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Classic Text No. 75

‘Essay on a classification of different genera of insanity’

by J. Baillarger (1853)

Introduction and translation by

G. E. BERRIOS*

Less well known than some of his contemporaries, Jules Baillarger (1809–90) tends to be celebrated by ‘who said it first’ writers as the man who assisted the ‘birth of bipolar disorder’. This view is based on the anachronistic claim that Baillarger’s ‘insanity with a double form’, Kraepelin’s ‘das manisch-depressive Irresein’, Leonhard’s concept of Bipolarität and DSM-IV’s ‘Bipolar I and Bipolar II’ Disorder somehow constitute an incremental approximation to the same ‘disease’. Baillarger is important because he was a high profile conceptual interlocutor in the great 19th-century debates on hallucinations, hypochondria, language disorders, General Paralysis of the Insane, cretinism and goitre. Classic Text No. 75 is a translation of Baillarger’s important 1853 paper on the classification of madness, and it is a good illustration of the popular method of top-to-bottom psychiatric taxonomy. Written before psychiatrists felt the need to conceal the theoretical nature of the exercise behind a farrago of ‘empirical evidence’, it shows how hidden assumptions govern the way in which the boundaries of mental disorders are actually drawn.

Keywords: Baillarger; classification; concepts; France; mental disorder; psychiatry; taxonomy; top-to-bottom; 19th century

Introduction

Less well known than some of his contemporaries, Jules Baillarger tends to be celebrated by ‘who said it first’ writers as the man who assisted the ‘birth of
bipolar disorder’ (Pichot, 1995, 2006). This view is based on the anachronistic claim that Baillarger’s ‘insanity with a double form’ (la folie à double forme) (Baillarger, 1854), Kraepelin’s ‘das manisch-depressive Irresein’ (Kraepelin, 1913: 1183), Leonhard’s concept of Bipolarität (Leonhard, 1980: 149) and DSM-IV’s ‘Bipolar I and Bipolar II’ Disorder (American Psychiatric Association, 1994) somehow constitute an incremental approximation to the same unitary disease. Baillarger is important on account of something else, to wit, his role as a conceptual interlocutor in the great nineteenth-century debates on hallucinations, hypochondria, language disorders, General Paralysis of the Insane, cretinism and goitre (Semelaigne, 1930).

Jules Gabriel Françoise Baillarger was born in Montbazon, Indre-et-Loire, on 25 (or 26) March 1809 to well-to-do farming stock. After attending the Lycée de Tours (where it is reported Trousseau was teaching at the time!), he trained in medicine at Paris (Ritti, 1892). Following a recommendation by Cloquet, Baillarger joined Esquirol’s group in 1832, and after the death of the latter he was appointed by Mitivié (Esquirol’s nephew) to the superintendency of the madhouse of Ivry (Magnan, 1903). Co-founder of the Annales Médico-Psychologiques (1843), La Société Médico-Psychologique (1852), and L’Association mutuelle de médecins alienistes de France (1865), Baillarger maintained a high professional profile until his death on 31 December 1890. In 1875, on account of ‘his advanced age’, he turned down the newly created Chair of Mental Diseases at the Paris Clinical School (Morel, 1996).

The paper whose translation follows is a transcription of a lecture delivered by Baillarger before the Société Médico-Psychologique in 1852. Published at a time when the traditional classifications of madness (i.e., those composed by Pinel and Esquirol) started to be called into question, it illuminates the conceptual processes that motivated such a challenge; more to the point, it shows how preconceived taxonomic criteria determine, in a top-to-bottom fashion, the very ‘clinical’ boundaries of mental disorders (Berrios, 1999b). Although the same mechanism is in operation in our day, it can no longer be seen for it hides behind the farrago of ‘data’ that current psychiatrists call empirical evidence.

In this paper, Baillarger was directly reacting to the earlier classification by Esquirol (Huertas, 2008) that had since been modified by Georget. Baillarger’s view was that the concept of ‘lesion’ would be a more useful taxonomic criterion than any overt behavioural markers. The problem was that the notion of ‘lesion’ reigning in his time was as abstract and ill-defined as it is nowadays. According to a popular definition, lesions were: ‘The alterations resulting from any cause of the vital properties or the texture of our bodily parts; it follows that the lesions that give rise to all the diseases that affect our body can be clearly divided into organic and vital lesions …’ (Merat, 1818: 485). Although by the middle of the century the notion of ‘vital lesion’ was seriously challenged (together with the rest of vitalism in medicine), the concept of ‘physiological lesion’ was accepted, and this kept the concept of lesion vague and under-defined (Verneuil, 1869: 205).
By providing a new basis for the old distinction between partial and general lesions of the intellectual and moral functions, Baillarger was able to reshape and reshuffle all the clinical categories extant at the time. It could be speculated that this change was responsible for the development of the view that mania and melancholia were expressions of a primary ‘lesion of mood’, that is, of the view that was to come via Kraepelin into the twentieth century.

