CHAPTER 3
CIRCULAR MADNESS

The creation of manic-depressive disease lay 70 years in the future when in 1830, Rufus Wyman then the superintendent of McLean Hospital described the following case. “In diseases of the pathetical states or functions, there may be exaltation or depression of one or more of the passions…. Exaltation, and depression of passion, are sometimes manifested alternately in the same individual. [One of my patients] has been for several years subject to alternations of these states, without disease of the intellectual powers. During the state of depression he talks little – scarcely answers questions – goes to bed early – sleeps well – rises late – takes food regularly – is indifferent about his dress – refuses to walk, or ride, or to attend church – writes no letters – reads no newspapers – discovers no interest in any person or kind of business. He is not anxious, or distressed on any subject –is perfectly quiet and inoffensive.

After being depressed for two to five weeks he gradually becomes more active, gay and full of business. As a first change, he begins to smile, and answer questions; then to sit up later, sleep less and rise earlier – walks, and rides when requested. In a few days he begins to converse freely, read newspapers and play at chess. Next he calls for his best clothes – is anxious to attend church, visit every where, and see every body – plans voyages – is full of business – writes letters to all parts of the United States, to England, France, Holland etc. – becomes gay – dances - sings – is irascible – offended when opposed – passionate and violent – tears his clothes – breaks windows, swears, strikes, kicks, bites, dashes drinks in the faces of attendants and sometimes says “I would send you to hell if I could”; but instantly, sensible of the inhumanity of his wishes, and becoming calm adds with good feeling, “ but I would remove you to heaven in one minute”. The paroxysms of passion, in various degrees are repeated many times in a day, from the most trifling causes, and without malice.

In this case, the changes from depression to exaltation of passion are usually sudden, and sometimes instantaneous. The paroxysms are, almost universally free from any apparent disease of the intellectual powers. His letters are well written, his plans of voyages are judicious, and the whole discovers an intimate knowledge of business. When the transitions are gradual he appears, during the intervals, quite well for several weeks, and is a kind hearted, intelligent, agreeable man”[1].

Wyman’s case looks now like a wonderful description of manic-depressive disease but this is not what it was. He was supporting Esquirol’s notion of monomanias by describing an individual with severe impairments of functioning in the absence of any intellectual disturbance.

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[1] Wyman R (1830). Exaltation and Depression. In Hunter R, MacAlpine I (eds) (1982) Three Hundred Years of Psychiatry. 1535-1860, Carlisle Publishing, New York, pp 810-811.

In 1837, James Prichard when describing moral insanity wrote "The most frequent forms, however, of the disease are those which are characterized either by the kind of excitement already described, or by the opposite state of melancholy dejection. One of these is, in many instances, a permanent state; but there are cases in which they alternate or supersede each other; one morbid condition often lasting for a long time, and giving way, without any perceptible cause, to an opposite state of the temper and feelings. .. When this habitude of mind is natural to the individual and comparatively slight, it does not constitute madness; and it is perhaps impossible to determine a line which marks a transition from pre-disposition to disease; but there is a degree of this affection which certainly constitutes disease of mind, and that disease exists without any illusion impressed upon the understanding. A state of gloom and melancholy depression occasionally gives way after an uncertain period to an opposite condition of preternatural excitement. In this form of moral derangement the disordered condition of the mind displays itself in a want of self-government, in continual excitement, an unusual expression of strong feelings, in thoughtless and extravagant conduct… Not infrequently, persons affected with this form of the disease become drunkards.." [2]

Faced with descriptions like Wyman's and Prichard's, it is clear that alienists had cases of manic-depressive illness in their care before the disease was first described. In this sense, the issue of priority in the discovery of manic-depressive disease is almost irrelevant – this was a disorder clamoring to be described. But the question of who discovered manic-depressive illness - bipolar disorder - gave rise to one of the most celebrated priority disputes in psychiatry. The fact that both Jean-Pierre Falret and Jules Baillarger could ignore earlier precedents and dispute the priority between them brings home the fact that, despite compelling clinical appearances, there were fundamental conceptual problems that had to be overcome before the new disorder could be recognized.

War in Paris

Jules Baillarger was born in 1815, twenty-one years the junior of Jean-Pierre Falret. After training in medicine, he moved to Charenton to study with Esquirol. Esquirol had been the first to consider hallucinations in detail. Baillarger pursued research on hallucinations winning the Prix de l'Académie in 1842. In 1840 he was appointed to the Salpêtrière, where Falret was also working. He moved to the asylum at Ivry a few years later. In 1843 he established the Annales Médico-Psychologiques, which became the leading French psychiatric journal. In 1852 he established the Société Médico-Psychologique, the first scientific association for French Psychiatrists. He held the organs of power in French psychiatry, and

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[2] Prichard JC (1837). Moral Insanity. In Hunter R, MacAlpine I (eds) (1982) Three Hundred Years of Psychiatry. 1535-1860, Carlisle Publishing, New York, pp 840. In 1844, Carl Flemming outlined a similar condition and gave it a name, Dysthymia mutabilis; for details see Shorter ES Dictionary of Psychiatry, pp. 165-166

was offered the first Chair in French psychiatry when it was created in 1875 but declined on the grounds of age[3].

Falret was born in Marseille in 1794. Entering medicine aged 17, he came under the influence of Pinel and Esquirol and became an alienist. He was Chef de l'hospice at the Salpêtrière from 1831. Falret's interests overlapped heavily with Baillarger. Following Bayle, during the 1830s both Falret and Baillarger studied brain anatomy in the hope of pinpointing other disorders, before concluding that post-mortems were unlikely to yield further breakthroughs. Both focused on hallucinations in the 1840s. In 1841 Falret began teaching a clinical course in the Salpêtrière that was to provide the basis for his claims to priority when the two collided over their subsequent area of mutual interest.

Let's listen to Baillarger first. "All the writers on mania have considered the transformation of mania into melancholia or vice versa to be fairly common. They have also all perceived these facts to be two different disorders, two distinct attacks, which succeed each other more or less within a single patient. This is an opinion, which I have sought to combat. Indeed I would like to demonstrate that we have here not two diseases but a single one; the two supposed attacks are nothing but two stages of a single attack"[4].

Baillarger's first presentation of his ideas was at a meeting of the Académie de Médicine de Paris on the 30th of January 1854. The Academy was an exclusive society, which at the time probably had about 80 elected members including Baillarger and Falret[5]. Baillarger's lecture was published in the Bulletin of the Académie, almost immediately afterwards[6]. A few months later it was published in the Annales médico-psychologiques[7], and the main ideas were outlined in the Gazette hebdomadaire, on February 3 1854[8].

"There are no states which show more marked differences from one from the other and more striking contrasts than melancholia and mania. The melancholic is weak and irresolute; his life is spent in inertia and mutism; his conceptions are slow and confused. The maniac by contrast is full of confidence, of energy and audacity; he deploys the greatest activity and his loquacity has no limits. It would therefore seem, in theory, that two states so opposed must be foreign one to

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[3] Francois-Régis C (1999). Jules Baillarger (1809-1890). In Francois-Régis, C, Garrabé J, Morozov D (1999). Anthology of French Language Psychiatric Texts. Translation J Crisp. Institute Sanofi-Synthélabo, Paris.

[4] Cited in Francois-Régis C (1999). Jules Baillarger (1809-1890). In Francois-Régis, C, Garrabé J, Morozov D (1999). Anthology of French Language Psychiatric Texts. Translation J Crisp. Institute Sanofi-Synthélabo, Paris. Pp 181-182.

[5] Pichot P (1995). The birth of the bipolar disorder. European Psychiatry 10, 1-10.

[6] Baillarger J (1854). Notes sour un Genre de Folie dont les accés sont carecterisé par deux period régulairè, l'une de depréssion, l'autre d'excitation . Bulletin de l'Académie de Médicine 19, 340-352.

[7] Baillarger J (1854). De la folie à double forme. Annales médico-psychologiques 6, 369 - 391.

[8] Baillarger J (1854). Notes sour un Genre de Folie dont les accés sont carecterisé par deux period régulairè, l'une de depréssion, l'autre d'excitation.

another, and that a great distance must separate them. This is not however that which is demonstrated by observation. Indeed we see, in many cases, melancholia succeed mania and vice-versa, as if a secret bond united these two diseases. These singular transformations have often been reported"[9].

After noting that Pinel, Esquirol, and Guislain cite comparable transformations, Baillarger says that the fact seems to him not to have been sufficiently studied. "By bringing together and comparing a certain number of observations, it becomes clear that there exist quite numerous cases in which it is impossible to consider in isolation and as two distinct disorders the excitation and the depression which succeed each other in a single patient. This succession, indeed, is not a matter of chance, and I have been able to confirm that there exist connections between the duration and the intensity of the two states, which are clearly nothing other than two periods of a single attack. The consequence of this view is that these attacks properly belong neither to melancholia nor to mania but that they constitute a special kind of mental alienation, characterized by the regular existence of two periods, one of excitation and the other of depression".

