14. Nihilistic Delusions*

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1840-1889

IN 1852, Lasègue presented an important paper in which he separated delusions of persecution from other types of melancholia. His article was the starting point for complementary works which have made this one of the most easily recognizable forms of mental illness in respect of its symptoms, course, and outcome. Alongside Lasègue, we must mention Morel, Foville, Legrand du Saulle, and particularly Falret, who presented to the Société Médico-Psychologique a composite picture of the successive phases and development of the illness as it was possible to give.

Our knowledge of the other varieties of melancholic delusional states is not nearly so complete. Simple melancholia, melancholia with stupor, and melancholia with anxiety have been carefully described. It is known that these forms are often intermittent and that they sometimes become continuous and then chronic. But, as far as I know, the characteristic features and successive phases of the accompanying delusions have not been studied to the same extent as have delusions of persecution.

I propose in this paper to describe a particular type of delusional formation which seems to me to develop in a considerable number of melancholic patients. The description seems to apply especially to patients displaying morbid anxiety. It relates to the habitually negativistic tendencies exhibited by these patients who do not entertain ideas of persecution.

The attitude of many mentally sick people is negativistic. To them, reality has become alien or hostile: the clearest proofs, the best authenticated assertions, and the most affectionate assurances are met with disbelief or irony. This negativistic attitude, however, is particularly marked in certain melancholics, as Griesinger noted: 'Under the influence of the deep-seated emotional malaise which forms the essential psychological disorder in melancholia, the mood becomes completely negative....' Later on, he says, 'The patient confuses the subjective change in his own attitude to outside things, with a real objective change.'

in them; and this is the beginning of a dream state in which, at its peak, the real world seems to the patient to have disappeared completely, or to be dead. There remains only the cruel imaginary world in which he finds himself.

I would tentatively suggest the name "nihilistic delusions" (délire de négations) to describe the condition of the patients to whom Griesinger was referring, in whom the tendency towards negation is carried to its extreme. If they are asked their name or age, they have neither. Where were they born? They were not born. Who were their father and mother? They have no father, mother, wife, or children. Have they a headache or pain in the stomach or any other part of the body? They have no head or stomach, and some even have no body. If one shows them an object, a rose or some other flower, they answer, 'That is not a rose, not a flower at all.' In some cases negation is total. Nothing exists any longer, not even themselves.

These same patient who deny everything also oppose everything and resist everything that they are requested to do. Some madmen, according to Guislain, have powers of opposition which have to be seen to be believed. Great efforts are needed to get them to make up their minds to change their demeanor. They refuse to go to bed and will not get up. They oppose everything that they are asked to do. It is a sort of 'resistant insanity'.

Guislain groups with this state such phenomena as mutism, refusal to eat, and the curious disposition of some people to retain their urine and excrement. But he does not draw attention to the nihilistic delusional state of which 'resistant insanity' is, so to speak, only the mental aspect. It is the same with most writers on the subject; and it seems strange that a mental disorder with such marked characteristics has not attracted more notice. Neither the cases nor even the phenomenon itself have received much attention and it is only the hypochondriacal form of nihilistic delusions which has been widely noted since the work of Baillarger.

In my opinion Leuret's *Fragments psychologiques* provides the most characteristic description. Here is a summary of the questions and answers:

'How are you, Madame?' 'The individual that I am is not a woman, please call me "Mademoiselle".' 'I do not know your name: will you tell me what it is?' 'The individual that I am has no name. She does not want you to write anything down.' 'But I should like to know what people call you, or rather what they used to call you.' 'I know what you mean. It was Catherine X... You must not speak any more of the past. The individual that I am has lost her name. She gave it away on entering the Salpêtrière.' 'How old are you?' 'The individual that I am has no age.' 'Are your parents still alive?' 'The individual that I am is alone, completely alone. She has no parents and never had any.' 'What have you been doing and what has happened to you since you became the individual that you are?' 'The individual that I am has been living in a mental hospital... They have carried out physical and metaphysical experiments on her, and are still doing so. She knew nothing about this work before 1827. Here is an invisible being descending; she is coming to blend her voice with mine.'

As well as very marked nihilistic delusions, Leuret's patient presented numerous hallucinations. She felt herself to be tormented by invisible people, by physics and metaphysics; in short, she showed symptoms of persecutory delusions. Complicated cases like this, in which the two delusional states coexist, are not uncommon. I will quote some examples later on. But most often the two kinds of delusions are seen separately in different patients.

Through all the phases of his illness, from initial hypochondriasis to megalomania, the true sufferer from persecutory delusions is no more likely to exhibit nihilistic tendencies than most mentally sick people. He is negativistic because of suspicion, a fear of being tricked or because he is completely dominated by his delusional ideas and hallucinations, even to the point of living in an imaginary world. These tendencies, however, are very different from the systematic attitude of negation, which is the subject of this paper.