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Mental alienation consists in a privation of free will resulting from incomplete development or lesion of the understanding (lesion de l’entendement). It is divided into imbecility (la imbécillité) or arrested development of the moral1 and intellectual2 faculties;3 madness (la folie) or brain affection without fever, ordinarly of long duration, and characterized by a disorder of understanding of which the patient is not aware and which may lead him to perform acts which his will is unable to control; and dementia (la démence) or weakening of emotions, intelligence and will of which the subject is not aware. I shall only deal here with madness and its classification.4

Let us remind ourselves of the current state of our science and particularly of Esquirol’s classification still predominant today. For Esquirol [1838]5 the forms of madness are five: “1. Lypemania (Lypémantè) (melancholia of the ancients), a madness (délire)6 focused on one or a small number of objects and accompanied by a predominant sad or depressive mood; 2. Monomania (Monomanie) a madness directed to one or a small number of objects and accompanied by excitement and a predominantly expansive and gay mood; 3. Mania (la manie) a madness referred to all manner of objects and accompanied by excitation; 4. Dementia or loss of reason resulting from a reduction in the energy that drives the organs of thinking; and 5. Imbecility, idiocy or lack of reason resulting from a lack of development of the relevant organs.” (Vol. 1, p22).

*Translation of: Baillarger, J. (1853) Essai sur une classification des différents genres de folie. Annales Médico-Psychologiques, 2nd Series, 5, 545–66 (transcription of a lecture delivered by Baillarger before the Société Médico Psychologique in 1852); original punctuation and italics are retained.
To lypemania, monomania and mania, Georget added a fourth type, \textit{stupidity}, which he defined as the accidental absence of manifestations of thinking due to either absence of ideas or to inability to express them. Current alienists, therefore, recognize the following:

- Partial Madness (\textit{délire partiel}) \{ with excitation and gaiety \textit{monomania}\textsuperscript{22} with retardation and sadness \textit{melancholia}\textsuperscript{23} \}
- General Madness (\textit{délire général}) \textit{mania}\textsuperscript{24}
- Suspension of the Intellect \textit{stupidity}\textsuperscript{25}

In this classification Partial Madness has two genera, monomania and melancholia; while general madness has only one, mania. Stupidity is not related to either partial or general madness.

I wish to suggest that all genera should come under:

1. Madness with partial lesion of intellect (\textit{lesion partielle de l’intelligence})
2. Madness with general lesion (\textit{lésion générale}).

The first class would include \textit{monomania} and the second \textit{melancholia} and \textit{mania}. Two differences separate this classification from the one mentioned earlier: 1. \textit{melancholia} is now classified under madness with general lesion\textsuperscript{11} and 2. \textit{stupidity} ceases to be a genus. In other words, there are only three classes of madness: monomania, melancholia and mania.

Are these changes needed? In the field of classification the best is frequently the enemy of the good, and changes should not be suggested unless needed. The reader will have the opportunity to decide for himself. First of all, it should be noticed that I have added the term ‘\textit{lesion}’ to \textit{partial} and \textit{general madness}. This is less unimportant than it might first appear. Indeed, it seems to me that, when used alone, the phrases \textit{partial} and \textit{general madness} are unclear.

In this context, the word madness (\textit{délire}) is a synonym of insanity (\textit{folie}).\textsuperscript{12} Hippocrates defined the former as a madness without fever (\textit{délire sans fièvre}) hence when one says \textit{partial} and \textit{general madness} it seems evident that one is saying partial and general insanity. But, can it be predicated of insanity (\textit{folie}) that may be partial or general? To answer, the nature of insanity must be clarified. Insanity includes two distinct elements: a trouble, disorder, or lesion\textsuperscript{13} of the intellect; and an absence of awareness\textsuperscript{14} of the said trouble, disorder or lesion.

