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HISTORICAL PAPER

The birth and death of a diagnosis: monomania in France, Britain and in Ireland

Dermot Walsh*

Health Research Board, Knockmaun House, Lower Mount Street, Dublin 2, Ireland

Objective. The purpose of this paper is to trace the origins and decline of the diagnostic entity monomania, which became prevalent in the early 19th century and to investigate its use in Irish psychiatry.

Method. The French psychiatric scientific writings of the early 19th century have been surveyed to identify and describe the clinical entity of monomania. The clinical description of monomania has been investigated and its cultural diffusion through literature and the arts has been reviewed. The increase in its use as a diagnosis and its ultimate decline has been documented in France, Britain and Ireland. The clinical characteristics leading to the diagnosis in Ireland have been investigated through the clinical symptoms recorded in patients accorded this diagnosis in the 19th century case books and committal documentation of the Richmond District Asylum and case books of the Central Mental Hospital.

Findings. The diagnostic entity of monomania first emerged in France in the 1820s and had disappeared from use in the hospitals of Paris by 1870. It first appeared in Ireland in the patients' admission register of the Richmond District Asylum in 1833 and increased substantially before decreasing just as markedly with the last patient, given the diagnosis on admission being in 1878. However, the diagnosis of monomania was applied to admissions to the Central Mental Hospital as late as 1891. The Irish asylum case books have been of limited value in elucidating the clinical and symptomatological presentations leading to its use by 19th century Irish psychiatrists.

Conclusions. Monomania, although enjoying a scientific and cultural success in France, both within and without psychiatric circles, was a tenuous clinical entity with an ill-defined and uncertain core and fragile boundaries, both in France and more particularly in Ireland. In pure form, rarely described, its closest modern equivalent would have been delusional disorder, but case descriptions only occasionally correspond to this concept as it is understood today. Its popularity dating from around 1830 declined and by the 1870s it was in terminal decline. The factors delineating its rise and fall are unclear.

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Birth of monomania

To understand this concept we must go to France. The word first appears when introduced by the psychiatrist Jean-Etienne Dominique Esquirol around 1810 when, in a medico-legal text book of 1827, he states he had proposed, about 15 years earlier, that partial insanity should be called monomania (Esquirol, 1838). The word attained formal linguistic recognition when approved by the Academie Francaise in 1835 (Goldstein, 2001). Even before this it had been adopted by literary sources such that we find it in Balzac by 1834. It also appears in the wonderful castings and lithographs of contemporary French politicians by Daumier, personages for whom he had nothing but distain, and whom he entitled 'Monomaniacal Varieties of Political Lunatics' (Delteil, 1925).

* Address for correspondence: Dr. D. Walsh, Health Research Board, Knockmaun House, Lower Mount Street, Dublin 2, Ireland.
(Email: dwalsh@hrb.ie)

But what did Esquirol understand by monomania? In his 1838 publication, he wrote 'It denoted an idee fixe, a term used earlier in French psychiatry, a single pathological preoccupation in an otherwise sane mind'. It had passed the boundary of what we would call an overvalued idea into the territory of delusion. However, Esquirol was exercised in his description of monomania as part of a wider revision of psychiatric classification in general, essentially that of his mentor, Philippe Pinel. He had discarded the word melancholia in favour of lypemania while retaining that of mania. Now, monomania appeared as somewhere between the two. It could, in its content, embody some of the gloomy preoccupations of the melancholic or lypemanic on the one hand and the excited, expansive ideas of the maniac, on the other. In fact, he described it in cases in which the delusion was limited to one or a small number of objects with excitation and a predominant gay and expansive position. In comparison, mania was where the delusion (delire) extended to all sort of objects and was accompanied by excitation.