In general, patients with persecutory delusions do not present either the deep depression or the crushing anxiety of true melancholics. They do not seem to suffer from that deep disturbance in their very soul which Griesinger considers to be the essence of melancholia. It is here that we find the breeding ground for the systematized nihilistic delusional state, in which delusions develop in a distinctive way over a longer or shorter period of time. Further, in advanced chronic conditions of this type it is not uncommon for these delusions to outlast the general symptomatology seen at the beginning of the illness and for patients like the one described by Leuret to show no signs of visible depression or anxious agitation.

I have just drawn attention to the twin sources of nihilistic delusions, namely melancholia with depression or stupor, and melancholia with agitation or anxiety. However different the external manifestations of these two forms of melancholia may be, one cannot help noticing the similarities between their delusions. These similarities are particularly striking in cases where depression and anxious agitation alternate in the same patient, while the delusions hardly change at all.

In these types of illness anxiety is the dominant feature, along with fears, imaginary terrors, and feelings of guilt, perdition, and damnation;
according to Griesinger, a terrible inner anxiety lies at the basis of melancholia with stupor. The patients blame themselves as being useless and unworthy, and for bringing unhappiness and shame on their families. They believe that they are going to be arrested, condemned to death, burnt, or cut to pieces. As Falret often pointed out, these fears of prison, condemnation, and torture must not be confused with true delusions of persecution, which are relatively rare in patients of this sort. These patients are quite different in that it is they themselves whom they accuse, believing that if they were to be handed over and sentenced to death, it would be no more than the justice merited by their crimes.

From this standpoint, two main classes of melancholics can be distinguished: (1) those who blame themselves, and (2) those who blame the outside world and above all the people in their social environment. The members of the latter group make up a 'persecuted' category which Guiulain had already classified as 'insane accusers' (aliénés accusateurs).

This division of melancholic patients roughly corresponds to Baillarger's distinction between 'melancholia with general mental disturbance' and 'depressed monomania', and also to Foville's 'general lypemania' and 'partial lypemania'. In general, one can say that true melancholics accuse themselves, while patients with 'depressed monomania' accuse other people. However, it is quite common to see the latter group in the course of an attack take on the characteristics of general melancholia, whether this be of depression or anxiety. It is also possible for melancholics with guilt feelings to assume the appearance of 'depressed monomania' at a more advanced stage of their illness.

Underlying these external manifestations, ranging from stupor to anxious agitation verging on mania, there are undoubtedly deeper morbid tendencies which distinguish between melancholics with and without persecutory delusions. Perhaps the tendency just described for patients to blame either themselves or other people furnishes the most direct manifestation of the internal factors which constitute the true foundation of the illness.

These tendencies often exist for many years, long before the delusional state becomes apparent. To a very limited degree one can even find them in many people in good mental health who can also be divided into two quite distinct categories. Thus, long before they can be deemed insane, the 'persecuted' melancholics are suspicious and mistrustful, harder on others than on themselves; similarly, some anxious patients, long before they are stricken with an attack of real mental illness, are over-scrupulous, timid, self-effacing, and harder on themselves than on other people.

I insist on this distinction in the melancholic delusional states, though most authorities do not make it. Marcé appears to imply its existence by drawing attention to the ideas of ruin and guilt and the consequent 'hypochondriacal' delusions of true melancholics in whom he relieves ideas of persecution to the category of monomania. He does not, however, elaborate on the distinction which can in any case be pushed too far, since some 'persecuted' patients present characteristics of true melancholia, and other patients with morbid ideas of ruin and guilt resemble 'monomaniacs'.

We must now look at the delusional process, by which self-accusing melancholics come to suffer from nihilistic delusions. First, to recapitulate the principal characteristics of their mental state, the mildest form of the disorder is known as 'simple melancholia' or 'melancholia without delusions', which Falret more accurately called 'mental hypochondria' and which he has described in some detail. These patients, supposedly without delusions, are in fact suffering from a depressed delusional state that affects their spiritual and mental faculties and already takes on a visibly nihilistic form. They feel shame to the point of self-loathing, and despair of ever regaining their lost faculties. They have for the intellectual capacity they used to have, the feelings which have been extinguished and the energy which have lost completely. . . . In their own eyes they have no heart and no affection for parents, friends or children (Falret). They often believe that they are ruined, a delusion that seems to be in the same nihilistic category. Thus a patient may believe that he has lost his material fortune at the same time as his spiritual and intellectual gifts; nothing in which man takes pride remains to him.

All this is the reverse of the delusions of grandeur in which patients believe themselves to possess immense wealth, as well as every talent and skill. The affective hypochondriasis rests on the basis of general melancholia and a vague and indefinite state of anxiety. The patients feel that everything is different inside and outside themselves; they are utterly wretched because they cannot see things from the same angle as before (Falret).

In these mild cases there is already, as it were, a veil through which the patient receives only a confused impression of reality. Everything seems changed. As the morbid condition intensifies the veil thickens and, in cases of stupor, ends by blotting out the real world altogether. The patient is then in practically a dream state, as Baillarger rightly points out.