He then describes a series of cases to illustrate the key features of *folie a double forme*. The first involves the 28-year-old Miss X who had several attacks of mania from the age of 16 and from the age of 21 had a fairly constant illness during which in the first 15 days she would have a profound melancholia followed by a mania, which would then last for the same time. She might then have an intermission of short duration lasting a few days, or at the most 2-3 months, before a new attack began.

The second case was a man he had heard about from Esquirol, who Baillarger describes as having attacks of mania that would last 10-12 days followed by a period of despondency, usually happening with no transition and often during his sleep. This differed from Miss X only in terms of having a slightly shorter period.

Third was a woman seen by Esquirol, who had an episode of melancholia at the age of 28 and nothing else until the age of 36. She then began to have attacks, which would begin with a melancholia that lasted six weeks and was then replaced by a general excitation, insomnia and agitation which would last for two months before the patient recovered, and remained well for 8 months. Every year the attacks recurred with similar symptoms at the same time of the year.

The fourth case was Mr X, who had had a 20-year period of alternating excitation and depression. He would fall into a state of melancholia lasting several months, and then would gradually recover his animation and pass through a very short interval of reason before his activity increased to a point of a furious excitation.

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[9] From Baillarger J (1854). Dual Form Insanity. In Francois-Régis, C, Garrabé J, Morozov D (1999). Anthology of French Language Psychiatric Texts. Translation J Crisp. Institute Sanofi-Synthélabo, Paris. Pp 186-198.

“Although very old, he is at times affected by attacks of priapism and goes as far as to run around his garden prey to a lascivious fury”. This period can last three months before he gradually relapses back into a “splenetic state”.

These cases differed from a larger group in which patients alternated between 6 months of depression and 6 months of overactivity, exemplified by the 24-year-old Miss M, who began with a melancholic episode when she was 20. These came on in a regular pattern starting in May, and lasting to October, when she would appear to recover before then passing into an excited and manic state. At the time of the lecture, Miss M had had four cycles of this kind.

Finally Baillarger described the case of a 25-year-old man, who became excited and grandiose every Autumn for three years running, who then in Spring calmed down and sank into states of depression during the Summer months.

Commenting on these cases, Baillarger mentioned that other cases showed much shorter durations. One patient had been recorded as showing signs of melancholia, followed by signs of mania, which alternated every two days. Other patients had attacks lasting six or eight days. The briefer the episodes, he claimed, the more precise the correspondence between the length of attacks of mania and of depression. Some patients with brief episodes regularly went to bed melancholic and woke up manic. These correspondences he suggested cannot be seen as clearly when the melancholic or manic periods last for up to five to six months before any transition between one state and another. In these cases, transitions often take place much more slowly and imperceptibly.

One of the critical problems for Baillarger, which brings out the conceptual difficulties he faced in establishing the new disorder, lay in a group of patients who achieved equilibrium between episodes of mania or melancholia. They no longer showed signs of delusions. He describes coming to the wrong clinical judgment on a number of occasions in letting patients go home, when it was clear retrospectively that signs of their next illness episodes were already there.

The fact that Baillarger felt a need to account for patients who had intervals of a month or more apparently well before relapse, is illuminating. The theoretical problem that lengthy euthymic intervals posed was that they left him open to the claim that if patients were well for such a long period was it not more reasonable to see in this two distinct diseases which succeed each other rather than two phases of the same illness. “Is there not here in fact an intermission? And is this intermission not sufficient for one to admit two attacks and not one alone?”

For Baillarger, this issue raised in profound form the question of what is madness. At this point he distinguishes between lesions of the intelligence and a loss of awareness of these lesions and argues that it is actually the loss of awareness that a belief is delusional rather than the presence of a bizarre or intensely held belief that constitutes madness. On this basis he argues that

patients who are not apparently deluded or hallucinating for a period of some weeks may nevertheless still be mad, or at least may not have returned to their pre-morbid mental state.

He gives the example of one of his patients whom he had let go home, but who still retained a slight tendency to isolation and to taciturnity that her relatives could have told him was not natural to her. This difference from normal however did not prevent her having excellent manners and being very hard working and seeming in every way reasonable. But the fact that she relapsed quickly after discharge provided the grounds for thinking that the equilibrium of her faculties had not been entirely restored, and this was something, he suggested, that her relatives could have told any clinician who had cared to ask them.

A further problem lay in the agitated overactivity that might be present at the start, at the end, and in the course of the disorder. In contrast to the regular periods of the disorder itself, he argued that agitation appeared irregularly.

Reviewing the clinical picture, Baillarger outlined a number of different patterns. Some patients might have only one attack of melancholia brought to an end by an attack of mania or vice versa. Others might have attacks that recurred up 10 times at intervals of 2, 4 or 6 years. A third group had intermissions at regular intervals. And a final group had attacks without any intermissions. “The disease, which usually lasts for several years, can thus be compared to a long chain in which each attack is one of the links”.

He concludes: “Outside monomania, melancholia and mania, there exists a special type of madness characterized by two regular periods, one of depression and the other of excitation. This type of madness occurs in the form of isolated attacks, or recurs in an intermittent fashion or the attacks can follow each other without interruptions. The duration of the attacks varies from two days to one year. When the attacks are short the transition from the first to the second period take place in a certain manner and ordinarily during sleep. By contrast when the attacks are prolonged it takes place slowly and by degrees. In the latter case patients appeared to enter convalescence at the end of the first period but if the returned health is not complete after fifteen days, six weeks at the most, the second period breaks out”.

Two weeks after Baillarger made his presentation, on February 14th 1854, Falret began his presentation to the same Academy with the following words[10]: “At our last meeting, our honorable colleague, Dr Baillarger, read a paper on a new type of insanity - la folie à double-forme. I must tell you, Gentlemen, that to me this type of insanity is not new. I have been aware of it for a long time, and for more than 10 years I have described it in my lectures at the Salpêtrière. Many similar

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[10] Falret JP (1854). Mémoire sur la folie circulaire. Bulletin de l’Académie de Médicine 19, 382-415. Also see Sedler MJ (1983). Falret’s Discovery: The origin of the concept of bipolar affective illness. American J Psychiatry 140, 1127-1133.

cases have been presented by the students there and discussed in our clinical seminars. We even gave it a name because, in our opinion, it is not a mere variant but a genuine form of mental illness. We call it *folie circulaire* because the unfortunate patients afflicted with this illness live out their lives in a perpetual circle of depression and manic excitement, which is typically brief but occasionally long-lasting".

He then quoted from his lecture series in the Salpêtrière that had been running for several years and that had been published a few days before Baillarger's presentation[11]: "The transformation from mania to melancholia, and vice versa, has always been considered merely adventitious. However, not enough attention has been paid to the fact that there is a certain category of patient who continually exhibits a nearly regular succession of mania and melancholia. This seemed sufficiently important to us to serve as a basis for a specific mental disorder, which we call folie circulaire because these patients repeatedly undergo the same circle of sickness, incessantly and unavoidably, interrupted only by rather brief respites of reason. Of note, however, is that these two states, which in their continual succession comprise folie circulaire, are neither melancholia nor mania in the usual sense of these terms. It is as if the basic features of these two conditions are present without their extremes. First of all, there is no incoherence of ideas, as in true mania, but simply manic exaltation, that is to say, mental hyperactivity with a constant need to move and markedly disorganized behavior".

Falret's presentation was very different to that of Baillarger. He described no cases but rather instead the features of mania and depression. Arguing that the mania and depression were not as bad as full-blown mania or melancholia, their conjunction he said produces a disorder that is worse. A disorder in which "we have never observed a complete cure, nor even a lasting improvement".

He distinguished folie circulaire from mania. "In ordinary mania one occasionally sees melancholic states of varying degree and duration. Sometimes, manics exhibit a more or less prolonged state of depression before they explode; or, before their recovery is complete, a period of prostration may ensue, which is probably due to nervous exhaustion…. But, in order to be called folie circulaire, depression and excitement must succeed one another for a long time, usually for the whole of the patient's life, and in a fashion very nearly regular, always in the same order, and with intervals of rationality, which are usually short compared with the length of episodes…

"We believe it constitutes a genuine form of mental illness, because it consists of a group of physical and mental symptoms which stay the same for any of the respective phases which succeed one another in a determinate order so that, once the symptoms are identified, the subsequent evolution of the illness can be

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[11] Falret (1854). Leçons clinique de médecine mentale faites à l'Hospice de Salpêtrière. Paris Baillière.

predicted. Indeed, it is a more authentic category of disease than either mania or melancholia because it is not based on a single cardinal symptom – the degree of delirium, sadness, or agitation – but is instead founded on the conjunction of three specific states occurring in a determinate, predictable, unalterable order".

