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THOUGHT LEADERS INVITED REVIEW

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

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

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

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

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

Biographies of Roubinovitch and Toulouse and Their Collaboration

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

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

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

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

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

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

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Table 1. Additional quotations

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

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

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

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

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

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

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

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

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

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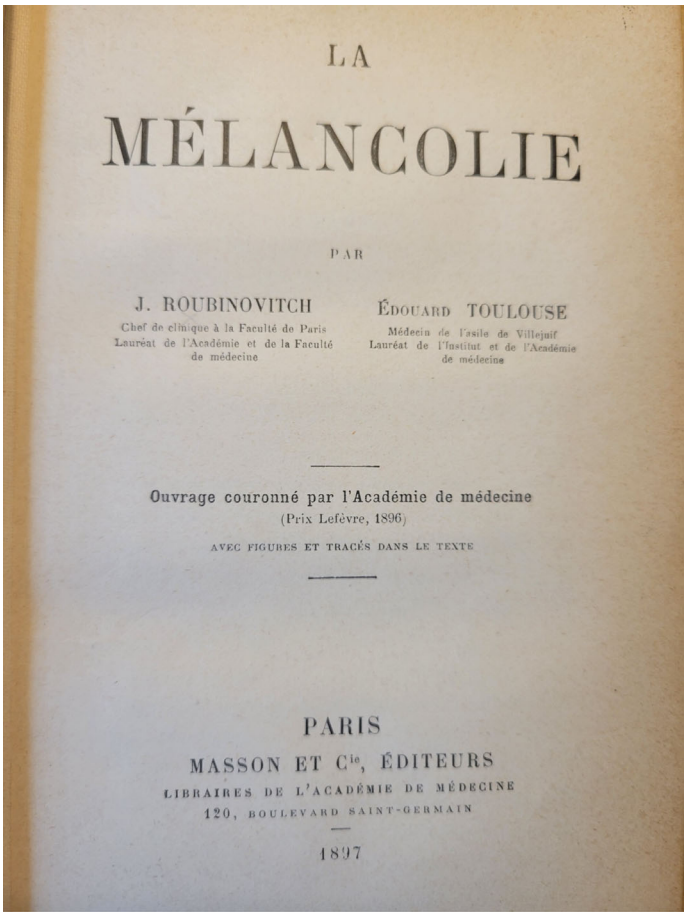
LA

MÉLANCOLIE

PAR

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

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

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

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

1897

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

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

Background

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

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

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

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

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

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

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

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

R&T continue

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

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

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

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

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

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

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

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

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

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

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

Chapter III – Symptomatology

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

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

Symptomatology – Consistent Symptoms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

They continue:

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

Sleep problems are prominent features of the disorder:

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

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

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

Symptomatology – Variable Symptoms

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

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

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

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

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

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

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

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

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

They then turn to consider suicidal ideation:

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

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

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

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

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

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

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

Chapter IV – Clinical Varieties of Melancholia

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

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

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

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

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

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

Stuporous Melancholia

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

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

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

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

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

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

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

Anxious Melancholia

Often,

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

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

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

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

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

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

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Delusional Melancholia

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

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

They emphasize the role of psychalgia or mental pain:

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

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

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

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

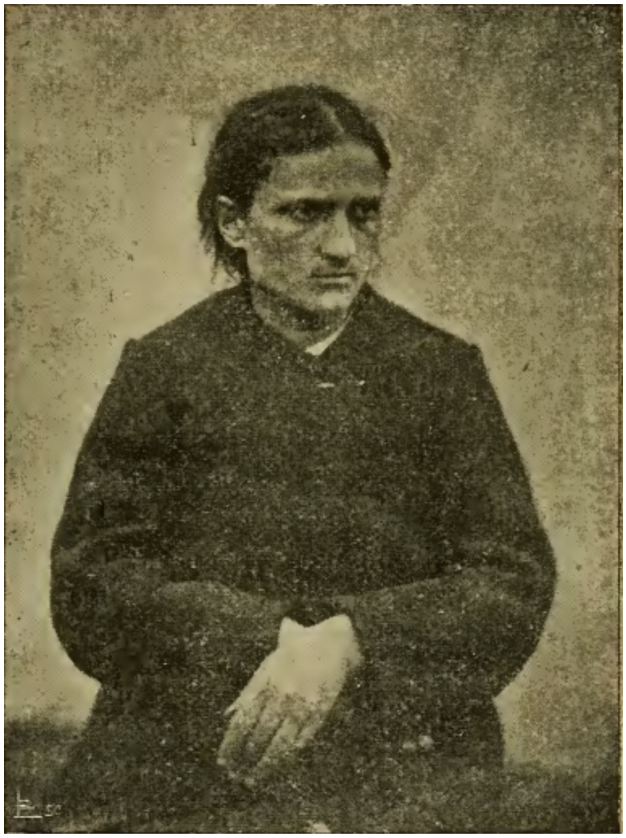

Figure 3. A case of delusional melancholia—p. 189 of the volume.

Hypochondriacal Melancholia

R&T write that

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

The syndrome typically develops in the following sequence:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

While generally positive,

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

Discussion

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

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

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

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

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

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

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

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

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Author Contributions

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

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