From this and every other point of view, there would seem to be a difference only of degree between these states of 'mental hypochondriasis' and melancholic disorders, with ideas of guilt, ruin, damnation, and systematic nihilism. The hypochondriasis is like a rough sketch which, with its lines accentuated and its shades darkened, would present a finished
picture of these more advanced forms of melancholia. Feelings of self-disgust become delusions of guilt and damnation; fears become terror; external reality, transformed and perceived confusedly, ends by being denied. Certain nihilistic traits appear very early in these hypochondriacs. Their denial of the possibility of a cure or of any relief in their sufferings is one of the first of these ideas to be expressed, and some patients will later go as far as to deny the existence of the outside world and even of themselves.

It is very important to make a clear distinction between this condition of 'mental hypochondriasis' and the mental state of the ordinary hypochondriac. Although one must, according to Baillarger, admit that there are cases of melancholia without delusions, it is nevertheless important to be on the alert for certain hypochondriacs who resemble the melancholics with whom we are dealing. Whereas the true melancholic is in a state of general depression, this does not apply to the hypochondriac who can be temporarily roused by some distraction from his apparent prostration, emptiness, or helplessness. The ordinary hypochondriasis to which Baillarger is referring is in many ways very close to delusions of persecution, of which it is often just the first phase. His distinction is justified mainly by the different ways in which the two kinds of hypochondriasis develop. In general, one can say that mental hypochondriasis bears the same relation to delusions of ruin, guilt, perdition, and nihilism as ordinary hypochondriasis bears to delusions of persecution.

When nihilistic delusions are formed they are concerned either with the patient's own personality or with the external world. In the former case the resulting hypochondriasis is analogous to the special delusions which Baillarger has listed as occurring in general paralysis. The patients believe that they no longer have a stomach, a brain, or a head, that they no longer eat or digest their food or go to the lavatory; in actual fact they do strenuously refuse food and often retain their faces. Some, as I reported in a paper presented to the Société Médico-Psychologique, believe that they will never die. This idea of immortality is found especially in cases where anxiety and agitation predominate. In stupor, the patients are more inclined to think that they are dead. One sometimes sees cases which present alternately the idea that they are dead or unable to die, corresponding respectively to states of anxious agitation and to dull depression.

The hypochondriacal delusional state, presenting predominantly mental symptoms at the outset, includes both mental and physical phenomena at a more advanced stage, especially when the illness has become chronic. Patients who begin by claiming that they have neither heart nor intellect, end by disclaiming their bodies also. Some, like Leuret's patient, only speak of themselves in the third person. With 'persecuted' patients the process is reversed. The hypochondriasis is expressed in predominantly physical terms at the outset, but later on the patients are preoccupied with their mental faculties, which, they believe, are being blunted by people preventing them from thinking, talking nonsense to them; and tapping their intellect.

These two forms of hypochondriasis differ not only in the course they take. The anxious hypochondriacs bear the stamp of humility; they believe that they have nothing and are nothing of any worth, that they are rotting away, suffering from ignoble illnesses like syphilis. Fédéré has already noted the connexion of this delusion with what he calls 'damnomania'. By contrast, the 'persecuted' hypochondriacs have, on the whole, a very good opinion of themselves and of their constitution, which is robust enough to endure so many ills. They blame outside influences—the air, the damp, cold, heat, food and, above all, medication. If it is a question of syphilis, it is not the syphilis but the mercury which becomes the cause of all their sufferings. They end by blaming the doctor and their delusions of persecution become permanent (Legrand du Saule, Gazette des hôpitaux, December, 1881). Whereas the 'persecuted' hypochondriac believes himself to be the object of harmful influences which converge on him from outside, the anxious patient, on the other hand, imagines that he is their source and that he is spreading them all round him. He imagines that he is bringing bad luck to the people near him, to the doctor looking after him, and to the servants who attend to his needs. He believes that he will transmit some deadly illness to them; that he will compromise or disgrace them; that the house where he lives will be under a curse, that the trees and flowers will wither as he walks in the garden.

Hypochondriacal nihilistic delusions are often bound up with altered states of sensation. Anaesthesia is common in stupor, as all authorities have pointed out, and is also exhibited by some anxious melancholics. Others seem to display hyperaesthesia instead: these patients do not want anyone near them and cry out when they are touched, repeating again and again 'Don't hurt me!' To what extent such changes in sensation run parallel to the development of the hypochondriacal nihilistic delusions is a question of pathogenesis which I will not try to elucidate. I will simply point it out as a distinguishing characteristic between the two kinds of hypochondriacal delusions; it is common in the nihilistic patients, very rare among the 'persecuted'.

When the delusions are concerned with the external world, the patients imagine they no longer have a family or a country, that Paris has been destroyed, that the world no longer exists. Religious beliefs, and especially belief in God, often disappear, sometimes very early in the illness. As Griesinger points out, when patients...
nihilistic thoughts, they are too anxious and agitated to be capable of recollection and prayer.