As an example, let us consider a patient with hallucinations. There is first the hallucination itself - a lesion of the intellect and perception, and secondly the conviction that the hallucination originates in the external world (e.g., caused by a persecutor), that is, the patient is not aware that the hallucination is a symptom of his intellectual disorder. Is the lesion or the lack of awareness thereof the central phenomenon? It is evident that it is not the lesion, for a man can hallucinate without being alienated, that is, he shows agreement with his doctor on the fact that his affliction is pathological. Therefore, the fundamental
phenomenon seems to be the loss of awareness.* But can this loss be partial? Surely not, for changes in magnitude can only characterize the lesion and not the loss of awareness. Based on this, it would be more reasonable to say that there can be madness with partial lesion and madness with general lesion. This is not just a play on words.

Using the same reasoning, it would make little sense to say that the stuporous patient is suffering from either partial madness or general madness. It could, however, be said with sense that stupidity is characterized by a general lesion of the intellect; and since stuporous patients have no awareness of their problem it should be in order to consider stupidity as a form of madness resulting from a general lesion. Similar analysis could be applied to those patients suffering from a weakness of the will, but there is no need to elaborate this point further.

In addition to changes in magnitude, lesions of the intellectual and moral faculties show other features, some opposed to each other. It will now be clearer that while madness can be classified on the basis of the extension and characteristics of its underlying lesion, the fundamental feature, that is, the loss of awareness remains the same.

The following are the main lesions of the intellectual and moral faculties:15

1. Delusions (les conceptions délirantes)16
2. Hallucinations
3. Unusual impulsions
4. Excitation of the intellect
5. Depression17 of moral and intellectual faculties.

The above are found in different combinations. The first three lesions are often found together; 4 or 5 can be seen accompanying the first three, but they exclude each other. For example, a patient can present delusions, hallucinations, unusual impulsions and excitation or depression but the latter two are never found together; they may, however, succeed each other in the same patient.

*"The essential symptom of insanity - that which characterizes it and without which it would not exist, and which also provides the basis for its classification into genera, species and varieties, depends upon a lesion of cerebral functions; it refers to that intellectual disorder called insanity (délire); there is no madness (folie) without insanity (délire)” (Georget [1820], De la Folie, p75). It is this view of madness which we wish to combat. While it is the case that the classification of madness must be based upon such disorders of intellect, the latter are not its essential feature. While it is true that there is no madness without some disorders of the intellect, it is also the case that the latter can be present without madness. The essence of mental alienation relates to the correct assessment (by the patient) of these disorders. Are they or not under the control of the will. All that Georget does here is repeat Esquirol’s definition of insanity: “a cerebral affection without fever, usually chronic, characterized by disorders of emotions, intelligence, or will.”
It follows from this that it makes sense to divide the lesions of the intelligence into partial (delusions, hallucinations and unusual impulsions) and general (excitation and depression). The latter can range from light manic excitation to acute madness or from slight obnubilation of intelligence to complete stupor. Irrespective of the severity and type of disorder, however, all faculties are involved. This means that there is a crucial difference between partial and general lesions, namely: that while the former remain as moral or intellectual lesions and have no bearing on the rest of the organism, the general lesions involve all the relational and (even) nutritional functions. Excitation of the moral and intellectual faculties is accompanied by marked muscular activity, loquacity, insomnia, and frequent changes in sensation. Depression of the same said faculties is, in turn, accompanied by reduced muscular energy, weak voice, cold extremities, obtuse sensibility and urine incontinence. Nothing like this occurs in the patient with partial lesions, be these delusions, hallucinations or unusual impulsions.

Now, for as long as the patient remains aware of his state and can master his impulsions, partial (and general) lesions can occur without being accompanied by madness (délire). Indeed, it is not uncommon to find patients who are aware of the fact that they are hallucinating;\(^{18}\) the same is the case for delusions (les conceptions délirantes)\(^{19}\) and unusual impulsions. Likewise, I have seen depression of intellect affecting all the organism in which patients do not lose awareness of their state and hence do not do anything unreasonable. It is otherwise in the case of excitation where, although patients may at some stage have awareness of their state, they cannot control their impulses.\(^{20}\)

In summary, it seems to me that the basis for all classification is the distinction between partial and general lesions. Based on this principle, I believe that it possible to classify insanity into three classes: the first would encompass all the partial lesions; the second would comprise those patients in whom the predominant symptom is the general excitation of the faculties; and the third would have as its main feature a general depression of all intellectual and moral faculties.\(^{21}\)