Just as Baillarger had, Falret tackled the lucid interval. "At this point, the patients present such a contrast with the state which is just ending that they do seem reasonable by comparison. Some of them are sufficiently in control of themselves so as to no longer exhibit any thought disorder that may have been present only temporarily. They often hide certain wild ideas that are left over from the phase of exaltation, while other ideas begin to surface that herald the coming phase of depression. To appreciate their actual condition, one must look for what is missing rather than to what is manifest. Then one sees that the patients do not speak, or do much of anything, as one would expect if they were in a normal state. These negative findings are of considerable value when it comes to the question of whether or not these patients are in a lucid interval... one will find exceptional cases where their thinking seems to have been restored to its former state, but this state lasts only briefly, even in circular insanity with long phases".

"Is it a frequent form of mental illness? Judging by what little attention such cases have received up until now, and by the small number of cases one finds on the wards, it does not appear especially common; but there are many causes that interfere with an accurate appreciation of the actual frequency".

One of these factors he notes is the existence of milder forms that never reached the asylum: "Moreover, since this form of mental illness … does not ordinarily present the degree of intensity found in true mania or in partial insanity, properly speaking, it follows naturally that such patients often remain in society. We are convinced of this by direct observation; in fact, we were asked to examine some patients who had long been afflicted with this disorder, but who had never aroused sufficient concern in their parents for the latter to make the decision to hospitalise them.

"The parents find it a simple matter to conceal from others the condition of their child because their relatives are similarly unable to see in the patient a state of insanity. When the patients get excited, the way one gets during a particular phase of intoxication, then people exclaim that they are having their "happy hour"; the parents rejoice in their vitality, in their high spirits, and everyone goes along with this interpretation of the situation. When their mood changes and they are disorderly or mean, people say that they are in a bad temper, that they are acting strange, restless, are difficult to live with; but it is only on occasion, and without much insistence, that anyone calls them crazy".

Falret noted that the disorder appeared to have a large hereditary component and that it was up to three times more common in women. He also pointed out

several advantages of knowing that this was a disease and that it had a natural history, even if the prognosis was poor. It meant that the clinician would be in a better position to decide if any therapies made any difference to this course. It also meant that clinicians faced with a patient charged with a crime would be able to predict for the Court what would happen next to the patient, thereby sidestepping the irresistible impulse problem, and demonstrating that many of the behaviors of the affected person truly stemmed from a disease and were not under their control.

Baillarger responded to the lecture in acrimonious terms[12], and disputed the priority for the rest of his life, whereas Falret barely made reference to it again[13]. In 1894 busts of the two men were placed at the entrance to the Salpêtrière at the same ceremony. Opinions in French psychiatry have oscillated regarding the allocation of priority with majority opinion favoring Baillarger for a long time and more latterly favoring Falret.

But does any of this matter? The bitterness of the priority dispute seems out of proportion to the issues. Given that manic-depressive disorder looks like it would have forced its way onto the clinical radar at some point, was the contribution of either man particularly gifted? Rufus Wyman's clinical description is more convincing to the modern eye. Indeed perhaps out of a need to establish the novelty of the new entity, both men stressed the regularity of cycling between poles of the disorder, and how it was possible to predict when patients would flip from one state to the other, in a manner that now seems simply wrong.

The condition was also, by both men's admission, rare. For a disorder that was fundamentally incurable, it was odd that between them they had no more than a handful of active cases – Falret notes 4 at the time of his lecture and Baillarger seems to have had no more, even though these two men could call on the resources of two large asylums.

Neither Falret nor Baillarger's presentation in fact secured the niche that was later manic-depressive disease. A profusion of terms swirled around French psychiatry for decades after with Billod in 1856 using folie à double phase[14], and others using folie alterne. Berrios has suggested that the concept didn't become established even in Paris until the mid-1880s when the Academy sought submissions on the issue and awarded a first prize to Ritti, whose presentation on the issue was titled folie à double forme[15].

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[12] Baillarger J (1854). (Discussion of Falret's lecture). Bulletin de l'Académie de Médicine 19, 401-415.
[13] Pichot P (1995). The birth of the bipolar disorder. European Psychiatry 10, 1-10.
[14] Billod E (1856). Des diverses formes de lypemania. Annales Médico-Psychologique 20, 308-338.
[15] Berrios GE (1996). The History of Mental Symptoms. Descriptive psychopathology since the nineteenth century. Cambridge University Press, Cambridge.

What happened in Paris had little effect in Germany. When Emil Kraepelin outlined the new concept of manic-depressive disease in 1899 he cited neither Baillarger nor Falret. There were good reasons for this in that manic-depressive disease was not something that he posited had regular and predictable periods. Indeed Kraepelin's disorder might not involve any cycling at all. It was only in 1966, when oddly once again two academics described a new disorder at the same time, bipolar disorder, that what had happened in Paris a century earlier once again became relevant.

However there is another continuity. A key feature that united Falret, Baillarger and Kraepelin was a new emphasis on the course of the disorder. It is this perhaps more than anything else that justifies focusing in on the watershed years of the 1850s in Paris. In this sense Falret in particular departed from what had been there before and heralded what was to come.

Karl Kahlbaum & Cyclothymia

In reaction to the Enlightenment, a romantic movement dominated German psychiatry from the early 19th century. The romantics were keenly interested in the place of the soul in illness and regarded all forms of madness as having a common root in disordered passions. By 1860, Wilhelm Griesinger emerged as the leading figure in an alternative or biological tradition. Griesinger was a figure very like Laycock in Britain, who in the 1840s posited that a great deal of brain functioning might be based on reflexes, and that all mental disease was likely to be brain disease, with the additional specification by Griesinger that there was essentially one brain disease. Taking the example of GPI, which typically gave rise to melancholic, manic, and demented states in the course of the disorder, Griesinger argued patients might progress through various stages yet still have the same disease. Neither Griesinger nor the romantics put much emphasis on the clinical observation of patients. This was the background facing Karl Kahlbaum, whose contributions to our story start in the 1860s.

For over 50 years Western psychiatry has credited Emil Kraepelin as being its founding father. The creation of DSM-III was supposedly an expression of a neo-Kraepelinian movement, which sought to return psychiatry to its clinical roots in detailed observation of patients, after an interlude in which the discipline had dallied with psychoanalysis. But arguably psychiatry is now neo-Kahlbaumian, and perhaps the main reason neo-Kraepelinism came into fashion is that no-one knew anything about Kahlbaum.

Kahlbaum is an intriguing figure for many reasons, one of which is the difficulty in getting to know anything about the man. Born on the 28th of December 1828 in Prussia, to a family who could sponsor his education and subsequent work, he was a liberal Catholic in a conservative Protestant state, at a time when these

things counted enough to block his entry into the university establishment[16]. He moved instead to a Sanatorium in Görlitz near Dresden, which he bought and transformed from an institution for epileptics to one for psychiatric patients. There he was joined by Ewald Hecker, another whose career path was blocked by politics[17], and whose sister Kahlbaum later married at the age of 50.

Between them, Kahlbaum and Hecker introduced fashionable reforms such as greater patient freedom and the removal of restraints. But when describing their patients they eschewed fashion, and described their cases in a new way. Central to this was a consideration of the longitudinal course of the patient's condition. This approach, Kahlbaum argued, should give rise to clinical entities or syndromes[18]. This was a much fuller version of the idea that Falret had put forward in 1854.

When he first presented his ideas in an academic forum, it seems he was ridiculed so badly that he deferred publication of a new syndrome based on these ideas - hebephrenia. This ridicule might prompt the suspicion that Kahlbaum must have been a singularly poor presenter of material and perhaps this accounts for his later obscurity. However, his later work reveals another reason for the rejection. To appreciate his ideas, the reader or listener needs to "free oneself of the authority of a certain philosophical axiom… namely, the axiom of the unity of the soul. Even the most important truths may become substantial obstacles to scientific progress if interpreted narrowly or excessively generalized … The concept was derived from only a single phenomenon of the mind, the unity of self-awareness… [it] has had a disastrous impact"[19]. This mission statement ran smack up against the central tenets of both Romantic psychiatry and popular sentiment, and embraced all of the difficulties entailed in embodying the mind, described in the last chapter.

A great deal of what we know about Kahlbaum comes second hand through Hecker. Whether because of an innate shyness or unfavorable reactions to his ideas or to the fact that his academic background would not have been seen as respectable, Kahlbaum rarely presented material and only had 16 publications to

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[16] S Krueger (1999). "Karl Ludwig Kahlbaum," Address American Psychiatric Association Meeting Washington May 15 1999; Braunig P, Krueger S (1999). "Karl Ludwig Kahlbaum," American Journal of Psychiatry 156: 989.

[17] Krueger S, Braunig P (2000). "Ewald Hecker". American Journal of Psychiatry 157, 1220.

[18] K Kahlbaum (1863), Die Gruppirung der psychischen Krankheiten und die Eintheilung der Seelenstorungen. AW Kafemann, Danzig; part of which has been translated by GE Berrios as "The relationships of the new groupings to old classification and to a general pathology of mental disorder". History of Psychiatry 7 (1996): 167-181; Hecker also put forward this argument a few years later in more readable form - Hecker E (1871/2004). On the origin of the clinical standpoint in psychiatry. History of Psychiatry 15, 349-360.