However, the maniac in classic guise had more fundamental disturbances of thought and behaviour which were not encountered in the monomaniac. Esquirol published the clinical details of patients whom he had labelled monomaniac; most of the patients appeared to have grandiose delusions, with one believing that he was the Dauphin of France, whereas others had grandiose plans for improving society (Esquirol, 1838). Furthermore, monomania could be subdivided according to the typology of the predominant delusional preoccupation; thus, there was 'monomanie ambitieuse' in those grandiose and in the case of artisans preoccupied with their trades or businesses 'monomanie d'affaires' (Goldstein, 2001).

The story now passes to another psychiatrist, Etienne-Jean Georget, himself a pupil of Esquirol. He introduced monomania into forensic psychiatry, advocating it as a defence in criminal cases coming before the courts. In two publications of 1825 and 1826, he exemplified his ideas concerning a number of criminal cases coming to court in and around Paris (Georget, 1825). In these he diagnosed monomaniac homicide in which the monomaniac, he claimed, was driven by his/her illness to murder. One of these became a cause celebre, that of a Mlle Cornier, a servant, who killed her master's small child (Georget, 1826). Georget's use of monomania as a defence in such cases was opposed and resented by administrators and lawyers. Lawyers, in particular, were of the view that psychiatrists were impinging on their territory and should not be heard in court. Georget's unpopularity on these grounds, in certain quarters, determined that Esquirol was unable to get him a post in a public asylum (Goldstein, 2001). Georget's understanding of monomania was that it 'was an unshakeable conviction often with delusions of grandeur – a small number of fixed ideas, dominant, exclusive, under which rolls (sic) the psychosis, and a reasoning often sane on every other subject' (Georget, 1820). His premature death at age of 33 of tuberculosis, in the arms of Esquirol who was in tears, prevented him from developing his ideas on monomania further.

The interdisciplinary arguments between psychiatrists and lawyers as to the legitimacy of monomania continued apace in France. The diagnosis was quite popular among psychiatrists there in the 1830s and 1840s; both Esquirol and Georget, at one time or another, claimed it to be commoner than mania. Esquirol (1838) estimated that in the 1840s monomania accounted for 10% of admissions to both Paris public asylums, the Bicetre (male) and the Salpetriere (female). However, it fell into decline when the concept was attacked on clinical grounds by Morel and later by Falret, who had given one of the earliest descriptions of what we now call bipolar disorder, calling it *folie circulaire*. They contended that patients given this diagnosis were mentally ill on wider grounds (Falret, 1854). Moreover, one of its foremost and earliest advocates, Brierre de Boismont, defected from the earlier concept. As a result, the proportion of patients diagnosed as monomaniacs declined steadily from 14% of Saltpetriere admissions in 1850 to 2% in 1865 and none in 1870 (Goldstein, 2001).

Monomania and the work of painter Theodore Gericault

Jean-Louis Andre Theodore Gericault was born into a provincial bourgeois family in Rouen in 1791. The family moved to Paris when Gericault was 4 years old. Educated at the Lycee Imperial, formerly Louis le Grand, he avoided conscription to Napolean's Grande Armee by subterfuge and, determined to make his name in the arts, he enrolled in the Ecole des Beaux Arts, thus launching his artistic career. He was aflame with humanitarian and romantic sentiment, embittered by France's recent historical past and the social injustices of the ancient regime (Athanassoglou-Kallmyer, 2010). One of his major works, and the one by which he is best known, is the Raft of the Medusa, still in the Salon Carre of the Louvre, depicting dead, dying and starving persons adrift on a sea-tossed raft. They had been thrown there by the dignitaries aboard the ship Medusa en route from France to Senegal, which had run aground. In an effort to refloat it, the proletarian passengers were cast adrift on the raft. This picture was exhibited in the Rotunda in Dublin for an entrance fee, payable in part to the artist, from February to March 1821 (McEvansoneya, 2008).

