety of general mental change observed in cases of insanity, the alteration is qualitative rather than quantitative. It

may be regarded as a change in the general attitude of the mind towards its experience, either transitory or more or less permanent. Under this heading are included excitement, depression and apathy.”)

The work of Kleist has met with little acceptance so far, outside Frankfurt. An isolated and independent attempt with, in this respect, not entirely dissimilar results, has been that of Shaw Bolton (161) in England to discover a structural basis for the symptoms of mental disorder. Under the group heading “*amentia*” he was led to include a great variety of disorders—feeble-mindedness, paranoia, manic-depressive types, and psychopathic personality; his other division, “*dementia*”, ranged from *dementia præcox* to *dementia senilis*. In the “*amentia*” groups, he concluded from his clinical and minute histological studies, there is evidence of subevolution of the brain without structural lesions. The choice of the term “*amentia*” was unfortunate, since among German and American writers it is used, after Meynert, to designate confusional states.

BIOLOGICAL STUDIES.

Efforts, with strong dualistic bias, were made to find the somatic basis or “*essence*” of the disorder. Attention at first centred on the ductless glands and the vegetative nervous system. Stransky (162) put forward the theory of endocrine pathogenesis for manic-depressive insanity in 1911; many workers have dealt with it since, but most inconclusively. The accent has shifted somewhat; it is now rather the bodily concomitants than the somatic basis of the disorder that are the object of countless investigations into chemical and physical changes in metabolism. To enumerate the investigators would be idle, nor are there as yet any definite and specific conclusions concerning depressive states of the manic-depressive group. It is of interest to mention here the revival of ancient views about the rôle of the liver. Jacobi (163) has concluded from interferometric studies, and Ewald (159) from another, admittedly inadequate series of investigations, that in mania the thyroid gland, in melancholia the liver play a certain part. Büchler (164) found the bilirubin value in the blood to be raised in 90% of melancholic patients. Chiray has in many articles described an atony of the gall-bladder with biliary stasis; in his and Zitzermann’s paper (165) (1930) there is a reference to Pécholier (who showed that veratrine, the active principle of white hellebore, is a powerful cholagogue, thus efficacious in melancholia) and to many other French writers who have thought the liver and melancholy to be causally connected, as the common people suppose, and *puns aver*. Chiray and Zitzermann give their X-ray findings of atony of the gall-bladder, together with detailed accounts of their procedure for collecting the thick, black, stagnant bile from depressed people, most of them with digestive symptoms; they raise and reject the possibility of the biliary phenomena being secondary to “*vagotonic imbalance*”,

and report how the parasympathetic and other symptoms of the depressive attack are ameliorated if the biliary atony be dealt with by daily duodenal lavage, the use of olive oil, etc. These observations are given at length here for their historical interest. There have been few opinions on mental disorder expressed in past times for which one cannot find a counterpart in the writings of the present century, often couched in such terms as to suggest a revival rather than a modern analogue. To illustrate this further would be otiose ; the above example is a sufficient warning against neglect of the ancients, or supposing them wholly in oblivion.

It is necessary to speak particularly of the investigations into the relation of character to physique that are usually associated with the name of Kretschmer (166, 167), their most active and brilliant representative. His correlation of the cyclothymic or manic-depressive psychic constitution with a pyknic habit of body has been the most fruitful and acceptable of a number of bold assumptions, qualified by statistical data. There has been much criticism of Kretschmer's claims, now greatly reduced. The methods of examination and criteria of particular body-types have been shown to be open to objection, but it seems plain that a higher proportion of manic-depressive patients show pure pyknic build than may be found in schizophrenic patients or in the average population. Less popular, but equally or more valuable, has been Kretschmer's (167) work on temperaments. In this field he has prosecuted inquiries that may be compared with the work of August Hoch and Adolf Meyer in the United States. It is the restatement, with fresh knowledge, of the older doctrines. Kretschmer pointed out a "diathetic proportion", a relation between hypomanic and depressive qualities, characteristic of "cycloid" people, and described the characteristics of the depressive temperament, among others. The value of these studies of constitution has been less in their accepted conclusions or results than in the stimulus they have given to the study of the pre-morbid personality, the total make-up of the individual.