This brief description of nihilistic delusions and the various forms they take would not be enough to establish them as a special kind of melancholia. I should like to show that together with these delusions there are many other closely associated symptoms which constitute a true illness, distinct in its characteristics and development. For this purpose delusions of persecution can be taken to serve as a prototype and I shall try to give a clinical picture of the nihilistic patient by bringing out the differences and contrasts that he presents compared with the ‘persecuted’ patient.

I have already begun the comparison by showing the difference between the ‘mental hypochondriac’ and the ordinary hypochondriac, between the anxious melancholic who blames himself and the ‘persecuted’ melancholic who blames the outside world. When the illness becomes worse, or takes a more serious form at the outset, hallucinations appear in addition to the hypochondriacal symptoms already outlined and the delusions of ruin and guilt. These hallucinations have particular characteristics which merit attention in their own right. They are especially frequent in states of stupor, but occur also in the ‘anxious’ variety of the illness. The patient may believe himself encircled by flames. He sees a precipice at his feet, imagines that the earth is going to swallow him up, or that the house will crumble away. He sees the walls tremble and believes the house to be mined. He hears the preparations for his execution, the guillotine being erected. He hears the roll of drums and the crack of firearms and thinks he is going to be shot; he sees the rope which is to hang him and hears voices reproaching him with his crimes, reading him his death warrant or repeating again and again that he is damned. Some patients have hallucinations of taste and smell and imagine that they are roasting away, that their food is completely changed, or that they are being offered filth, faecal matter, or human flesh.

Generally the content of the hallucinations of patients with guilt feelings reflects their current preoccupations. According to Baillarger, who has clearly described these phenomena, one melancholic who blamed himself for imaginary crimes was obsessed day and night by a voice reading him his death warrant and describing the tortures in store for him. Another patient, whose history has been given by Michéa, believed that she was guilty, that she was being pursued by the police, and that she was being threatened with death. She was sent to a mental hospital and a few days later, when the ‘hysteria’ was at its height, she constantly saw a rope which was to be used to strangle her lying at her feet and a coffin ready to receive her body. Some patients believe themselves to be damned and see the flames of hell. They hear gun-fire and believe

they are going to be shot. Guislain has drawn attention to the close connexion between fear of demons, suicide, and the kind of hallucinations in which patients see flames and outbreaks of fire everywhere.

The hallucinatory state of patients who are anxious, agitated, or stuporous is altogether different from that of the ‘persecuted’ melancholics: first, because of the visual hallucinations, which are rare among the latter group, and also because of the character of the auditory hallucinations which, like the visual phenomena, simply confirm the delusional ideas, so that it is difficult sometimes to tell one from the other. The hallucinatory experiences of anxious patients also lack the independence characteristic of these phenomena in the other group, and are therefore not so distinct in character or development. The ‘persecuted’ patient, on the other hand, gradually reaches the stage of carrying on a dialogue. He can be seen listening, and impatiently or angrily replying, to his imaginary interlocutors. Nothing of the kind happens to the anxious patient. If he speaks it is to repeat the same words over and over again, or perhaps the same sentence or groaning sounds. His flow of words has the quality of a monologue on one theme, and he does not exhibit any of the repercussions of thought, any thought-echo or special vocabulary such as make the chronic ‘persecuted’ patient’s conversation instantly recognizable.

At the beginning of this paper I pointed out the opposition and systematic resistance put up by the deluded patients through their nihilistic attitudes. The rigidity and muscular tension which they often display show that their inertia is only apparent and their resistance not simply passive. As soon as one tries to change their attitude, or to get them to move their limbs, they contract their muscles and resist energetically any change in their habitual position.

Though tremor is seen in some anxious patients and cataleptic phenomena occur in states of stupor, it is more important to note that anxious patients often have impulses towards suicide and self-mutilation, especially when they are under the sway of religious ideas. These phenomena constitute yet another difference which distinguishes them from the ‘persecuted’ patients, among whom suicide is much less frequent and self-mutilation very rare indeed. Anxious patients who believe themselves damned are the most prone to suicide. Even while they believe that they are dead or that they never can die, they still try to destroy themselves. Some want to burn themselves, fire being the only solution; others want to be cut in pieces, and try by every means in their power to satisfy the morbid need for mutilation, destruction, and total annihilation. Some are violent towards those about them, seeming to want to demonstrate that they are indeed utterly depraved and devoid of all
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moral sense. Often they pour out insults and blasphemies; how, they maintain, could devils or the damned do otherwise?

The refusal to take food, which is so closely linked to 'resistant insanity' (see p. 354), also presents some special characteristics in nihilistic patients. Usually the refusal is absolute and applies to all food indiscriminately. The patients refuse to eat because they believe that they have no stomach—the meat and other food just falls into the skin of the belly—or that the damned do not eat because they have nothing to pay with. Some, however, dominated by less intense delusions of guilt or ruin, pick and choose their food. As a penance they only eat dry bread or will not allow themselves dessert. The 'persecuted' patient, on the other hand, examines his food carefully, looks out for what seems good, and rejects anything that he suspects. When he comes across food which he believes to be free from poison, he eats voraciously so that refusal of food is not usually complete.