**First genus: Monomania**

Whether single or combined, its principal symptoms are delusions, hallucinations and unusual impulsions. Monomania includes all forms of madness with partial lesions without exception. In addition to its narrow compass, monomania is characterized by lucidity, clarity of ideas, and the apparently normal state of the intellect: “Outwith their partial madness, monomaniacs feel, reason and behave like everyone else” (Esquirol, [1838]:Vol. 2, p1). According to Guislain [1852], monomaniacs “conserve the demeanour of the normal man; their memory is intact, they can count and calculate, can tell just from unjust, and up to a point can look after their affairs and adequately conduct themselves in the world.” (Vol. 1, p27).
Patients with monomania do not habitually exhibit either excitement or depression of their moral and intellectual faculties. Although on occasions they may show episodes of excitement, anger and violence against those who oppose their ideas, this should not be confused with continuous manic excitement. Indeed, monomaniacs may not show their delusions at all, and nothing in their conversation may suggest that they have a partial lesion of their intelligence.

The patient suffering from a habitual or continuous state of excitement or depression is very different and his symptoms are there for all to see. Without difficulty one can ascertain in the subject with mania loquacity, an animated physiognomy, and an excess of activity; and in the patient with melancholia, the blurring of facial features, mutism and slowness of responses or stupor. At its most intense, manic excitement becomes similar to acute madness (délire aigu) and looks very much like febrile madness. When melancholic slowness becomes severe, the subject is said to have fallen into stupor.

Monomania does not resemble anything else. A bizarre combination of madness and reason, it seems unrelated to any organic lesion. Monomania is the real form of madness.

Second genus: Mania

Mania is characterized by a general and permanent surexcitation of the moral and intellectual faculties manifested by alteration of facial features, untidiness of clothing, fits, fury, acts of violence, and disorganization of ideas succeeding each other without rhyme or reason. This has led the medically untrained to consider the maniac as the real madman. It has been explained above why this is not the case. According to Pinel [1809] “mania is characterized by nervous excitation or by extreme agitation sometimes only manifested by fury and general madness (délire général), and sometimes accompanied by extravagant claims and a disorganization of all intellectual functions.” (p139). Esquirol [1838] writes: “In mania all manifests exertion, violence and energy; all is disorder and perturbation; absence of harmony being the most salient feature of maniac madness.” (Vol. 2, p147). According to Guislain, the pathognomonic features of mania are: exaggeration, exaltation, agitation, aggressive emotions. The disease is characterized by petulance, force and power; and its forms range from simple excitation to acute madness (délire aigu). In all cases diagnosis is made simple by the presence of an over-active cerebral function manifested in constant loquacity, monotonous repetition of certain phrases, general madness with agitation or occasional muteness (taciturnité) but always accompanied by agitation and disordered behaviour and violence.

Subjects with mania can be rendered reasonable for an instant by firmly requesting their attention, but when left to their own devices they restart their ravings as if controlled by an inner force. Mania must not be confused with monomania: excitation is habitual in the former but only transient and
motivated in the latter. The over-activity of the cerebral function also affects the functions of nutrition making the patient meagre, sleepless and constipated.

**Third genus: Melancholia**

Its features are the opposite of those of mania. The subject with melancholia is downcast and apathetic and spends his day in the same place. Intellectual and physical effort, however slight, will be tiresome and laboured to him; his movements are as slow as his ideas. Oppressed by an unexplained sadness, his mind may be overtaken by delusions with the most painful content thereby differing from the monomaniac who, albeit transiently, is able to abandon his fanciful ideas. The intelligence and body of the melancholic are passive and unable to fight or resist. As the patient gets worse his mind sinks into a twilight and he becomes stuporous. This dulling of the intellect extends to the rest of the organism, causing fading of the voice, slowing of the circulation, coldness of extremities, paralysis of sphincters and incontinence of urine and faeces.

The three types of insanity included in this new classification are adequately characterized. All that is left now is to justify their impact on current practice. The word melancholia has been used to refer to all cases with depression of the intellectual and moral faculties, i.e. having as central feature a general lesion of the intelligence. Until now, this term had been applied to sad monomania (as opposed to gay monomania) and the melancholic had been, first of all, a monomaniac, that is, someone who apart from his delusions showed lucid intelligence, was able to sustain a conversation and (to a large extent) could look after his affairs. Despondency was not necessarily part of his condition; indeed, according to Esquirol there were melancholics who showed great activity: “they are always on the go, searching for enemies and for those causing them suffering. They complain to all and sundry about their misfortunes, fears and despair.”