[19] Baethge C, Salvatore P, Baldessarini RJ (2003). "On Cyclic Insanity", by Karl Ludwig Kahlbaum, MD; A translation and commentary. Harvard Review Psychiatry 11, 78-90. Kahlbaum K (1882). Über cyklisches Irresein. Der Irrenfreund – Psychiatrische Monatsschrift für praktische Aerzte 24, 145-157. Quote from page 85.

his name. It fell to Hecker to outline his ideas on hebephrenia and later cyclothymia.

The difficulties in getting to know Kahlbaum would perhaps be solely of interest to an academic historian were it not for the fact that his ideas on hebephrenia, catatonia, dysthymia, and cyclothymia as well as his methods for investigating clinical syndromes shaped the Kraepelinian template. To add piquancy to this issue, Kahlbaum is the dominating figure in Kraepelin's memoirs, and catatonia and hebephrenia were the two disorders Kraepelin thought about most. It is also clear that early in his career Kraepelin considered going to train with Kahlbaum but was advised that this would be a bad career move.

Hecker later in 1871 published the first account of hebephrenia and launched the term into the psychiatric literature, where it was to have a key place for a century[20]. This was a disorder affecting young men, characterized by severely disorganized behavior. The patient was often silly and fatuous or apparently unable to plan and execute behavior. Instead they might copy the actions of the examiner, repeating words and phrases or gestures. They might or might not have delusions or hallucinations. This condition had a very poor prognosis. The syndrome was the first building block in Kraepelin's later dementia praecox.

In 1874, Kahlbaum described another syndrome - catatonia[21]. This became a key syndrome in the evolution of both dementia praecox and bipolar disorder. Catatonia is one of the most extraordinary conditions in psychiatry. It was first described by Galen 1700 years beforehand and given the name cataplexy. In mild forms, the patient may simply be stuporous. In severe forms, patients often lay or stood motionless in odd sometimes apparently physically impossible postures for hours or days, defecating and micturating on the spot, inaccessible to human contact. Kahlbaum outlined overactive and underactive forms of the disorder, which he saw as a motility psychosis – a madness affecting the motor areas of the brain. These states were usually episodic, with the underactive forms lasting over a year on average and the overactive forms more likely to clear up in 6 months. Some forms could be periodic.

While many catatonic patients spontaneously recovered, others became chronic. Most psychiatrists, up to the 1960s, had seen patients of this type, who had been

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[20] E Hecker, "Die Hebephrenie". Archiv fur pathologische Anatomie und Physiologie und fur klinische Medizin 25 (1871): 394-429. Part of which was translated in MJ Sedler, M.-L Schoelly, "The legacy of Ewald Hecker: A new translation of "Die Hebephrenie". American Journal of Psychiatry 142 (1985): 1265-1271.

[21] K Kahlbaum K (1874), Katatonie oder das Spannungsirresein. (Birlin, Kirschwald, 1874). Transl by Y Levij, T Pridan, (Baltimore: JohnsHopkins University Press, 1973); M Lanczik, "Karl Ludwig Kahlbaum and the emergence of psychopathological and nosological research in German psychiatry," History of Psychiatry 3 (1992): 53-58. For a contemporary American reaction to the syndrome and descriptions of cases see J G Kiernan, (1877), "Katatonia: A Clinical Form of Insanity" (1877), Reprinted in American Journal of Psychiatry 151, sesquicentennial supplement, 103-111.

mute and inaccessible residents of the hospital sometimes for decades. From 1900, however, under the influence of Kraepelin, this syndrome had become catatonic schizophrenia and as such the failure of these patients to recover was not so surprising – unless one knew that this was not what Kahlbaum had described. Catatonia was an extraordinary as well as fearsome condition that appeared to have vanished by the 1960s, so that today's clinicians may never have seen a case. Its disappearance is commonly attributed to effective early treatment with antipsychotics, even though the development of antipsychotics involves screening tests in which agents that trigger catatonic states in animals are selected for further investigation[22]. There are no grounds to think that antipsychotics would lead to the disappearance of catatonia.

Where Kraepelin subsumed catatonia for the most part into schizophrenia, an alternative German tradition stemming from Carl Wernicke, and later championed by Karl Kleist and Karl Leonhard, saw catatonia as a prototypical bipolar disorder, and as a condition that exemplified the need for a new concept – that of cycloid psychosis. It was this tradition that gave rise to the birth of bipolar disorder in 1966 (see chapter 5).

Within the psychotic domain, Kahlbaum also described a condition he termed paranoia. Far from the classic picture of insanity, individuals with paranoia could appear perfectly normal. They were able to reason and argue logically on a wide range of issues until the questioner touched on a sensitive point. Then, the interviewer would become aware that on certain issues a passion had engulfed the individual and there was no reasoning with them. Formerly, the term paranoia had been a synonym for insanity or mania but in Kahlbaum's hands it was transformed into a partial insanity that emerged at vulnerable life points.

In 1882, Kahlbaum outlined two affective disorders - cyclothymia and dysthymia – against a background of circular or cyclic insanity. Circular insanity was a severe disorder, which led to hospitalizations for both manic and depressive episodes, in which the patients were typically psychotic[23]. He suggested that this condition was by then widely accepted in psychiatry, with general agreement that it was marked by a stability of symptoms during recurrences. But, although arguing the condition was widely accepted, he makes no reference to Falret or Baillarger.

Cyclothymia in contrast was a pure mood disorder, which showed minimal intellectual derangement and typically did not require hospitalization. Patients cycled from an excess of vitality - hyperthymia - to a lack of vitality – depression,

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[22] Healy D (2002). The Creation of Psychopharmacology. Harvard University Press, Cambridge Ma, chapter 2.

[23] Baethge C, Salvatore P, Baldessarini RJ (2003). "On Cyclic Insanity", by Karl Ludwig Kahlbaum, MD; A translation and commentary. Harvard Review Psychiatry 11, 78-90. Kahlbaum K (1882). Über cyklisches Irresein. Der Irrenfreund – Psychiatrische Monatsschrift für praktische Aerzte 24, 145-157.

a state that might today be called bipolar II. Dysthymia, a word used by Hippocrates to describe the woman at Thasos, similarly was a pure state of depression without compromised intellectual functions. Cyclothymia and dysthymia were “a partial disturbance of the mind, a primary mood disorder. The other group involves a complete disturbance of the mind... ending in a state of degeneration”. Cyclothymic patients recovered, circular insanity patients didn’t.

In laying out Kahlbaum’s work on cyclothymia[24], Hecker notes that cyclothymia might be relatively common in the community without people being admitted to an asylum. One of the key features about the disorder in these community cases according to Hecker was that other physicians, the relatives or even the patients themselves commonly did not recognize any abnormality. Everyone seemed much more likely to think of the excited phase as being one in which the person was back to normal. This had led Kahlbaum to suggest that most cases of periodic depressions were likely to be cases of cyclothymia.

The 5th edition of Kraepelin’s textbook had been released in 1896 just as Hecker outlined Kahlbaum’s thinking on cyclothymia, and Hecker read Kraepelin’s emerging views as supporting this position. He also notes with excitement a German translation of a monograph by Carl Lange of Copenhagen[25], in which Lange described periodic depressions in patients who had never been in an asylum and described them in a way that distinguished them from classic melancholia. Hecker claimed that he was seeing just the same kind of mood disorders in the community “very often”, and he went further and argued that Lange was probably describing the depressive phases of cyclothymia. This was a disorder that, as we shall see in the next chapter, Lange also claimed responded to treatment with lithium.

Hecker went on to note that even the depressive phase of cyclothymia may go unrecognized with patients primarily complaining of somatic symptoms that were diagnosed as neurasthenia. In his article, he gives classic descriptions of endogenous and bipolar depressions. These patients he noted have psychomotor retardation stemming from an inhibition of activity, and an indifference to things that formerly brought interest and enjoyment. Even though, they have had prior episodes from which they recovered they are typically hopeless as to the possibilities of recovery, leaving them at risk of suicide. “When observing these states, one cannot help thinking of a machine whose oil has completely dried up, so much so that the gears can move only with great difficulty and rub each other painfully”.

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[24] Baethge C, Salvatore P, Baldessarini RJ (2003). Introduction: Cyclothymia, a Circular Mood Disorder, by Ewald Hecker. History of Psychiatry 14, 377-399. Hecker E (2003). Cyclothymia, a Circular Mood Disorder, Translated by Baethge C, Salvatore P, Baldessarini RJ. History of Psychiatry 14, 377-399. Hecker E. Die Cyklothymie, eine cirkuläre Gemüthserkrankung. Zeitschrift für praktische Aerzte 7, 6-15.
[25] Lange CG (1886). Om periodiske depressionstilstande. Copenhagen Jakob Lunds.