Depression and suicide haunted Gericault's mind. His uncle and maternal grandmother had died insane as did a cousin. In the autumn of 1819 Gericault went into a deep depression. He believed himself to be the victim of persecution and that boatmen on the Seine were conspiring to kill him. He was treated in the clinic of Esquirol where Georget worked. Later, in London when the Raft was on exhibition there, he had more depressive spells and may have attempted suicide. In 1823, he lost most of his fortune because of dealings with a dishonest investment broker. His mood darkened and he spent time in bed because of a major and unspecified illness. He was described as lying torbid for weeks, possibly because of recurring episodes of depression. While in bed he was visited by Alexandre Dumas and also Magendie (of the foramen) and Dupytren (of the contracture) and died on 26 January 1824, aged 32 (Athanassogluo-Kallmeyer, 2010).

Before taking to his bed he undertook his portraits of the mentally ill, perhaps because of growing social and political interest in mental illness in France, exemplified by the moral approach to the mentally ill as illustrated

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by Pinel's humanism at the Bicetre and partly because of his own psychiatric difficulties. Gericault therefore decided that he would like to study and depict the physiognomy of mentally ill persons. To this end, he consulted the psychiatrist who had previously treated his depressions, Georget (Goldstein, 2001). Esquirol himself had earlier commissioned drawings of the insane in Paris hospitals from the painter Gabriel. The purpose of the Gericault portraits is contentious. One suggestion was that they were therapy for his own psychological problems, another to illustrate psychiatric texts, another as decoration for a psychiatrist's office, possibly Georget's, or to illustrate public lectures by psychiatrists Esquirol or Georget (Athanassogluo-Kallmeyer, 2010).There were precedents. At this time too, the French painter Eugene Delacroix showed the poet Tasso amid the insane in the hospital of Santa Ana in Ferrara and Hogarth, the English artist, the Rake's progress to the mad house of Bedlam.

Next to the Raft the resulting paintings of the insane were the most appreciated of Gericault's output, not least because of a current belief that the physiognomies of mental patients were useful diagnostically, a view to which Esquirol subscribed. Gericault sourced his female patients from the Salpetriere with Georget's assistance and the male patients from the Bicetre. There were originally 10 of these paintings but only five survived. Painted for Georget, they were sold following his death in 1828, to two of his pupils, five each to Drs Lacheze and Marechal. The five belonging to Marechal have disappeared and the other five were offered to the Louvre, which refused them at the time but later acquired one. The extant five represent patients suffering from monomania. Of these, one depicts a man with a mania for child abduction, taking children from the street to his home believing himself to be their father, another suffered from delusions of grandeur, convinced he was a marshal of France, and the third delusionally believed his property was being stolen from him. Of the two women, one with depressive delusions believed she was a thief and the other was stated to have lost her reason because of gambling, the latter being the portrait purchased by the Louvre. The other four paintings are to be found in museums in Lyons, Winterthur, Ghent and Springfield, USA. With the advent of photography, patients in asylums were immortalised by their photographs on the first page of their case books – a practice that continues to this day in certain quarters.

Major exhibitions of Gericault's works include a legendary exhibition at the Galerie Chartpentier Paris in 1924, a major exhibition at the Grand Palais in Paris in 1991, at Vancovour and at the Ecole National Superieur des Beaux Arts in Paris, both in 1997, the Fitzwilliam Museum, Cambridge England in 1997/1998 and finally a substantial exhibition at the Musee des Beaux Arts of Lyons, entitled 'Gericault; La folie d'un Monde' in 2006. This last exhibition was based on the museum's monomaniac of envy and included Ghent's kleptomaniac and the Louvre mania of gambling. Of the two remaining pictures, the man suffering from delusions of military rank at Winterthur, Switzerland, was ineligible for the exhibition because of the restrictions imposed by the museum's founder and the monomaniac kidnapper at Springfield Museum of Art at Massachusetts could not be lent because of its fragile condition. These pictures have been described as the *raison d'etre* of the exhibition and had a section devoted to themselves entitled 'Portraits of the Insane'. A commentator remarked that 'they show that concepts of madness and health, clinically definable insanity or ideals of beauty, notions of reason, truth, or even reality, are interchangeable units within the arbitrariness of whatever ideological system where one happens to reside. The line between the reasonable and the unreasonable, between the sane and the insane, is very thin, and none managed to transform it as convincingly into painting as Theodore Gericault' (Fehlman, 2006).