It has been suggested that melancholics who remain silent and concentrate on themselves have their minds occupied with fixed ideas and their mutism results from stubbornness; in other words, their minds remain highly active. There seems to be a great difference between these cases and the form of melancholia I outlined above. The former are active, powerful and lucid while the latter are apathetic, feeble and obnubilated; in other words, they show a partial and a general lesion, respectively. I do not underestimate the seriousness of trying to change the meaning of the word melancholia. The current state of science, however, requires that melancholia be either used with this new sense or abolished altogether. The very history of the term justifies this claim.

Under melancholia Pinel conflated states of congenital absence of intellect with its states of deterioration after this faculty had reached full development. In his classification, however, he assigned a separate place to states of extreme depression of intelligence including under this rubric forms of accidental idiocy suddenly appearing in the wake of sad emotions and culminating in mania.
Tidying up this confusion, Esquirol classified under idiocy only the states of congenital absence of intelligence, and under dementia those cases of incurable obliteration of the faculties which Pinel had still classified as idiocy. States of severe depression of intelligence Esquirol called ‘acute dementia’. Based on the view that the incurable abolition of the faculties differed from their depression, Georget renamed acute dementia (démence aiguë) stupidity (stupidité). Extreme degree of depression of the faculties has thus been successively called accidental idiocy, acute dementia and stupidity. In his excellent book on the subject, Étoc-Demazi [sic, 1833] has suggested that extreme depression of intelligence or stupidity is not a form of madness but a complication of both monomania and mania. This completes the first stage of the history of the states of depression of intelligence.

The second stage started when the relationship between stupidity and melancholic madness was studied. When in 1843 I published the first cases showing such relationship, I named the condition melancholia with stupor. Afterwards Delasiauve [1851] gathered more data and proposed the term melancholic stupor. Then Sauze [1852], from Marseille, coined ‘mixed stupidity’ to name a state of transition from stupidity to melancholia characterized by symptoms from the two conditions (p95). I believe that it is inexact to say that a ‘transition’ takes place between stupidity and melancholia, although it can happen the other way round. Evidence for the latter can be found in Sauze’s own work (p53). Thus, melancholia with stupor, melancholic stupor and mixed stupidity emphasize the same clinical fact, to wit, that a close association exists between stupor and melancholic madness. If I refer to my own observations, corroborated later by Delasiauve and Sauze, it is because other physicians have adopted the same view, for example, Renaudin and Aubanel both heads of large institutions and known to science for their excellent research.

What I call melancholia with stupor, Renaudin [1849] has named ‘stupid lypemania’ (la lypémantie stupide). There is no need to quote this distinguished physician exploring the phenomenon of depression of intelligence. Similar ideas have recently been expressed by Sauze [1853] who, after stating that stupidity frequently follows sadness, suggests a relationship between the cause and the nature of the disease. After illustrating how stupidity can be brought about by misery and sorrows of all kinds, Sauze continues: “Can this not explain to a certain extent the predominance of depressive moral causes in the production of stupidity? In the absence of any lesions of the intellect our spirit may when under the influence of sadness or pain fall into a dejection similar to that seen in the patient with stupidity. Acute fear likewise may imprint upon the face the peculiar features of stupor. A man affected by sadness and sorrows is inactive and apathetic. If the causes remain, the spirit will become powerless and unable to resist. No longer stimulated by the spirit, the body will become numb, stupor will ensue and the digestion and circulation will slow up.” All this being exact, we must emphasize Sauze’s point about the existence of a relationship between sadness and the nature of the disease.
Aubanel is even more explicit than his student. For him stupidity is a form of profound melancholia (see the April issue of AMP).

So much for stupidity as the extreme depression of the faculties related to melancholia. We need now to study its moderate and milder forms for, as I first reported in 1843, both depression and excitation show a range of intermediate states. All this makes me believe that in most cases stupidity is the most severe form of melancholia. In the milder and moderate forms no one would doubt the melancholic nature of the disease. The mild nature of the stupor spares the intellectual faculties and allows the recognition of the sad tenor of the ideas. It is at this stage that many suicidal attempts take place.