Kahlbaum described the exalted phase of cyclothymia as hyperthymia to emphasize the novel concept of a disorder in which mood only was affected. Kraepelin later referred to these states as hypomania, a term popularized by Mendel in the 1880s[26]. In this phase, Kahlbaum and Hecker described the patient as being expansive and often more talented than they might be when well. Patients who were not usually very musical might sing and play instruments and sound quite good. They often showed poetic talents or a more stylish taste in clothing than would be normal for them. Hecker described a patient who became engaged to be married in every euphoric phase, only to break off the engagement in the following period of depression. These features though could be very subtle and only a proportion of cases toppled over into a state that everybody could recognize as illness – such as when the patient began to show an "urge to purchase things" and to squander money, or a boisterous tendency to play tricks and to become engaged in atypical activities.

Having described the depressive and exalted phases, Hecker then went on to note that many cyclothymic patients have a "moral deficiency" that leads to a tendency to lie, become intoxicated, involved with bad company and the like. This observation of an increased frequency of substance abuse and features that might now be described as personality disorder has been borne out by subsequent studies. A linkage between bipolar disorder and substance abuse is widely accepted and there are many who would implicate a bipolar process in the generation of many personality disorders, as we shall see.

It was important for Kahlbaum and Hecker to be able to distinguish between the depressive phase of cyclothymia and melancholia. This they did by arguing that in cyclothymia, patients had a complete lack of delusional ideas, and that when depressed patients often slept in a way that was not typical of melancholia where insomnia was much more likely to be a feature. Cyclothymia also had a younger age of onset than melancholia, which started in later years.

When it came to treatment, Hecker suggested that it might not be a good idea to treat the depressive phase of the illness vigorously as "the consequence of such an approach is only a worsening of the excited phases of the disorder". "In my opinion, the primary aim of treatment should be to limit the manic exultation as much as possible". In order to limit the manic exultation he suggests that a depressive episode can be used to explain the nature of the disorder to the patient and to encourage their efforts to control themselves and to recognize the emergence of a phase of exultation and to suppress it as early as possible.

Emil Kraepelin & Manic-Depressive Insanity[27].

[26] Shorter E (2005). Hypomania. In A Historical Dictionary of Psychiatry. Oxford University Press, Oxford, pp 132-133.
[27] Hoff P (1995). Kraepelin. In Berrios GE, Porter R, A History of Clinical Psychiatry. Athlone Press, London, pp 261-279; Berrios GE, Hauser R, Kraepelin. In Berrios GE, Porter R, A History

Emil Kraepelin was born in Northern Germany in 1856, the same year as Freud, two years after Falret and Baillarger's celebrated dispute. He studied medicine in Würzburg and then moved to Leipzig where he worked with Wilhelm Wundt, widely credited as the first psychologist. Wundt's research was on the cerebral reflexes posited by Laycock and Griesinger. He studied the time it took one word to elicit another, in order literally to localize them on the basis of reflex associations. Kraepelin's contribution to this research was to investigate the influence of drugs on these processes, for which he coined the term pharmacopsychology[28].

Kraepelin then moved as a physician to the Estonian asylum at Dorpat, and 5 years later to Heidelberg, where he spent 12 years before moving to Munich. He began writing a textbook of mental medicine in 1883 while still in Leipzig, because he wanted to marry and needed the money[29]. While in Dorpat and Heidelberg his interest turned to the clinical trajectory followed by his patients. "I soon realized that the abnormalities at the beginning of the disease had no decisive importance compared to the course of the illness leading to the particular final state of the disease, just as happened with the various forms of paralysis (syphilis)"[30]. This appreciation played a growing role in the successive editions of his textbook, becoming the key issue in the 6th edition published in 1899 in which he used this as the central criterion on which to differentiate manic-depressive insanity and dementia praecox[31].

Kraepelin never completely abandoned his prior interest in psychological research. He continued to have an eye for fundamental brain mechanisms, such as inhibition and disinhibition that might play a part in disease processes, but by the mid-1890s, he had become scornful of brain mythologies. His focus on disease course put him on a path that was distinctively different to Vienna's more neurologically oriented Theodore Meynert, and Breslau's Carl Wernicke (see chapter 5) and later the emerging dynamic psychologists linked to Freud. In 1895, Freud and Josef Breuer had published Studies on Hysteria, which inaugurated a new era. Little of this impacted on Kraepelin, who was dealing with an entirely different patient group to Freud.

The drama in Kraepelin's 1899 Textbook lies more in the emergence of dementia praecox, later schizophrenia, than it does in the appearance of manic-depressive insanity. In the 5th edition published in 1896, he had maintained a separation

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of Clinical Psychiatry. Athlone Press, London, pp 280-291; Engstrom EJ, Kraepelin. In Berrios GE, Porter R, A History of Clinical Psychiatry. Athlone Press, London, pp 292-301.

[28] Kraepelin E (1892). Ueber die Beinflussing einfacher psychischer vorgange durch einige arzneimittel. Verlag von Gustav Fischer, Jena. Healy D (1993). One hundred years of psychopharmacology. Journal of Psychopharmacology 7, 207-214

[29] Shorter E (1997). A History of Psychiatry. From the Era of the Asylum to the Age of Prozac. J Wiley & Sons, New York.

[30] Kraepelin E (1987). Memoirs. Trans Cheryl Wooding-Deane, Springer Books, Berlin, pp 60-61.

[31] Kraepelin E (1987). Memoirs. Ed Hippius H, Peters G, Ploog D, Berlin, Springer.

between hebephrenia, catatonia and the paranoid psychoses but based on the new criterion of disease course in 1899 he included hebephrenia, catatonia and a range of paranoid psychosis within dementia praecox. This new disease was characterized by its progressive dementia. Disease course in Kraepelin's hands was being used as advocated by Kahlbaum and as is typically still used today. For instance the initial clinical presentations of Alzheimer's dementia and Jacob-Creutzfeld disease may be the same but in Jacob-Creutzfeld disease the decline is precipitate and this underpins the assumption that there are two different pathological processes at play.

Manic-depressive insanity had its place in the 1899 edition of the Textbook as a foil to dementia praecox rather than as a worked out condition in its own right. In order to bring out the importance of the disease course for his new system, Kraepelin had to have a contrasting disorder that did not lead to cognitive and clinical decline. Manic-depressive disorder was that contrast, and almost by definition as a result affected patients had to get better.

In constructing the category, Kraepelin took Kahlbaum's circular insanity and cyclothymia, as well as dysthymia, and stated that: "Over the years, I have convinced myself more and more that all of the described pictures are simply manifestations of a single pathological process... it is utterly impossible to find any definite boundaries between the different clinical pictures which have so far been kept apart[32]".

Simple alternation between excitement and stupor could not be a classificatory principle in that this happens in dementia praecox and GPI. But periodic, circular, and simple manias could all be regarded as manifestations of the one illness if they all showed a remitting course. Kraepelin argued that it was impossible to find sufficient regularity among the various different clinical presentations to distinguish them as different affective disorders. He argued that far from being consistently up or down, even in the course of one day many patients cycled through depressive and manic states or had mixed pictures such as agitated (overactive) depression or inhibited mania (manic stupor) or querulous mania. He also notes that patients can have a mixed condition in the sense of being manic one day and depressed the next. They can therefore alternate rapidly from pole to pole and also be disinhibited in relation to some activities while inhibited in others.

One of Kraepelin's collaborators Wilhelm Weygandt had first outlined this concept of a mixed state[33]. Weygandt argued that the brain had independent

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[32] Kraepelin E (1899). Psychiatrie. Ein Lehrbuch für Studirende und Aertze. Barth, Leipzig, Volume II Trans Ayed S (1960), Science History Publications, Canton MA, pp 272.
[33] Salvatore P, Baldessarini RJ, Centorrino F, Egli S, Albert M, Gerhard A, Maggini C (2002). Weygandt's On the Mixed States of Manic-Depressive Insanity: A translation and commentary on its significance in the evolution of the concept of bipolar disorder. Harvard Rev Psychiatry 10, 255-275.

affective, associative and activity faculties and each of these could vary independently – up or down. This gave rise to the possibility of elevations of mood for instance but inhibition of activity. The states predicted from the model can be read into real clinical pictures to some extent. It may have been Weygandt's work that finally led Kraepelin to throw a number of disorders that had previously been viewed separately into the manic-depressive hopper in the absence of any basis for distinguishing them.

Postpartum or puerperal psychoses were for instance tossed into the manic-depressive mix. Some forms of puerperal psychosis, Kraepelin argued, might become chronic cases of dementia praecox but for the most part these were cases of manic-depressive illness. He came to this view despite providing some of the most compelling descriptions of the distinctive features of puerperal psychosis, under the heading of acute confusional insanity[34]. This argued strongly for the possibility that puerperal psychoses, which clinically often resemble a steroid psychosis much more than either classic manic-depressive psychosis or schizophrenia, might be independent disorders. But the fact that the conditions remitted made them manic-depressive.