Monomania in Britain

However, monomania was not an exclusively French affair, although the references to it in the English scientific literature were somewhat later – in the 1850s and 1860s. Evidently it took some time to cross the channel. The first reference that I can find in the English psychiatric literature is by Munro in 1856 in his 'Classification of the various forms of Insanity', which is critical of the classic French nosology claiming that mania and monomania run into one another and vice versa. The symptoms of these various forms, he asserted, are frequently transcribed so that it is often impossible to declare, to which a patient belongs (Munro, 1856).

Then Harrington Tuke in 1861 in 'On the Classification of Insanity' examined the Frenchman Morel's recently produced classification, which deviated from that of Pinel/Esquirol. Tuke saw it as aetiologically based and rejected it in favour of the phenomenological nosology of earlier French psychiatry, although somewhat critical of that too (Tuke, 1861). Of course, aetiology *versus* phenomenology is a dichotomy with which contemporary classifications still struggle. Tuke is back to the attack in 1867 in his 'Monomania and its Relation to Civil and Criminal Law'. On the basis of his experience, apparently on contested wills in the civil courts, he pronounces that some medical authors ignore it and others vary in their acceptation (sic) of it (Tuke, 1867). Although Esquirol was triumphant that the Academie Francaise had accepted it in their dictionary of the French language, Tuke points out that they did so only

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in the literal sense, that is, in the sense of one delusion only being present. He then claims that such an entity, although theoretically possible is never seen and that it is practically an unknown malady and is never used in case books. He then quotes Benjamin Rush in the United States who, in forming his classification, attempted to understand what Esquirol had meant to convey by his definition of monomania. And having done Esquirol down, Tuke then proceeded to give his own definition of monomania coming back to use the term again but on his own terms. The word strayed to Germany, and Arlidge in 1863 quotes a classification of a Dr Hoffman of the Siegsburg asylum near Bonn as subclassifying monomania into the melancholic, excited, hallucinative and instinctive forms. The latter apparently coincided with 'moral insanity' (Arlidge, 1863).

The term had by now become the preserve of writers such as Dosteovsky, Edgar Allen Poe, Melville and many others. For example, William Gilbert, a naval surgeon and successful novelist and father of W.S. Gilbert of Savoy Opera fame, wrote an early novel entitled 'Shirley Hall Asylum, or the Memoirs of a Monomaniac' in 1863. This is self-narrated by an asylum resident who does not consider himself insane but is tormented by his attempts to invent a machine that would resolve the issue of perpetual motion. There apparently were many other outwardly well-appearing patients who turned out to be monomaniacs in the same asylum (Extra, 2010).

Sir Alexander Morison of Edinburgh (1779–1866), physician at the Bethlem, London, a specialist in mental disease, was active in this area. In his text book of 1843, 'The Physiognomy of Mental Diseases', he stated that 'there is no branch of medicine in which the study of Physiognomy (sic) is so necessary as that of Mental Disease. It not only enables us to distinguish the characteristic features of different varieties, but it gives us warning of the approach of the disease in those in whom there is a predisposition to it, as well as confirms our opinion of convalescence in those in whom it is subsiding. The appearance of the face is intimately connected with and dependent on the state of the mind; the repetition of the same ideas and emotions, and the subsequent repetition of the same movements of the muscles of the eyes and of the face give a peculiar expression which, in the insane state, is a combination of wildness, abstraction, or vacancy, and of those ideas and emotions characterising different mental disorders, as pride, anger, suspicion, mirth, love, fear, grief, etc.' (Morison, 1843). In the book, he deals with mania, monomania and dementia and gives drawings of patients suffering from these conditions, some when acutely ill and others when they have recovered. These delineations of his are fine work in their own right of high artistic merit. It is of interest that he himself was painted by the celebrated patient–artist Richard Dadd whose physician he was.