Excitation has been better studied than depression but there is little doubt that the slow and perfunctory nature of actions and the slight obnubilation of ideas seen in the latter are as much a manifestation of a general lesion as are the features of excitation. Stupidity is at the top of the scale of severity; then follow the moderate and slight forms of the condition. The neat distinction between melancholia and stupidity is made harder by the reasonable affirmation that patients affected by melancholia suffer from a general lesion of intellect. “In these cases” – states Sauze, “it becomes unclear whether the symptoms should be attributed to one condition or the other.” Delasiauve writes along the same lines: “One doubts about the nature of the symptoms”. However, it is important to know whether they relate to melancholia or stupidity.

The issue is not hard to resolve. According to its received scientific meaning, melancholia is basically a partial insanity (délire partiel). The patient with melancholia is a monomaniac (monomaniacque) who in spite of his delusions shows a lucid intellect and can, as Delasiauve noticed, converse well. When this is not the case, obnubilation of ideas, depression of intellect and a facial expression of sadness can usually be ascertained. In the presence of such signs of a general lesion of intellect there is little cause to believe, according to the received view, that such a patient is not a melancholic, and consequently his sorrow and sad delusions and hallucinations are all attributed to melancholia. The obvious obtusion of the faculties is either ignored or not taken into account. Although numerous, these cases are often said to be rare. I shall provide proof for this. After spending a year looking for cases with stupidity in a unit with 800 beds at the Bicêtre Hospital, Étoc-Demazière declared that he had found only one example! (p44).

What diagnosis then was given to those numerous patients showing depression of their faculties? In general, they were classified as melancholic. Indeed, obtusion of the faculties is clinically missed even by those whose attention is specifically drawn to its presence. Even Delasiauve himself has fallen into the same error. At least three out of the 8 patients he reported, he diagnosed as melancholic with a partial lesion in spite of the presence of a general lesion of intellect. Cases III and V are particularly telling: Patient B “was willing to reply but because of his confusion of ideas could only provide vague information. The progression of his disease clarifies his diagnosis which
is between lypemia and stupidity. For months at the time B can be in profound melancholia, saying nothing, refusing to eat, and cutting a desperate and grim figure.” This patient in fact could regain his lucidity. Because if this, should he be considered as a lucid melancholic? Is it not more obvious to believe that during his periods of mutism his intelligence was compromised in its entirety (lésée dans son entier)? Surprisingly, however, Delasauve diagnosed this case as one of pure melancholia.

Observation V is no less curious. “The face of the patient shows exhaustion and grief; he talks with difficulty but without undue resistance. His head is chaotic and he can hardly extricate his thoughts. Later he shows total uncommunicativeness and needs a lot of insistence to get him to drink or eat.” No one, surely, will suppose that this patient whose head is in chaos is a lucid monomaniac with periods of taciturnity. Applied to cases where the lesion of the intellect is general, the term melancholia makes no sense.

In summary, I would like to state that general depression of the intellect is ignored in a large number of patients diagnosed as ‘melancholic’, in which case the term becomes a misnomer. These patients should be given a different diagnosis, or the meaning of the word melancholia should be changed, or alternative diagnostic groupings and distinctions created.

All authors refer to a type of melancholia that follows mania, and examples can be found in mental asylums. These cases should not be diagnosed as melancholics either, for they suffer from a depression of the moral and intellectual faculties which is just a continuation of their mania excitation; nor should they be diagnosed as monomaniacs as the latter enjoy lucidity of mind and are capable of intellectual work. The dominant symptom of the melancholia that follows mania is a form of paralysis of the moral and intellectual faculties that abolishes strength and will.

We must now deal with the true melancholics of the type Esquirol grouped into a separate class and who are neither sorrowful nor prostrated and whose intellectual force is intact and show no confusion of ideas. “These patients are always on the go searching for those enemies who have caused them to suffer and telling about their ills, fears and desperation”. Here, in fact, the lesion of the intellect is partial; but I ask, is there need to have a special denomination for these monomaniacs? How are they different from the others? Let us explore why nowadays this distinction has become groundless.