I come now, at the end of this comparison, to the study of the course of the illness. Delusions of persecution are essentially remittent or, to put it another way, they come in recurrent attacks. The illness usually starts early, develops slowly and gradually, and lasts throughout life. The intermittent nature of the disorder is detectable even in its initial hypochondriacal phase, and also in those cases where the illness never seems to develop beyond this preliminary stage.

The illnesses of nihilistic patients follow quite another course, coming on suddenly, often in middle age, and affecting people of hitherto apparently sound mental health. Recovery, when it occurs, is as sudden as the onset: the veil is torn and the patient wakes up as if from a dream. It is hardly necessary to say that it is in the milder forms that hopes of recovery are highest. Melancholia without delusions, the so-called mental hypochondriasis, and anxiety states with ideas of ruin, usually remit. But the illness is liable to recur at long or short intervals and to take on the character of an intermittent form of insanity. This intermittent character sometimes shows itself even in incurable cases, in the form of short-lived 'awakenings' when it seems as though the patient is completely sane again. Griesinger states that he once saw a perfectly lucid interval occur in a patient suffering from profound melancholia who believed that she had lost her entire fortune and believed she was in danger of starving to death. It only lasted a quarter of an hour, came on for no discoverable reason, and disappeared equally suddenly.

Recovery is common where stupor predominates from the start, in spite of the strength and absurdity of the delusions. But it is not unusual for patients who have suffered from deep and prolonged anxiety and agitation with hallucinations and every sort of delusional fear to fall into a stuporous state, all too often mistaken for dementia, which goes on indefinitely. These patients often present 'resistant insanity' of the most severe kind. They can be mute, or sometimes simply repeat the word 'No'.

The prognosis is equally unpromising when the general melancholic disturbance is seen to decrease in intensity, while the delusional ideas and negative attitudes remain unchanged. The patients arrive at a systematized delusional state, from which recovery rarely occurs. Most of these cases also exhibit 'resistant insanity' for which, as Guistain pointed out, the prognosis is bad.

The course of the illness, its mode of onset, and its occasionally abrupt termination link nihilistic insanity with the group of mental illnesses which come on in bouts and with periodic insanity. Even if the name 'nihilistic delusions' were reserved for those cases which have reached the point of which I spoke at the beginning of this paper, one could say that the delusional state of negation is a chronic state peculiar to certain intermittent forms of melancholia which have become continuous. I only want to draw attention to one point, which seems to me to establish a difference between nihilistic patients and patients suffering from types of intermittent illness who are closer to periodic disorders. Information obtained about the previous history and character of the patients often reveals that they have always been rather melancholy, taciturn, over-scrupulous, dedicated to good works, always ready to serve others. Some are gifted with the highest moral qualities. Their morbid condition with its deluded state of humility does not stand in complete contrast with their previous way of life, but rather represents a morbid exaggeration of it. In short, this illness does not show overtly alternating phases like those periodic or intermittent illnesses in which the healthy state is quite distinct from the melancholic attacks.

This characteristic of nihilistic patients also makes it possible to separate them clearly from the majority of sufferers from hereditary illness, among whom they form a special class. If one may so express it, the distinction lies in the fact that they display an exaggerated form of the very moral qualities which are lacking in patients with other hereditary illnesses, and the absence of which leads to disordered lives, profound egoism, pride, lack of discipline, and anti-social offences.

Though in many cases the nihilistic delusional state appears to go with intermittent forms of mental illness, I must add that it is not uncommon to see it developing on the basis of hysteria and to come across it as a symptom of encephalitis. The delusions of smallness, noted in this illness by Materne, also appear closely related to nihilistic delusions and can coexist with them, as exemplified in one of the case histories below.
still keeping up the same muscular rigidity and resisting everything that she was required to do just as strenuously.

Mrs. E. developed a prolapse of uterus and rectum which it was impossible to support, because of the violent expulsive efforts she made as soon as a reduction was attempted.

She died in 1878 in a state of general debility.

Case 2. Mrs. E., aged 63, admitted to Vanves in May, 1868, was in a state of great anxiety and agitation. She thought she had nothing left, that she had ruined her family and was going to be put in prison. She was always on the move and never kept still. She groaned all the time, repeating that she was lost and ruined and that her children would die of hunger because of her.

She refused food on the grounds that she could not pay for it. She believed that she was suffering from a contagious disease and imagined that she smelt foul. She did not want anyone to come near her and believed that her touch brought death. She also believed that there was poison and filth in her food. The patient said she could neither eat nor walk and that she was quite intractable. She resisted every effort to give her the necessary personal care. It was a struggle to dress her, to get her up, make her go for a walk or feed her. She stayed constantly crouched in a corner, sometimes mute, sometimes uttering monotonous groaning sounds and repeating that she was a monster.