Alongside these biological studies others on inheritance have been prosecuted, chiefly by a small group directed by Rüdin (168). At first it appeared that manic-depressive insanity represented a dominant character, but the matter proved less simple. Kleist (155) thought that separate genes should be assumed for mania and for melancholia, but this is generally thought to be unsound. Kahn (169) has published reports on the children of manic-depressive parents ; of 50 children only 10 were manic-depressive. Lange (149) sums up his own conclusions as follows : manic-depressive insanity is unquestionably a hereditary disease ; not only are the manic-depressive disorders determined, but also in many cases the time of occurrence, and occasionally even the course of the disorder ; the genetic factors are complicated, and constellative external influences which cause changes in metabolism or in the brain are also important in deciding the time of occurrence of an attack. The work of Mott (170) in England has also to be mentioned in connection with studies in heredity.

PSYCHOLOGICAL AND PSYCHO-ANALYTICAL WORK.

Before passing to the American school of thought dominated by Meyer, there remains for consideration one important method of studying the depressive psychoses—the psychological. Kraepelin and his followers paid attention to this in some measure, especially as regards inhibition (*Hemmung*, retardation) but the application of Wundt's experimental or physiological psychology to the problems of psychiatry did not prove particularly happy. Janet (171) in France has made some notable contributions. Other investigators of the disorders of thinking and related matters in depressed patients have been influenced by philosophical teachings, as von Domarus (172) by Husserl's phenomenology, Kant (173) by Klages, K. Schneider (151) by Scheler, and Mayer-Gross (174) by Jaspers. The application of Rorschach's ink-blot experimental method to the differentiation of cycloid personalities seems of limited or doubtful value. But much more important than these has been the advent of Freud's psycho-analysis. To present in detail the conclusions reached about melancholia by Freud (177), Abraham (175, 176) and some less notable writers would be impossible here, and a critical examination of them, as of much other detailed work in the field of depressive states, is reserved for another place. It is idle to gainsay their importance. The psycho-analytic concern with melancholia may be said to begin with Abraham's (175) paper of 1911; it is carried on with Freud's (177) "Trauer und Melancholia" (1916-18), and is presented with clarity in Abraham's "Short Study of the Development of the Libido, Viewed in the Light of Mental Disorders" (176) (1924). Maeder (178), Brill (179) and Nunberg (180) are other writers on the subject.

Abraham's first paper (175) was based on the analysis of six patients; the structural likeness to obsessional neurosis impressed him, and he discovered striking points; whereas, for example, in the obsessional, substitutive aims take the place of unattainable sexual ones, in the depressive patient sadistic impulses towards the "love-object" are repressed; projection occurs, the patient feels hated by his environment; there arise guilt, self-reproach, anxiety; masochistic tendencies are reinforced.

Freud's illuminating paper (177) assumes that the loss of a "love-object" is the precipitating cause of an attack. The differences between the mourning or grief of the healthy person and the morbid depressive state lie chiefly in the withdrawal of love into the patient's self (giving up of "object-cathexis") and identification of the abandoned object with the self; it is thus a narcissistic regression; the desire to incorporate, *i.e.*, devour, the loved object is fixed at the oral stage, hence the difficulties about taking food. There is essential ambivalence in the love relationships, which makes itself felt when the loved object is lost. "The melancholic's erotic cathexis of his object undergoes a twofold fate: part of it regresses to identification, but the other part, under the influence of the conflict of ambivalence, is reduced to the stage of sadism

which is nearer to the conflict." "It is this sadism, and only this, that solves the riddle of the tendency to suicide." The complex of melancholia can withstand the desire for sleep (on the part of the ego): "the complex of melancholia behaves like an open wound, drawing to itself cathectic energy from all sides and draining the ego till it is utterly depleted." He recognizes constitutional factors, and says of the improvement that occurs towards evening that it is probably due to a somatic factor, and not explicable psychologically—a noteworthy recognition of possible somatic elements. Some unanswered problems, especially as to the economics of the situation (energy), are posited by Freud, who deals with the subject incidentally in his *Group Psychology and the Analysis of the Ego*.