To Esquirol monomania is a gay partial madness and melancholia a sad partial madness. The former, as suggested by Calmeil, has almost disappeared in the wake of our improved knowledge of general paralysis. “In monomaniacs, a mood of exaltation and expansiveness is accompanied by feelings of well-being, unassailable good health, and increased force. These patients concentrate on the good side of things, are full of joy, feel happy for others, and sing, laugh, and dance. They enjoy their grandiose thoughts, their feelings of richness and power and are over-active and over-talkative.” (Esquirol Vol. II, p6). This type of patient is often met with, but the fact that they are suffering from general
paralysis is made patent by the slight tremor of their lips and by changes in their sensibility; it is equally easy to ascertain whether they are already showing signs of dementia. The rest of cases are diagnosed as either monomania or melancholia. Many of Esquirol’s observations bear witness to the similitude of these conditions, so keeping the two diagnoses creates a problem. From what I have said it follows that:

1. The word melancholia does not apply to cases suffering from a general lesion of the intellect.
2. In those who do not suffer from a general lesion, melancholia becomes a synonym of monomania and hence is redundant. Continuing such use would encourage the wrong belief that melancholia and monomania are different disorders.

Based on these arguments I propose:

1. To use the word monomania to refer to cases of madness with partial lesion of intellect.
2. To keep the word melancholia to name cases showing a depression of the moral and intellectual faculties. Melancholia thus should imply the presence of a general and not a partial lesion of the intellect.

Translator’s Notes

1. During the 1850s, the adjective ‘moral’ was used in France to refer to ‘The intellectual, spiritual, as opposed to the physical’ (Larousse, 1874: 539) and did not necessarily carry a reference to moral conduct or to ethics. It was the same in England. For example, the University of Cambridge used to have a ‘Faculty of Moral Sciences’ which was concerned with the mores of men rather than natural kinds. For a discussion of the term ‘Moral Insanity’ during the first half of the 19th century, see Berrios, 1999a.

2. During this period, the concept of ‘Intelect’ was broad and meant: ‘Faculty of the mind that allows us to know and conceive, understanding. The physician explores the intellect and its diseases by means of semiology (séméiotique) ... The intellect, whose localization is in the brain, includes as faculties judgement, memory and imagination. These functions can be exalted, perverted, weakened or abolished ...’ (FVM, 1818: 438)

3. By lesions of the moral and intellectual faculties, French alienists during this period meant ‘the disorders of understanding and will’ (Rullier, 1815: 417). On the history of the concept of Faculty during the 19th century, see Berrios, 1988a.

4. Regardless of its versions, saliency and venues, classifying remains central to the theory and praxis of doctoring. The professionalization of alienism brought this classificatory drive into ‘psychiatry’ and it continues unabated. Whether the more botanico taxonomy, still popular in general medicine has any relevance to psychiatry, remains to be seen. The article by Baillearger herewith offered as a Classical Text is just one example of the many published in a century when any alienist worth his mettle had to offer his own personal classification of mental disorders. Individuals have nowadays been replaced by committees but the trend continues. Often enough it is claimed that current classifications are ‘empirically validated’. This confuses two levels of inquiry: the conceptual one, where the real decisions are taken as to how the functions of the mind are to be named
and classified and the empirical one which is always post-hoc and all but 'confirms' the higher level decisions. (On these complex issues, see Berrios, 1999b).

5. Baillarger did not give references, but they can be inferred. The dates of the works that he mentions are added in square brackets, and the references are included in the reference list below.

6. For an account of the history of this complex clinical concept, see Berrios, 1999c.


8. On the history of melancholia, see Berrios, 1988a.


11. Bringing mania and melancholia into the same clinical genre is an important moment in the construction of the affective disorders. Baillarger based his decision on the speculative claim that in both forms of madness there was a 'general lesion' of the intellectual and moral faculties. The primary result of such putative lesion was an intellectual or 'cognitive' disorder. It was only during the second half of the century that the intellectualistic interpretation was replaced by the view that the primary disorder in these conditions was one of affect, mood or emotion (Berrios, 1988c).

12. There are well known difficulties in the translation into English of the French terms folie and délire (Berrios, 1996: ch. 5). While the former could be roughly translated as madness, lunacy, or even insanity, the latter defies rendition for terms such as delirium or delusion (occasionally used by 19th-century alienists) are not even roughly equivalent. Tuke (1892: 332) was correct in stating: ‘Délire: French term not only for delirium but mania and monomania’.