The fate of Kahlbaum's catatonia was most curious. Kraepelin recognized that catatonic features occurred with some regularity in manic-depression. These he seems to have passed off as consequences of the mixed states that manic-depressive disease could give rise to. The occasional cases of enduring catatonia for him trumped the fleeting presentations found in mood disorders and as a result catatonia was subsumed into dementia praecox[35]. Just as with postpartum psychoses, the possibility that it might be an independent disorder almost vanished as dementia praecox and manic-depressive illness took hold.

Postpartum psychoses and catatonia hint at a limitation of Kraepelin's method. Kraepelin's clinics in both Heidelberg and later Munich were relatively selective in the patients they took and while he did follow up patients in the local asylums he was not able to follow up systematically cases that never returned. A large number of frank but transient and single episode psychoses accordingly were never likely to get the weight that they might get in a classification system based on a follow-up of all cases.

One key disorder suggests that Kraepelin's thinking became unduly rigid with disease course a criterion that trumped everything - the involutional melancholias. These classic depressive psychoses have their onset in the 50s or later and patients typically present a striking picture of disturbed sleep and appetite, diurnal variation of mood and either paranoid, nihilistic or guilt-laden delusions. In 1899 Kraepelin thought that these patients were much less likely to recover than other patients with mood disorders. As clear mood disorders, these

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[34] Kraepelin E (1899). Psychiatrie. Ein Lehrbuch für Studirende und Aertze. Barth, Leipzig, Volume II Trans Ayed S (1960), Science History Publications, Canton MA, pp 28 – 33.
[35] Fink M, Taylor MA (2003). Catatonia. Cambridge University Press, Cambridge.

should have been added to manic-depressive illness, but their failure to respond suggested lumping them in with dementia praecox. He was unable to decide and let involutional melancholia stand as a separate disorder until the 8th Edition of his Textbook when he finally included it in the manic-depressive group[36]. This makes it clear that the classification system was based on a very simple criterion – whether the patient recovered or not. Overly simple, contemporaries such as Carl Wernicke said.

The idea of manic-depressive illness met with a muted response internationally. When Kraepelin's work was discussed in the English speaking world it was in terms of dementia praecox. Manic-depressive illness was all but ignored. By the end of the chapter it may be somewhat clearer why this should have been the case.

In America, Adolf Meyer initially welcomed Kraepelin's new orientation to clinical course as the breakthrough for which psychiatry was waiting[37]. But, Meyer, who later emerged as the leading figure in American psychiatry, shifted his ground between 1910 and 1920 and began to criticize Kraepelin as being too neurological, and as failing to take into account that the patient's disorder took place in the context of their life story. Simply writing patients off as having an inevitably deteriorating condition was not good medicine. Meyer preferred to talk instead of paranoid, hebephrenic, catatonic and simple parergastic reactions, and in terms of manic and depressive thymergastic reactions[38]. Following the publication of an English translation of Eugen Bleuler's work on schizophrenia in 1950, parergastic reactions and dementia praecox diagnoses were subsumed into schizophrenia, a much more commodious concept capable of extension to include a wide range of odd behaviors. There was a vogue to see many artists as incipient schizophrenics, just as there now is to see them as manic-depressive. It was only after the emergence of schizophrenia that manic-depressive illness was free to develop in its own right.

In Britain, the reception of Kraepelin's ideas was mixed. An early criticism came from the Dublin physician Connolly Norman, who rejected dementia praecox as over-inclusive[39]. Indeed Norman was one of the first to put on the record the risk that institutionalization might confound the clinical picture, by creating a misleading impression of degeneration or dementia.

Thereafter there were regular references to Kraepelin at psychiatric meetings in Britain. These were all in terms of the validity of dementia praecox; some disliked the term dementia and some disliked praecox. Manic-depressive illness

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[36] Kraepelin E (1921). Manic-depressive insanity and paranoia. Livingstone, Edinburgh.
[37] Meyer A (1896). Book review. American J of Insanity 53, 298-302.
[38] Healy D (2002). Mandel Cohen and the Origins of the Diagnostic and Statistical Manual, Third Edition: DSM-III. History of Psychiatry 13, 209-230
[39] Norman C (1904). Dementia Praecox. British Medical Journal 972-975; Healy D (1996). Irish Psychiatry in the Twentieth Century: Notes Towards a History. In 150 Years of British Psychiatry, Vol 2 ed Freeman H & Berrios GE, Athlone Press, London, 268-291

was rarely raised[40]. An English translation of Kraepelin's work did not become widely available until after the War.

The reaction to Kraepelin was probably also colored by the First World War, when hostility to his concepts was fuelled by hostility to all things German. Some traces of this can be seen in the writings of Michael Shepherd, who features prominently, later in this story, who as late as 1995 argued that Kraepelin was an unimaginative German nationalist, whose thinking contributed to later Nazi eugenics[41]. Shepherd found it unbelievable that having deposed one idol, Freud, American psychiatry would have replaced him with Kraepelin.

The French were also reluctant to embrace Kraepelin. The key issue here again was dementia praecox. They were unwilling to accept that all psychotic disorders had the common degenerative clinical course Kraepelin proposed for dementia praecox.[42] Dementia praecox was at least considered in France – manic-depressive disorder made no inroads on folie circulaire. But the greatest resistance came from Germany itself, as will be outlined in chapter 5.

Ultimately, however, when it came to manic-depressive insanity, the somewhat unimaginative Emil Kraepelin was on a winner. He had picked the name that worked. Names as well as concepts have survival value. They contribute to what might now be called branding. From this point of view dementia praecox was as poor a choice of name as possible but manic-depressive disease worked in that everyone could bring to it what they wanted.

But why manic-depressive illness? Why not manic-melancholic disease given that almost all the depressions he was faced with were melancholic in terms of their severity and clinical features? The answer lies in another quirk in the man – he had a partiality for novelty. Melancholia was an old-fashioned word. Depression was creeping into use; the first major paper on depressive illness was Carl Lange's in 1886. Despite being encrusted in Latin, dementia praecox was also a relatively new concept.

Most clinicians, if now asked to picture a classic case of manic-depressive illness or bipolar disorder, can do so just as readily as they might conjure up an image of Parkinson's disease. In the midst of the concepts that have swirled around this disorder then there seems to be a pure form that has stabilized a variety of quite different concepts. These concepts speak to competing views as to what constitutes a disease. Does it primarily hinge on some ideal form, or is the

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[40] Ion RM, Beer MD (2002). The British reaction to dementia praecox 1893-1913 part 1, History of Psychiatry 13, 285-304. Part 2, 13, 419-432.

[41] Shepherd M (1996). The two faces of Emil Kraepelin. British Journal of Psychiatry 167, 174-183; Shepherd M (1998). Psychopharmacology specific and non-specific. In Healy D, The Psychopharmacologists vol 2 Arnold London, pp

[42] Pichot P (1982). The diagnosis and classification of mental disorders in French-speaking countries: background, current views and comparison with other nomenclatures. Psychological Medicine 12, 475 – 492.

clinical course its primary characteristic, or does it hinge on treatment responsiveness. The various formulations outlined in this chapter from Falret onwards have all at one point claimed that without a close approximation to the true disorder, it would not be possible to find out what treatments really work. One of the key issues for the remainder of the book is the converse of this - if one of the affective disorders responds to some treatment, can we then assume we have found a distinct disorder?

If a treatment works might it help us decide whether Falret, Baillarger, Kahlbaum or Kraepelin were closer to the mark. But before moving on in the next chapter to the role of lithium, we can look at whether any of these concepts put forward by the professoriate impinged on the real world of asylum medicine. The French and Germans refused to use each other's concepts. If asylum physicians elsewhere used neither French nor German concepts, and indeed were reluctant to take up any concepts put forward by academics, then none of these debates would have much impact on the lived experience of patients.

A Window on the Past

Emil Kraepelin traveled widely in Europe and Asia. He was not however an Anglophile and he only came to Britain once, where he visited two places. Despite his travels, his Memoirs are one of the most tedious books ever written. One of his few passionate moments is when he describes London: "I thoroughly disliked [London] and the way of life with its endless uniform rows of houses, its lack of beautiful buildings and views, its confusing masses of people, its dull air, monotonous, tasteless cuisine and bleak Sundays". The only other place he visited was North Wales: "It was a pleasant feeling to leave the noisy, foggy city of London and to arrive at the ancient city of Chester. From here we made a 4 day journey through North Wales, mostly on foot, visited Llandudno, Betws-y-Coed…. and climbed Mount Snowdon in the rain"[43]. Unfortunately, while he visited Bedlam in London, he does not appear to have visited the asylum at Denbigh in North Wales.

The asylum that opened in North Wales in 1848 was representative of most 19th century asylums in the Western world from California through to Estonia. The reasons for its construction were repeated elsewhere, the cases it took were identical to those taken elsewhere, and the trajectory of its history maps onto popular and academic notions of the rise and fall of these institutions.