Abraham's lengthy and candid paper of 1924 (176) can only with difficulty be summarized. The conclusions as to depression are bound up with his views on the fixation points in the development of the libido. In the melancholic, as in the "obsessional" patient, there is a common relation to the anal sadistic organization: the former regresses to the ontogenetically earlier of its two levels, at which hostile tendencies of destroying and losing the object predominate, the latter only to the later conserving and controlling level. In melancholia there may be regression further to the oral phase, where also there are two levels, on the higher of which only can an ambivalent attitude of the ego emerge. There are a number of ætiological factors in the "choice of neurosis": first, a constitutional factor, though he thinks that what is inherited is not a manic-depressive tendency as such, but an over-accentuation of oral erotism; this predisposition helps to bring into operation the second factor—special fixation of the libido on the oral level; thirdly, a severe injury to juvenile narcissism; fourthly, a disappointment in love before the œdipus wishes have been surmounted; and finally, a repetition in later life of this primary disappointment. It is against the original "love-object" that all the patient's anger is directed, though a substitute has provoked the immediate attack. With time and gradual appeasing of the sadistic desires, the introjected "love-object" is again safe and, for the patient, becomes again part of the outer world, ceasing to be part of himself: this is, for his unconscious, an act of evacuation.

The re-statement of these views in terms of ego, id and super-ego has received relatively little attention; Rickman (181), accepting Abraham's and Freud's conclusions, remarks that the difference between mania and melancholia consists in the relation of the ego to the super-ego: in melancholia there is pathological separation of function, with cathexis transferred from the ego to the super-ego; in mania, fusion; this is, of course, a translation into psycho-analytic terms of the obvious situation. These psycho-analytic investigations, conjectures and conclusions, extended also into the field of therapy, offer at least an explanation, however speculative in places, of many of the obscure manifestations of melancholia: even though unaccepted, they

are exerting influence on psychiatrists who approach the problems with other methods of a familiar and on the whole more trustworthy kind.

ADOLF MEYER'S INFLUENCE.

It is not possible to end this *résumé* without some further remarks on the work of American psychiatrists, among whom the psycho-biological view of Adolf Meyer (134) has chiefly prevailed. His work in the field of dementia præcox has made more stir, as it has been more actively put forward, than that on the affective disorders, but his general formulation of a psycho-biologically integrated organism reacting to situations covers the whole of the phenomena, emancipated from any dogmatic nosological scheme: "We work with a reasonably limited number of reaction-sets, that is, groups of facts that have a specific meaning for us. These may be of the nature of part-disorders—the irritable weakness type, the anxiety-reaction, the hypochondriacal, the dysmnesic-hysterical, the obsessive-ruminative and the simple defect type of facts; or we consider the more sweeping reaction sets, the thymergastic or affective, the parergastic or twist, the dysergastic or toxic and the anergastic or organic defect complexes, always remembering that any one patient can present more than one of these sets of facts. We study the factors entering into the disorders, the poisons and infections (exogenic), the metabolic (organogenic) components, and then the constitutional and the more definitely modifiable and adjustable psychogenic experience-determined factors and special function-tendencies." Ergasia, being the term used for performance or psycho-biologically integrated activity in general, there are, among others, the thymergastic reactions, in which depressive states may appear as reactions (protective at any rate in intention, designed to withdraw the individual from an ill-adjusted situation), with concomitant phenomena on various levels—vegetative, kinetic, and topical mental, characterized chiefly by diffuse general inhibition. There may be sadness, with feelings of difficulty and dearth of ideas and activity, or actual retardation; catathymic reaction, with harping on one set depressive topic; or the dominant affect may be not sadness but anxiety. Neurasthenia, hypochondriasis, anxiety attacks and obsessive-ruminative states of tension are, together with hysteria, denominated "merergastic reactions", by which is meant a substitutive disorder not involving the whole personality and behaviour. In these and other reaction sets it is not a disease or even a diagnosis that is set forth, but a suggestion of fairly definite situations, reactions and kind of personality, all of which need evaluation in any particular case. The insistence is not primarily on outcome, but on the possibilities of therapeutic modification. The full working out of these doctrines cannot be given here; their influence as far as affective disorders are concerned may be traced in the work of Meyer's colleague, August Hoch, on benign (depressive) stupor (182), states of