Between 1800 and 1900 the meaning of délire changed in French psychiatry. Thus, Laguerene (1792: 341) defines délire as: ‘Délire is a class of lesions affecting the intellectual functions in which the judgement of external objects during full wakefulness conceives of them in colours and relationships which are not in keeping with their reality’. Two decades later, Esquirol (1814: 251) teased out the putative causal stages of the mismatch: ‘A man is in délire when his sensations are not in keeping with the external objects, when his ideas are not in keeping with his sensations, when his judgements and decisions are not in keeping with his ideas; and when his ideas, judgements and decisions are independent from his will …’

By the middle of the century, and reflecting contemporary usage, Baillarger could write: ‘Le mot délire … est ict synonyme de celui de folie’. Given that both terms are usually rendered as madness, how is the translator going to proceed? For a superb analysis of the untranslatability of these terms into English, see Auvray-Assayas et al., 2004.

This broad definition of délire has persisted in French psychiatry. Commenting on the excessive intellectualization of délire, Porot (1975: 177) has stated: ‘At first sight délire presents itself as a disorder of the intellect, as a disorder of thinking. For too long délire has been studied and talked about from the perspective of delusions. In fact, behind the disorder of intellect there is almost always a profound alteration of the mind and the personality …’ (my italics).

13. Baillarger’s use of the term ‘lésion’ is not in keeping with contemporary usage. By the 1850s relevant sources suggest that there was within medicine a reaction against usages which departed from the organic definition: ‘In medicine the term lesion names any change in the shape, position, or internal structure of the solid organs of the body, or in the composition of liquids and gases … some authors use it in a broader sense to refer to vital lesions. They base this view on the claim that in certain diseases one can ascertain changes in function but it is not possible to identify the changes in the solid organs. This view is false. On the one hand each function relates to an organ whose manifestation of activity
it is, it originates from it, grows with it, and ceases with it, and it would be difficult to
conceive that a function can change without a change in the related organ. On the other,
progress in pathological anatomy and medical chemistry allow the identification of changes
which until now were not possible’ (Larousse, 1873). In this regard, Baillarger’s usage
comes across as metaphorical.

14. For Baillarger ‘loss of awareness of illness’ (la perte de conscience de trouble) was a hallmark
of madness and not a ‘symptom’ of it. This latter view is, unfortunately, fashionable at
present; see Marková (2005) for an excellent analysis of Baillarger’s view (p. 14) and a
reaffirmation of the broader conception of insight.

15. It would seem that here Baillarger is using ‘lesion’ as a synonym of ‘symptom’.

16. In terms of clinical semantics and context, ‘delusions’ seem an adequate rendition of ‘les
conception délirantes’.

17. During the 1850s ‘depression’ was still being used in its pre-psychiatric meaning. For a
detailed analysis of the introduction of this term into psychiatry, see Berrios, 1988c.

18. The view that hallucinations could be seen in the sane, or that there could be hallucinations
with and without insight is an important contribution of the first half of the 19th century
and revolved around the idea that organic and vesanic (insane) hallucinations were fun-
damentally different phenomena. It is unfortunate that this view has been lost and that
biological psychiatry has championed a unified view of hallucinations. See: Berrios, 1990b,

19. Baillarger’s interesting claim that delusions can be accompanied by awareness of their
nature takes us back to the history of the construction of the concept of delusion, to
the time before it was believed that insightlessness was essential to the definition of
delusions. In the 1850s the concept of obsession and that of delusion were in a process

20. Why should this be the case, i.e., Baillarger never said that ‘insight’ can only accompany
general lesion causing depression of moral and intellectual functions. One can only
speculate that he was still influenced by the early 19th-century view of mania as the
madness par excellence (Berrios, 1981b).

21. This is an important suggestion. Until the first half of the 19th century, classifications of
madness had been based on the more botanico methodology, that is, on salient behavioural
features (Berrios, 1999b; López-Piñero, 1983). Baillarger introduced as a taxonomic
criterion an abstract and speculative notion. At the time, and in the field of alienism, the
concept of ‘lesion’ was at best extrapolative and at worst metaphorical. Classifications
were no longer to be made in terms of what the patient did but in terms of the putative
changes in his ‘faculties’ that the alienist believed were causing the mad behaviour. Since
Baillarger had no observational access to the faculties themselves, he could only ‘surmise’
their state. It goes without saying that the central principle of his taxonomy was question-
begging. For all the ‘progress’ that psychiatry has achieved by the 21st century, current
classifications are still affected by the same difficulty.

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