Of monomania Morison acknowledges the influence of Esquirol. The term monomania, he said, is applicable to cases of insanity, in which we have a small number of predominant and exclusive ideas, upon these deliriums or wanderings is (sic) fixed, the judgement being sufficiently sound upon all other subjects; in cases of mental disease ranging under the diagnosis of manias, we find incoherence, a medley of insane ideas and actions. In monomania, we find the physiognomy in a fixed expression characteristic of the peculiar ideas, which preponderate in the mind of the patient. He goes on to speak of monomania of elevated ideas, monomania with paralysis, and monomania of love and depiction of all three states presented in six drawings, and he also appends case descriptions. The first of the three is characterised by grandiose delusions, the second apparently ends in paralysis of the insane and the third is of erotomania. (Morison, 1838)

Monomania in Ireland

The sources of enquiry concerning monomania in Ireland employed here are the reports of the Inspectorate of Lunacy, the Census of Ireland for the year 1851 and the records of the Richmond District Lunatic Asylum and of the Central Mental Hospital (CMH).

The diagnosis of monomania in Inspectorial reports first appeared in Ireland in the Report of the Inspectors-General of District Local and Private Lunatic Asylums in Ireland for 1844 published in June 1845, the inaugural report of the Inspectorate. It relates that there were 14 male patients in the Connaught Asylum suffering from monomania on 1 January 1845 and 1 male patient in Clonmel Asylum. No diagnostic information is supplied for the other asylums in this report. Thereafter the Inspectors are silent on monomania until they began supplying diagnoses on those admitted to and resident in the district asylums from the Eighth Report (1857) onwards, some years after admissions with this diagnosis began to appear in mental hospital records. This Eighth Report states that in the 2 years ending on 31 March 1857, 135 admissions were given this diagnosis. There were 53 admissions for the 2 years ending 31 March 1861 (Tenth Report, 1861), 129 in 1869 (Nineteenth Report, 1870) and 102 (55 male and 47 female) of a total of 2132 admissions in 1875, the last year in which this diagnosis was returned on admissions (Twenty Fifth Report, 1876). In 1879, of a total of 8490 patient residents, 538 were designated monomaniac (Twenty Ninth Report, 1880) and 514 on 31 December 1881 (Thirty First Report, 1882). By 1882, the word no longer appears and a new diagnostic classification occurs in Inspectors' reports without monomania.

Monomania is encountered in Part Three, Report on the Status of Disease, Census of Ireland for the year 1851

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published in 1854. Part Three, presented by William Donnelly, Register General and Chief Commissioner and William R. Wilde Assistant Commissioner, includes a section (section three) dealing with a census of Lunatics and Idiots enumerated on a special return referred to as Form 1, requiring the names or initials of all individuals 'confined or under treatment in the different Lunatic Asylums of Ireland, as well as Lunatics and Idiots in Goals and Workhouses'. Among the numerous details requested were those relating to 'the peculiar form of Insanity, duration and presumed cause of disease'. Efforts were made, in addition, on Form D, to assemble similar information concerning lunatics and idiots who were either at large or in the custody of their friends at the time of the census. Form D was 'placed in the hands of the enumerators chiefly Constabulary and Police' who were instructed 'that these classes should be described from the best local information they could acquire'. The results were presented in a table setting out 'Description of Disease' in six diagnostic categories. The great majority of individuals were returned as having mania with a small proportion, given the classification of dementia. Curiously, melancholia does not appear as a diagnosis. However, monomania is returned as a separate category and contains 190 persons so designated, 112 male and 78 female of a total of 4981 lunatics enumerated or 3.8%. Although the return gives 1641 (32.9%) as being at large, these numbers are not broken down by diagnosis nor are the diagnostic groups classified as whether in institutional care, with friends or at large. In relation to the forms of insanity returned the report was circumspect – 'The terms used for expressing the different forms of disease in these tables are those afforded by the several public institutions, and as such, whatever may be their value, we are compelled to adopt them'. Beyond this it is unclear as to how the diagnostic categories were devised. The report also includes the presumed cause of disease among a variety of supposed aetiologies differentiating between moral and physical causes as well as giving basic demographic and social information on persons in each category. For monomania 36 cases were allocated to physical causes, of which by far the most common was intemperance, 16 male and 2 female, whereas 49 were assigned to moral causation, with the commonest cause by far returned as 'reversal of fortune'. The remainder of the 190 monomaniacs were returned as unspecified as to cause. The report was at pains to point out that there are minor differences between the numbers appearing in the report compared with that of the Fifth Report of the Inspectors of Lunacy, which was published in May 1851. In contrast, monomania did not appear in these Inspectorial reports until 1857, as described below.