perplexity (184), and (in common with McCurdy) the so-called involitional melancholia (183). McCurdy's (185) analytical and descriptive studies of emotional reaction, including the depressive ; Greenacre's (186) investigation of schizophrenic characteristics occurring in affective disorders, with which Kirby also dealt ; and Hohman's (187) discussion of thymergastic reactions may also be mentioned.

OTHER RECENT VIEWS.

The influence of Meyer's teaching has been considerable in England also during the last lustrum. So far as depressive states are concerned, the English position was stated in a discussion on manic-depressive disorder in 1926, when Mapother (188) gave a critical presentation of the whole problem, in which he incidentally laid stress on the impossibility of sharp or fundamental distinction between psychotic depressive states and the related "neurotic" states, especially of anxiety ; this view, based by Mapother on clinical observation, but receiving independent support from Abraham's psycho-analytical work referred to above, has been contested by many English psychiatrists, who put forward therapeutic accessibility as the chief point at issue ; their views were expressed in the discussion on Mapother's paper and at the Royal Society of Medicine (April, 1930) (189). Gillespie (190), a thorough-going believer in the essential difference between "cyclothymic" and "psycho-neurotic" depression, has in several papers accepted in effect Lange's differentiation of the types of depression, as laid down in the latter's 1926 paper on melancholia. Kraepelinian influences of an older date are still occasionally evident in England, alongside bold psycho-analytical advances ; as regards depression, the main currents are those alluded to above. Much work on metabolic changes has also been prosecuted, but so far with no special bearing on depression. In France the vegetative changes have received much attention, as may be seen in the following quotation from Laignel-Lavastine's (191) book : " La mélancolie est un syndrome, caractérisé par un sentiment de tristesse et d'impuissance, expression psychique d'un état cœnesthésique pénible, l'inertie motrice et le ralentissement de l'activité vitale, surtout visible dans le domaine des idées et de la parole " (" Melancholia is a syndrome, characterized by a feeling of sadness and weakness (the mental expression of a painful state of cœnæsthesia), motor inertia and slowing of vital activity, especially evident in ideas and speech "). Von Monakow, of Zürich (192), recently, in collaboration with R. Mourgue, put forward a comprehensive biological theory covering the psychoses, in which the rôle of the instincts and the time-factor receive much attention. Erwin Straus (193) in Germany has likewise emphasized the importance of the time-factor, especially in depressive states, in two recent publications.

There has been very little written in this review as to therapeutics. Notable as have been the changes in the general care of the insane, there is little to be

said about the particular treatment of depressive states. To hinder suicide, to prevent irritation, and to provide for nutrition, sleep or rest and, in due course, occupation and interests, have long been the objects of judicious treatment, conscious that of the factors potent to heal, time is more important than any kind of interference so far attempted. Only psycho-analysts have of late challenged this; their hardy claims are as yet unconfirmed. The differentiation of psychogenic from endogenous depressions, already alluded to, with the consequent adoption of active psychotherapy for the former as against resignation in the latter, has been urged recently, with scarcely enough consideration for the frequent difficulties that attend any such attempt at discrimination. The advocates of mental hygiene are hopeful as regards prophylaxis, but their optimism has so far more of an affective than of a demonstrable scientific foundation.

It has been difficult to avoid turning a history of melancholia into a history of psychiatry. It has been also difficult to set forth the interplay between different countries and different schools, the submission in every age to current philosophical and medical conceptions—a constant intermingling of streams which could better be set down, as it seemed, in a straightforward chronological account, than if one should attempt to follow the parallel development of discrepant modes of thought. There are still many modes of thought in psychiatry, many methods of research, not wholly discrepant nor unsusceptible of co-ordination, if not of fusion; among them the biological conception is now chief, and likely to be unifying.

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