Before there was an asylum in North Wales, parishes raised money to assist relatives to look after idiots and the insane at home. To a 21st century eye, this might seem like a model of community care, but what struck those concerned about the plight of the mentally ill in the 19th century was the scope in this community system for gross abuse in some cases and a more general deprivation of access to medical advances that it inflicted on all patients. The

[43] Kraepelin E (1987). Memoirs. Trans Cheryl Wooding-Deane, Springer Books, Berlin, pp 55-56.

advocates of medicalization had no reason to suspect that institutionalization might be anything other than a good thing.

Around 1800 the British economy was changing. Industrialization and a changed pattern of landowning was creating a laboring class, where before there had been peasants. For the purposes of looking after each other, the peasantry had been linked through parishes and it was the parish that offered financial support in the case of mental illness to relatives or for boarding out.

With a labor market came the need to consider the question of poor relief for laborers who were laid off and did not have a farm to return to for subsistence. A new system of poor relief built workhouses for the indigent poor, and reorganized parishes into poor law unions, which were administrative units large enough to support the building of a workhouse.

A Madhouses Act of 1828 made it obligatory for parishes to return an annual list of lunatics, especially dangerous lunatics. The Poor Law of 1834 recommended that such patients be removed to madhouses or asylums rather than catered for in the workhouse. In France in 1838 a comparable law drafted by Esquirol mandated the building of asylums across the country.

When the Metropolitan Lunacy commissioners surveyed lunatics countrywide in 1842, Samuel Hitch, then one of the leading medical campaigners for asylums, came to survey North Wales. He reported that there were 664 lunatics in North Wales of which 19 pauper lunatics were in English asylums, 32 in workhouses, 303 living with relatives and 310 farmed out to strangers. He estimated only 6.5% of Welsh lunatics received care in an asylum compared with 42% in England.

The differences between Wales and Ireland were instructive in this regard. In Ireland the English felt free to deal with social issues in an interventionist way, using Ireland as a test-bed for social measures[44]. As a result, many of the earliest and biggest asylums in the new United Kingdom were established in Ireland – specifically in Dublin. Wales in contrast was part of, albeit a peripheral part of, the emerging British market economy, and social measures such as asylums had to take root in the native soil. It needed a set of reformers to raise consciousness of a problem and to agitate for change.

The reformers strategy was to discover and trumpet cases where the traditional system had failed. One such case was Mary Jones discovered by the lunacy commissioners in an attic near Denbigh. She had been confined on a foul pallet of straw for more than 15 years in a room with a stagnant and suffocating

[44] Robins J (1986). Fools and Mad. A History of the insane in Ireland. Institute of Public Administration, Dublin. Healy D (1991). The Role of Irish Members in the Medico- Psychological Association. Plus ca Change. In 150 Years of British Psychiatry ed Berrios G E, Freeman H L, Gaskell, London, pp 314- 320

atmosphere from the stored urine used in the family business for the treatment of wool. Her “chest bone protruded five or six inches beyond its natural place; and there was an excoriation of the parts below. The legs were bent backwards, and the knee-joints were fixed and immovable... She was emaciated to the last degree, her pulse was feeble and quick, and her countenance, still pleasing, was piercingly anxious, and marked by an expression of despair” [45].

Lord Ashley presented Mary Jones’ case in Parliament in July 1844 and again when he presented a bill making it a requirement for all counties to have an asylum. This was needed, he said, as in the case of Mary Jones her doctor testified that had she been caught in time there was a possibility for a cure. Cases such as this provided impetus to the cause of those who wanted to provide asylums to rescue their fellow human beings from degraded treatment and who believed that a regime of humane custodial care could in many cases restore wits to the senseless.

Where Mary Jones’ was confined to an attic, wandering lunatics might be handcuffed and leg-locked. But the community often resisted sending people away to the asylums - because of the costs involved. In North Wales, if local patients were to be hospitalized it would be in English asylums where the attendants and doctors spoke a foreign language. This was politically unsustainable. The remedy was to build an asylum in North Wales at Denbigh.

The choice of Denbigh was dictated by the geography that dictates all Welsh political and institutional developments. Four-fifths of Wales is formed of rugged folds of hills and mountains, so that 90% of the population is forced onto northern, western and southern coastal strips[46]. In the North, the mountains are highest rising to Mount Snowdon and the coastal strip is thinnest[47]. The asylum builders opted for Denbigh, a central Tuscan like town sitting on a hill, and dominated from the Middle Ages by an impressive castle. Denbigh offered reasonable access to everyone from North Wales.

Building began in 1844, ten years before Falret and Baillarger’s dispute. The story that unfolded was typical of asylum building everywhere. Within 10 years of opening in 1848, an apparently reasonable provision of 120 beds seemed like a serious underestimate. The hospital almost from the start ran at maximum occupancy. As early as 1860, further building was mooted. By 1862, when Kahlbaum was setting down his ideas on the importance of the clinical course for establishing disease entities, an extension of 200 beds was approved. This was completed by 1866 but by 1868 the asylum was full again.

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[45] Michael P (2003). Care and Treatment of the Mentally Ill in North Wales. 1800-2000. University of Wales Press, Cardiff.
[46] The political situation is caught by a 1990s bumper sticker, which proclaimed that if Wales were ironed flat it would be larger than England.
[47] This was the area in which JRR Tolkien set Lord of the Rings.

Through the following decades, new wings were added to the hospital to accommodate these extra patients and the hospital grew just as other asylums in American and Europe were growing. The end of year hospital census increased year on year from an initial 100 through to 1000 by 1914, peaking in 1948 at 1500 patients, the year before lithium and a cornucopia of newer physical treatments were discovered and a process of deinstitutionalization began.

The North Wales asylum offers an extraordinary opportunity to look at manic-depressive and other mental illnesses that cannot be reproduced elsewhere. When social scientists or historians look at the old asylums they see institutions that had been built in the countryside but which by the 20th century were almost all engulfed within cities. Asylums that began dealing with relatively small rural communities drawn from one ethnic group by the end of their life were dealing with multi-ethnic urban communities that in terms by population growth were many multiples of the communities that had been there before.

In contrast, around 1900, three-quarters of the admissions to Denbigh came from individuals with classic Welsh surnames such as Jones, Roberts, Pritchard, Williams, Evans, Parry etc. In 2000, over two thirds of the admissions still came from individuals with Welsh surnames. The overall population furthermore is almost precisely the same in 2000 as it was in 1900. There are variations so that there were more children in the 1890s, and fewer people over the age of 65 where now the ratio is reversed, but this difference is of lesser consequence when it comes to manic depressive illness and schizophrenia, which typically begin between the ages of 15 and 55; this section of the population was the same to within a 1000 people in 1900 as it was in 2000.

Anywhere else in the world, both because of geography and rising wealth, a growing number of people had a choice of hospitals but in North West Wales because of enduring poverty and by virtue of being hemmed in between the mountains and the Irish Sea, the insane had nowhere to go except to Denbigh. Because of the choice that opened up to people elsewhere, it is very difficult to know how representative patients ending up in the public or private asylums across the Western world between 1800 and 1950 were of the mental illness happening in their communities of origin, but this is not an issue for North Wales.

North West Wales did not urbanize. The area was desperately poor 150 years ago and remains one of the poorest regions of Britain today. There was effectively no private practice 150 years ago and there remains very little today. While people are much more mobile now and can travel to get ill elsewhere in Britain, because of the National Health Service patients with severe mental disorders are typically sent back to their point of origin for treatment.

The resulting asylum records shed light on three issues. One is the question of Kraepelin's involutional melancholia – was he right or wrong to include it in manic-depressive illness? The second is just how common was the new

disease, manic-depression. And the third is when did the new disorder begin to be diagnosed in an asylum like the one in Denbigh. On this score, it needs to be noted that the Denbigh asylum was progressive, being one of the first to open a pathology laboratory in Britain and extraordinarily quick to adopt convulsive and other therapies when they came on stream in the late 1930s. If manic-depressive illness had any traction as a concept, there is every reason to believe that the asylum at Denbigh would have picked it up relatively early. Later in chapter 5, we will see what happened in North Wales to the post-partum psychoses that Kraepelin added into manic-depressive illness. And finally in chapter 7, we will look at the age of onset of manic-depressive illness, as reflected in the asylum's records.

On the issue of involutional melancholia, there were 658 admissions from 568 individuals for severe depression, or melancholia - 17% of all admissions. Of these 57% were women. This gives an admission prevalence of 5.7/100,000 per annum, compared with an admission prevalence of 8/100,000 for severe depression today.

If we break these 568 patients down by age group and look at length of stay and rates of recovery we find that patients admitted in their 30s had a 76% recovery rate and a median length of stay of 224 days. Patients admitted in their 40s, had a recovery rate of 72% and a median length of stay of 285 days. The patients with classic involutional melancholia had an onset of a similar disorder in their 50s or 60s and older. For these patients the recovery rates were 65% and 56%, with lengths of stay of 261 and 203 days respectively. Overall patients admitted in their 30s or 40s were 1.2 times more likely to recover than patients admitted in their 50s or 60s. This hardly fits the picture of two different disorders.