On the plea of inferiority Mrs. E. would eat nowhere but at the servants' table.

She died in 1876, without the slightest change in her delusional state.

Case 3. Mrs. S., aged 53, had already suffered an attack of depressive melancholia which had not necessitated her admission to hospital. The melancholic delusional state recurred and she was brought to Vanves at the end of 1876.

The patient was in an extreme state of anxious agitation. She believed that she was guilty and lost and that she was going to be taken to prison. She tried every possible means of committing suicide. She heard voices, telling her of her guilt and that she was going to be condemned and taken to prison. She believed that she heard her husband's and daughter's voices, and that they were in prison because of her. She bewailed her lot continuously and refused food.

1880. Mrs. S. was still dominated by the same melancholic ideas. Most of the time she remained mute and motionless and did not answer if spoken to. At times she expressed quite absurd nihilistic ideas. She maintained that no one died any longer, that no one married or was born, and that there were no more doctors, prefects, notaries, or authorities. Whereas Mrs. S. had been in the habit of praying, she now felt it was useless since God did not exist. She resisted all personal care and tended to refuse food, maintaining there was lime and potassium in everything she was offered.

The patient's condition remains absolutely stationary at the present time (May, 1882) and she spends the whole day mute and immobile.

Case 4. Mrs. M., aged 57, a married woman with a family, appeared to have been very healthy up to the year 1878. She was then seized with an attack of
anxiety with dreadful fears. She used to see flames and outbreaks of fire, thought she was ruined and imagined that she was going to be tortured. After two months she suddenly recovered but some weeks later the feelings of disaster returned and she was brought to Vanves in a state of intense anxious agitation. She was groaning and in a continual state of terror, chiefly connected with fires.

Mrs. M. imagined she was ruined and about to be tortured, that her food was poisoned and that there was a spell on her. She appeared to have both auditory and visual hallucinations, maintained that terrible things happened every night in her room, into which unknown people used to come. She disclaimed her husband and children when they came to visit her, asserting that she had never been married and had neither father nor mother, husband or children. She claimed that neither the town where she was born nor the city of Paris existed any longer; that nothing existed now; that her daughter was a devil in disguise. The patient would not let anyone come near her and drew back in terror if anyone tried to touch her or take her hand, repeatedly saying 'Don't hurt me'. She denied everything and resisted everybody. It was a battle to dress, undress, or feed her, and she showed amazing strength in her powers of resistance.

In August, 1881, Mrs. M. had a sudden left hemiplegia; there was no change in the delusions. She retained partial use of the lower limb but the upper limb underwent contracture. She repeated the same nihilistic remarks all the time and her 'Don't hurt me' was a constant refrain; she stubbornly resisted everything that anyone tried to get her to do.

At the present time (May, 1882) the situation remains unchanged.

Case 5. Mrs. J., aged 38, was admitted to Vanves in August, 1879, in a state of melancholia with anxiety which had already lasted several months.

Mrs. J. imagined that her nerves were going to be cut, that she was to be made deaf, mute, and blind, and be submitted to all kinds of torture; she passed whole days groaning and imploring the Virgin and the saints to help her.

She displayed acute paroxysms of agitation with attempts at suicide. She refused food, stating that she was lost, damned, and filled up with oil. She felt that she was to be subjected to the most appalling tortures, but that she would never be able to die.

In the course of frequent paroxysms the patient rolled on the ground writhing and making all sorts of faces. Over and over again she repeated the same sentences which were often quite absurd and unintelligible but were always connected with the notion that she and everything about her were to be transformed and annihilated. She repeated 'There is nothing any longer; nothing exists any more; everything is made of iron'. She said that she herself had been changed into a small chicken, a fly, a piece of wool which could talk; that she was no longer anything, that she never ate and no longer had a body; that the people round her were only shadows.

Mrs. J. resisted everything done to help her. She retained her faces and urine and fought with incredible muscular strength against being dressed and undressed. At present (May, 1882) her condition remains unaltered and her delusions in no way improved.

Case 6. Mrs. C., aged 43, a married woman with a family, entered the mental hospital at Vanves in November, 1880. In 1875, after the sudden death of her father and an operation performed on her son for the correction of strabismus, this lady had already suffered a mild attack of anxiety, with insomnia and continual yawning. She was obsessed with the fear that her father had been buried alive and that her son would become blind as a result of the operation.

This anxiety state was resolved in about a month, but at the end of March, 1880, another attack came on rather suddenly. The patient was preoccupied with financial problems; she was bewildered and indecisive the whole time and could not sleep. She blamed herself and felt guilty. After some months she entertained hypochondriacal delusions, believing that she had no stomach and that her organs had been destroyed; she attributed these beliefs to the effects of an emetic which she had, in fact, been given.