The records of Irish asylums survive to a greater extent than those of most other institutions in the public sector, although often in poor condition because of storage in deteriorating buildings. This is mainly because the asylums themselves survived, at least until quite recently. As a result, many records were transferred to the National Archive in Dublin or, as in Cork and Ennis, to local archival preservation. The most comprehensive and extensive surviving collection is that of the Richmond Distinct Asylum in Dublin followed by that of the CMH and these are the sources of the information supplied here.

The Richmond Asylum has a register of admissions from 1828 onwards where among the details furnished on each admission is that of form of disease. The earlier admissions are almost entirely returned as mania or melancholia with some minority mention of dementia and epilepsy. Monomania first appeared with the admission of a 33-year-old woman on the 12th of November 1833. Thereafter, monomania admissions increased year on year to a total of 468, peaking at 49 in 1873 to decline until the last admission with this diagnosis on the 18th of December 1878. During these years there were 17 monomania admissions from 1833 to 1842, 66 from 1843 to 1852, 73 from 1853 to 1862, 178 from 1863 to 1872 and 134 from 1873 to 1878.

How did Irish clinicians make a monomania diagnosis? Data to address this question are scarce. The ideal method is to delineate case histories and symptoms through the study of case books. However, case books did not come into general use in Irish asylums until the 1890s after monomania had largely disappeared from the diagnostic repertory of admitted patients. These case books on admissions to the Richmond began in 1887 and were augmented by a census of those resident in 1891. That the Richmond was not unique in the absence of case books in the earlier years is corroborated by the fact that case books were available only from 1885 in Ennis and from 1892 in Sligo. Monomania does not occur in the admission registers of the 1880s and 1890s of the Clare and Sligo Asylums, which are among the best preserved documented asylum records apart from the Richmond. Similarly, the case books of the CMH date only from the 1890s. Most of the patients admitted to the Richmond from the 1850s onwards and diagnosed as monomaniac had died or been discharged when the 1891 case annotations of census patients were made.

Given that case books on admitted patients only began to be compiled in the Richmond from 1887 onwards, supplemented with a census of patients resident in 1891, one is reliant on clinical symptoms of patients, given a monomania diagnosis on the admission register and still surviving as inpatients. Of the 468 admissions given a monomania diagnosis 1833 to 1878, only 13 appeared in the 1891 census of whom three were female and all of whom had been admitted

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between 1869 and 1874. Their case books were initiated at the 1891 census and referred to symptoms either recorded as being present on admission by retrospection or present at the time of the census examination. Clinical descriptions of these patients were brief and unelaborated with short descriptive phrases such as 'dull and stupid', 'confused and incoherent', 'no delusions or hallucinations', 'talk disconnected and incoherent', 'weak-minded with deficient memory' and so on. Only in four cases were delusions mentioned and in only two of these was content described. Both of these latter appeared to have preserved personalities without apparent negative symptoms and both had systematised and grandiose widespread delusional formation over a variety of subjects. Although coming nearest to fulfilling the criteria for systematised delusional preoccupation starting from one initial delusional premise, neither could, on the basis of the clinical information available, be said to have been monothematic in delusional content and therefore their assignment to monomania is questionable. However, it must be recalled that some of the cases described by Georget and painted by Gericault had deviated from the original concept as defined and it is likely that these two Richmond cases would have been considered monomaniac by the French clinicians.