The main difference between younger and older age groups was an increased death in care rate. This rose from 10% for patients in their 20s to 44% in patients in their 60s. This however was not death after an extended and refractory treatment course but often death rather early in the course of the disorder. The data strongly suggest Kraepelin got the recovery rates of older patients wrong, and as a result he inappropriately separated involutional melancholia from the rest of manic-depressive illness.

But, the key things for us to look at are the rates of diagnosis of mania, and the point of impact of Kraepelin's concept of manic-depressive illness on British clinical practice. The first thing that strikes any reader of the records is that most patients apparently had mania. As late as 1900, patients who were suicidal, patients with senility, patients with what now would be called schizophrenia were all labeled as manic. Over 55% of the diagnoses are for mania – see Figure 1. Either this illness was dramatically more common 100 years ago than it is now or else the word mania has been used in a completely different way to the way it's being used now. Around 1900, the use of mania as a diagnosis begins to fall, and it falls progressively to the current rate of less than 5%.

A further large group of patients, 35% of all those who were admitted to the asylum, were diagnosed as having melancholia. Retrospectively these patients only appear to have had a severe depressive disorder in very few instances – 10%. Other patients, then diagnosed as having melancholia, would now be diagnosed as having schizophrenia, or senile dementia and the depressive pole of a bipolar disorder.

As regards diagnosis, the picture in the Denbigh records begins to change in the early 1900s with cases such as those of WT, who was admitted in 1891 at the age of 45 having been looked after at home for a number of years. He had been a businessman, who spent a great deal of time traveling back and forth between Wales and Argentina. His family wondered if his first breakdown 17 years previously, from which he had recovered at home, had stemmed from an engagement to a Catholic woman, or whether it had been triggered by the general alarum that had accompanied an outbreak of Yellow Fever. He had recovered but was never quite the same. He continued working until his early 40s, when his family committed him to the asylum where he remained until his death 23 years later.

On admission, in contrast to most patients, he seemed almost normal – far from manic in the sense of agitated or overactive. After some days the grandiosity and probable delusional beliefs became apparent. These periods of elation alternated with mute and almost catatonic states, and he settled down to a cycle of episodes of depression, followed by overactivity and periods of lucidity. In 1904, 13 years after admission, the notes indicate that his condition was then being viewed as circular insanity. Despite a wealth of detail, WT is in fact one of the most difficult patients to diagnose from the asylum, but the reference to circular insanity is the first of its kind from a North West Wales patient.

In 1906, a national conference on the classification of insanity in Britain introduced a new system of diagnosis to Britain[48]. This system proposed a new disorder, primary dementia, which was the equivalent of Kraepelin's dementia praecox.

Even before this conference, the North Wales records were recording diagnoses of dementia praecox. Thus Bessie Hughes, a 17-year-old girl admitted on the 16th of October 1905 with hebephrenic and catatonic features was noted to be a good case of dementia praecox, even though she was fit to leave hospital 9 months later. The records indicate that up till then a case like Bessie would have been diagnosed as melancholia with stupor. The term dementia praecox came into use rapidly in North Wales, and primary dementia was never taken up to the same extent. Dementia praecox was not definitively replaced by schizophrenia in these records until 1949.

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[48] Berrios GE, Hauser R, Kraepelin. In Berrios GE, Porter R, A History of Clinical Psychiatry. Athlone Press, London, pp 280-291

There could not be a greater contrast between the rapidity of the uptake of the dementia praecox concept and the use of manic-depressive illness as a diagnosis. The new national classification system subdivided mania and melancholia into recent, chronic and recurrent mania or melancholia, and introduced the term alternating insanity. But none of these terms were used with any regularity. The fall in the frequency of diagnoses of mania in the first instance stemmed from an increase in the use of the dementia praecox diagnosis.

The new classification had little effect on RO's diagnosis. Admitted in 1908 and discharged in 1909, RO was the first patient from North West Wales to be diagnosed with maniacal depressive insanity – a disorder not on the list. In fact, this odd use of words was a better description of his case as it was presented in the hospital records than a diagnosis of manic-depressive insanity would suggest, in that he only presents on one occasion, and shows features of agitated depression without any alternation of mood.

RO was an exception. Patients with mania or melancholia when admitted continue to be diagnosed as having mania or melancholia, rather than alternating insanity or manic-depressive illness, until September 1920, when a 30-year-old sailor, RP, was admitted with grandiose beliefs and violent behavior. He remained in hospital for over a year during which time, he had attacks of agitation at regular intervals. On discharge he was diagnosed as manic-depressive. RP was readmitted 2 years later and spent most of the following 15 years as an inmate of the asylum, developing into a case of folie circulaire. In 1931, he was noted to have a "manic-depressive phase well marked and alternate with complete cycle in about a month".

The diagnosis, however, did not come into regular use until 1924 when three women who were admitted were given this diagnosis. One was AA, whose records from 1924 outline a 60-year-old woman who had two admissions for involutional melancholia or what would now be diagnosed as psychotic depression – no hint of mania. ER also admitted and diagnosed in 1924 as manic-depressive had a postpartum psychosis. Finally WH had her 10th admission in 1924 and on that occasion was diagnosed as manic-depressive. She came much closer to modern ideal type of a manic-depressive - there had been 9 previous admissions starting from May 1900, mostly for mania, but none had led to this diagnosis.

Looking back through these records, it is relatively easy now to distinguish manic-depressive illness from schizophrenia or other disorders. One of the primary indicators lies in the use of the word dementia. Patients with schizophrenia came into hospital clearly mentally ill, having been in recent possession of their faculties but in the course of the years after their admission the hospital records show an increasing use of terms such as "he has become quite stupid or quite demented", "is good for nothing". Manic-depressive patients

in contrast got well and went home and on subsequent admissions to hospital were often described as being in exactly the same state that they had been in during the course of their previous admission. One of the great advantages of the North Wales Hospital records is that there were only two ward clerks who kept the records for close to a century and the physicians in the hospital were also a stable group so that patients presenting successively over 20 or 30 years or more might regularly meet the same physician.

Sifting through 3872 admissions from North West Wales between 1875 to 1924, it becomes clear that bipolar disorder patients are hard to find. Only 127 such patients were admitted for the first time during this period. This gives rise to 10 cases per million per year, a rate that remained constant across 50 years, and continues to hold true to today[49]. If Kraepelin hadn't lumped them together with the other mood disorder patients, who comprised over 80% of the manic-depressive cohort, the bipolar patients would have been close to invisible.

From this perspective, the struggles for diagnostic priority in Paris appear an irrelevance. Folie circulaire and other labels were simply not used in a working asylum like Denbigh before 1900. Had they been used, so few patients were involved that the issue would still have been a minor one.

Of these bipolar patients, 60% in North Wales were female, compared to the 66% Kraepelin reported. The average age of first admission was 32 years old, with the youngest admission being for a 17 year old. The average length of stay in hospital for any one episode was 6 months. Almost all patients went home well with only a very small proportion having continuous fluctuations in clinical state that precluded discharge. This group of 127 patients had 345 admissions and on average each person had 4 admissions every 10 years.

Today the district general hospital unit serving the same area has a slightly higher proportion of female admissions for bipolar disorder. The average age at first admission is 31 years old. The average length of stay is a month. But people have 6.5 admissions every 10 years. On any one day in the asylum, a visitor would have found on average 4 patients with bipolar disorder, whereas now in the 60-bed unit serving the same area they would find 6 patients with bipolar disorder. The rate of diagnosis of bipolar disorder in comparable unit in America now is likely to be much higher for reasons that will become clearer in chapters 6 & 7.

One of the biggest differences is in the way people present. In the 19th century, over 80% of the admissions were for mania. Today over 50% of the admissions are for depression. Either the presentation of the illness is changing, or treatment is having an impact on presentations, or we have a greater sensitivity to episodes of depression that would formerly not have led to admission. The

[49] Harris M, Chandran S, Chakroborty N, Healy D (2005). Service Utilization in Bipolar Disorder, 1890 and 1990 compared. History of Psychiatry 16, 423-434.

remaining chapters look at the impact of treatment on this most dramatic of psychiatric disorders.

A number of reasons can now be offered for the muted academic reception and slow clinical uptake of the manic-depressive concept. The concept of manic-depressive insanity was a complicated one that on the one hand included disorders not usually lumped together and on the other hand at least initially excluded one of the commonest depressive disorders – involutional melancholia. The majority of patients with the disorder had a condition that was quite different to one implied by the disorder's name. Retrospectively, the disorder Kraepelin had in mind would arguably have been more appropriately termed severe affective disorder rather than manic-depressive disorder. Finally in opting for manic-depressive disorder, rather than manic-melancholic disorder Kraepelin wittingly or unwittingly endorsed the notion of a relatively discrete mood disorder, when most turn of the century alienists saw insanity as involving a disorder of the rational faculty.

The bottom line must be that while the "ideal type" of a manic-depressive patient now seems compelling, it does not appear to have seemed as compelling to clinicians at the start of the 20th century, and paradoxically was not what Kraepelin had in mind.

FIGURE 1