When she arrived at the hospital Mrs. C. was in a state of melancholia with anxiety and paroxysms of manic agitation during which she writhed, made faces, and rolled on the floor groaning. These paroxysms alternated with periods of immobility and mutism. She maintained that her windpipe had been removed; that she no longer had a stomach or any blood; that she would never die; that she was neither alive nor dead; that she was a supernormal being with no place among the living or the dead. Stating that she was no longer anything, the patient begged for her veins to be opened, her arms and legs to be cut off, and her body to be opened up, so that it could be seen that she had no more blood and that her organs no longer existed.

This patient left the hospital after 2 months and I do not know what became of her.

Case 7. Mr. A., a man of 53, was admitted to the mental hospital at Vanves, in July, 1877. His attack of melancholia came on after he had been through a period of great distress, as he had lost his wife and son almost at the same time.

The patient accused himself of having caused the deaths of his wife and son. He maintained that he was rotting away, that he had contracted syphilis, that he was lost, damned, and the greatest criminal who had ever existed; he felt he was the Anti-Christ who merited burning in public. He was plunged in profound grief, weeping, and groaning and wishing he were dead. He attempted suicide more than once.

1880, Mr. A. always voiced the same misery and guilt-ridden thoughts. He stated that he was the 'damned one' who must burn eternally. He said that his body had rotted away, that he had no blood and no pulse; that his heart had stopped beating, his head was empty and his face not human; that he was waiting for the end of the world which was near.

At the present time (May, 1882), the situation is the same and the delusions are unchanged.

Case 8. Mr. A., aged 48, was admitted to the mental hospital at Vanves in March, 1879, after attempting suicide. He was in a state of intense anxiety and agitation. He tried in every possible way to mutilate, blind and kill himself.
he would not eat or take medicines or accept any kind of care because he considered himself unworthy. He thought of nothing but expiating his imaginary crimes: this was why he tried to do himself harm. He said he had fallen into an abyss of infamy into which he was sinking further and further every day. He begged for a rope to hang himself or for a strong dose of poison.

The patient did not appear to experience auditory hallucinations but he admitted to visual illusions. He invested the shapes of external objects with mystical significance. He thought he saw animals in the shapes of trees, etc.

1880. Mr. A. believed he was going to be tortured, plunged into freezing water, and fed on filth and excrement. He begged for hydrocyanic acid to put an end to it all. He stated that his brain had grown soft and that his head was like a hollow nut; he said that he had no sex, no testicles, that there was nothing left; that he himself was just 'a carcass'. He asked for a hole to be dug so that he could be buried like a dog. He also said that he had no soul and that God did not exist. At times he said he had neither wife nor children, but on other occasions he asked to see them and go back to them. The patient repeated the same sentences, supplicating again and again for hours on end: 'Kill me; kill me; don't give me a cold bath.' He tried every possible way of killing and mutilating himself; he wanted to put his eyes out and tear away his testicles. He was equally violent and abusive to those about him. There were moments when he spoke lucidly; and he was quite ready to recount different things that had happened to him in the past.

In May, 1883, the situation remains unchanged. Mr. A. repeats incessantly that he is unworthy and vile, and wants to become a booh blocker. He says that he has no testicles and must be killed.

Category II

Case 2. Mr. C., a man of robust constitution, married, with a family, had always led a regular and industrious life. His only excess, so it was said, was a tendency to overwork. He stayed every day in his office till 2 a.m. and was up again at 7 a.m. He had had violent migraines with vomiting for several years. In 1879 he complained of trouble with his eyesight and of misty vision. He consulted an oculist who, having carried out a retinoscopy, apparently asked him to balance on one leg, which he could not do.

About this time, the patient began to complain of frequent falls, often he came home and told his wife that he had almost killed himself, or that he had fallen and been helped up. At the same time his character began to change. He became gloomy, irritable, and apparently sunk in profound misery. He recounted dreadful pretensions and kept giving advice to his wife, including minute directions about the children, as if he felt threatened by an early death.

At the beginning of December, 1879, he fell again in the road, came home chilled to the bone, and was seized with a violent trembling and chattering of teeth. The doctor who was called apparently found no rise in temperature after this shivering attack. Similar attacks of shivering came on at different times every day and lasted 3 or 6 hours. The patient stayed in bed all the time under a pile of blankets. As soon as anyone took a bed-cover off he started to tremble again and his teeth commenced to chatter. He was quite unable to sleep.

After some weeks he left his bed, but could not take up his work again. He stayed the whole time at his office, neither speaking nor moving nor doing anything. He would not let anyone in, and sent his wife rudely away when she came to see him. At times he would repeat 'I'm an idiot', and say to his wife, 'So you won't give me back my old life?' or 'I ought to shoot myself'. 'I would ask God to let me die, but God does not exist'. One night he repeated the same incomprehensible series of syllables for hours on end.

In March, 1880, he started to express quite absurd nihilistic ideas. He said there was no more night and so refused to go to bed, spending whole nights in his office and telling his wife that he could not go to bed as it was still daytime. He said he was not eating any more; no matter how ample were the meals he flew into a rage, saying there was nothing on the table.