The other source of information in the Richmond archives concerns committal documentation, whether on application for admission by a relative or other or by order of the Lord Lieutenant as a dangerous lunatic. These committal documents were available on a sample of patients on the admission register given a diagnosis of monomania, in a third of whom the word monomania appeared on the committal form itself as well as on the admission register. The documents included a physician's certificate and a form that had three headings under which information was requested. These were form of disease, cause and prominent symptoms. This information was not always supplied. Scrutiny of 20 such documents yielded little support for the diagnosis of monomania, even in those cases where the committal form itself mentions that word. Some were cases of alcohol abuse, one was described as 'hysteria', and one was 'melancholic in danger of self destruction' another as having 'delirium with tendency to violence'. Only in six cases in all of whom the word monomania was mentioned in the committal document was the mention of 'delusions' and in only three cases was there some description or elaboration of what was the essence of the delusional. None of these three could be classified as monomania with any degree of confidence, given the paucity of clinical information supplied.

The admission registers of the CMH yielded 17 diagnoses of monomania on admitted patients from 1850 to 1891. Unlike the Richmond where the diagnosis was last given on an admission in 1878, four patients admitted, respectively, in 1885, 1887, 1889 and 1891 were so diagnosed. The admission register in seven cases added a short entry elaborating on the monomania diagnosis; these were in individual cases, 'religious monomania', 'monomania, vagrancy', 'monomania, wishes to bleed to death', 'monomania on the subject of landed property', 'monomania that farms in Kildare belong to him', 'monomania, thinks himself in possession of great wealth' and 'monomania of suspicion'. The case books of the CMH seem to have been established only in the 1890s and give clinical descriptions relating to the patient on admission many years earlier. Case note entries were available in only 5 of these 17 cases, because these patients were the only ones still resident in the 1890s when the case book entries were made, the others having died or been transferred to their regional district asylums. In two of these patients, there were descriptions of delusions noted, two of persecution, plots and poisoned food, grandiose in another, and in a third delusions and head noises identified as hallucinations. No relevant interpretable clinical information was given in the other two. Had further details been available, it is possible that some of these cases would have fulfilled criteria for monomania, as originally conceived.

Conclusions

Monomania was a diagnosis introduced into French psychiatry in the 1820s and flourished both in mental health usage and in the arts in that country. It was subsequently adopted in other jurisdictions including Britain and Ireland, culminating in popularity between the 1840s and 1870s before declining, earlier in France than in Britain and Ireland. Its contours were never precise and were often adapted to suit contemporary nosological convenience.

An attempt to determine how Irish psychiatrists interpreted and applied the diagnosis was undertaken. This enquiry was based on the 468 admissions on the register of the Richmond District Asylum given the diagnosis of monomania and a further 17 CMH cases similarly diagnosed. Because case book information dates only from the 1890s in both cases, the number of cases available for scrutiny from case book descriptions was limited to 18, 13 of the Richmond cases and 5 of the CMH. On the basis of this small sample, evidence that monomania as a diagnosis might be justified was restricted to eight cases and even in these it could not be unequivocally sustained in the absence of detailed clinical descriptions that were unavailable. It is therefore concluded that this diagnosis was used in an undisciplined manner by Irish psychiatrists of the 19th century. Although in a minority of cases the clinical

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picture might sustain a monomania diagnosis, in the majority of it was at a considerable distance from the original conception of the term as used early in the 19th century French psychiatry. It is likely that Irish clinicians may have had little understanding of the conceptualisation of monomania as described at outset, which in modern nosology, most closely approximates to delusional disorder.

Thus, the history of the rise and fall of monomania exemplifies psychiatrists struggling to comprehend the meaning of mental disorder in a symptomatic context just as ICD 10 and DSM 5 struggle, with the same exercise of appending meaning and order to the same symptoms. Moreover, if monomania attempted to describe delusional disorder but strayed beyond its confines so do, it seems, modern classifiers controversially broaden their diagnostic horizons to include mental states or behaviours formerly thought to be 'normal'.

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