Mr. C. was admitted to Vanves in April, 1880, and was found to be deeply disturbed mentally. He had no idea where he was nor how much time had passed since he left his house.

For much of the time he was quiet and said nothing, but at times he maintained that the people round him were assassins who were going to cut out his throat. He was seized by paroxysms of anxiety, during which he repeated the same words continuously in a wailing voice. He declared that he did not know who or where he was, that he was not married and had no children, father, or mother, and no name. According to his own account he never touched food, though in fact he ate a great deal. He felt he was in a desert where there was no one else and from which there was no escape because there were no more horse carriages. If he were shown a horse, he said, 'That's not a horse; it's nothing at all'. He resisted every attempt to look after his essential needs, refusing to have his clothes put on because, he said, his body was no bigger than a nut. He refused to eat because he said that he had no mouth or to walk because he had no legs. He would pull at his ears or nose and say they did not exist. Often he said he was dead, but during paroxysms of anxiety he said he was only half dead, and would never be able to die completely. He would take hold of his arm or his leg or calf and say 'This will never come off'.

At times Mr. C. appeared to have visual hallucinations. He saw women dressed in white coming down from the ceiling of this room. At other times he saw regiments of tiny horses, a 'few centimetres' high, crossing his room.

Physical examination revealed an impediment in his speech, an uncertain gait, and an inequality of his pupils. These symptoms of general paralysis became more and more marked during 1881. He also began to have delusions of grandeur relating to his past. He related how he used to be immensely rich and the foremost Barrister in Paris, a member of the Académie Française, and President of the Republic. Today, he maintained, he was nothing but a little idiot and, in addition, he was about to die.

By May, 1882, Mr. C. was reduced to a state of paralytic dementia. He can hardly walk and his speech is almost unrecognizable.
Case 11. Mrs. H., aged 31, was admitted in August, 1880. For about 15 years, following a serious attack of dysentery, Mrs. H. had had a cracking sensation in her back which she felt had become unhooked. At least four or five times since then Mrs. H. had stayed in bed for 9 or 10 months, once for more than a year. She claimed that she could not get up, and that her back was sinking into her stomach. About the beginning of 1880 she began to complain that everyone was against her; the ideas of persecution were concentrated on her son-in-law. She repeated for hours on end, "Why did my daughter marry X?" Admitted to Vanves in August, 1880, she said that she had been put under a spell, that she was damned and that there were animals, such as monkeys and dogs, inside her stomach. She heard voices, which in spite of herself urged her on to acts of violence. She begged for death but, at the same time, knew she could never die; in September of the same year she left the hospital in the same state of chronic insanity, to be transferred to another asylum.

Besides these few cases I could quote, at second hand, a fair number of case reports scattered in the literature that illustrate nihilistic delusions in their hypochondriacal form. I will, however, simply list the relevant references which are included in the bibliography, and will conclude this paper with a summary of the parallels between nihilistic delusions and delusions of persecution.

A Comparison of Delusions of Persecution to Nihilistic Delusions

Delusions of persecution

The patient does not usually present the general appearance of melancholia

Nihilistic delusions

Anxiety, groaning, precordial pain, etc. Patients belong to the category of melancholia with anxiety

Others fall into stupor. Some alternate between stupor and melancholia with agitation

Hypochondriasis, chiefly physical to start with

Hypochondriasis, chiefly mental at first

The patient blames the outside world, harmful influences coming from various quarters, especially from his social environment. He does not blame himself but rather boasts of his physical and mental strength and the excellent constitution which is able to endure so many ills

Suicide relatively rare

Suicide and self-mutilation very common

Homicide more common

Homicide less common
Delusions of persecution
Disturbances of sensation very rare
Continuous auditory hallucinations which develop in their own characteristic way

Nihilistic delusions
Disturbances of sensation, including anaesthesia
Often there are no hallucinations. When they do occur, they simply confirm the delusional ideas—consequently, there is no antagonism or dialogue between the patient and the voices which speak to him. When the patients talk spontaneously, they repeat continuously and monotonously the same words or sentences, addressed to the real people round them.

Visual hallucinations are very rare
Mental hypochondriasis follows; the persecutors attack the mental faculties of the patient to turn him into an idiot

Visual hallucinations are quite common
Physical hypochondriasis follows. The patient believes he no longer has a brain, stomach, heart, etc. He is either dead or will never die. His personality changes; some speak of themselves in the third person

Delusions of grandeur

Delusions of negation and annihilation. The patient denies everything: he has neither parents nor family; everything has been destroyed; nothing exists any longer; he is nothing and has no soul; God does not exist any longer

Partial refusal of food, through fear of poison. Patients pick over their food and eat voraciously when they are satisfied that it is not poisoned

Complete refusal of food. The nihilistic patients refuse because they say they are unworthy, cannot pay, have no stomach, etc.

The course of the illness is continuous or remittent with attacks
The course is at first intermittent, then becomes, continuous

SELECTED REFERENCES
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