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## Melancholy and Depression

*Though the doctors treated him, let his blood, and gave him  
medications to drink, he nevertheless recovered.*

Leo Tolstoy

It is generally accepted that the first term for a condition roughly corresponding to “depression” was “melancholy”, which dates back to Hippocrates and the dawn of medicine in the Hellenic world (fifth to fourth century BC). “Melancholy” refers to the basic foundation of Hippocratic medicine: the theory that the human body was made up of four “humours”. This was also echoed by Galenic medicine in the Roman world. In fact, this same idea was the theoretical foundation for most medicine right up until the nineteenth century, when it was finally abandoned because of the extraordinary advances in science and medicine during that period.

The foundation of the theory was that the human body was made up of four humours: blood, yellow bile, black bile and phlegm. Each of these was connected not only to the particular organ(s) where it was produced (the liver, the spleen, the gall bladder, the brain and lungs) but also to one of the seasons (spring, summer, autumn, winter) and

one of the four elements (air, fire, earth, water). Each of them was also considered to have particular qualities (warm and moist, warm and dry, cold and dry, cold and moist), and it was thought that the prevalence of particular humours also gave rise to certain personality types or “temperaments”: sanguine (blood), choleric (yellow bile), melancholic (black bile) and phlegmatic (phlegm).

Although humourist theory also took into account other factors—such as the environment, the season and the patient’s diet and stage of life—bodily health was thought to fundamentally depend on the humours. Balanced humours (eucrasia) resulted in good health, while unbalanced humours (dyscrasia) led to disease (Cabras et al. 2005). In contemporary terms, this theoretical framework would probably be defined as “holistic” because it saw a patient’s health as based on a range of internal and external factors.

The treatments derived from humourist theory were based on modifying certain dietary and external factors, as well as directly correcting the unbalanced humours in the patient’s body. In a patient with a sanguine temperament, for example, ailments would often be attributed to an excess of blood, and physicians would therefore try to reduce the amount of blood with leeches or bloodletting. This practice in particular was used widely right up until the end of the nineteenth century, as it was easy to come up with theoretical explanations attributing most health disorders to excess blood, which should be treated with bloodletting. Evidently, such treatments could only ever have negligible positive effects, so serious illnesses would often worsen during treatment, and it seems that when patients showed little response, physicians would then resort to repeated and extended bloodletting.

As well as bloodletting, physicians would also drain other fluids, attempting to remove the toxic elements responsible for the illness. They would do so by administering vomit-inducing medication (“emetics” such as ipecac and emetic tartar) or laxatives (“cathartics” such as cascara and senna), by cupping<sup>1</sup> and by applying “poultices” containing irritants and blister agents. “Demonic possession”, which was seen as a disease in itself, was the only exception to this because it was thought that it would not respond to medical treatment. Sufferers were instead left in the hands of religious authorities and exorcists (Greenstone 2010; Grube 1954; Lawlor 2012; Neuburger 1944; Belofsky 2013).

One famous historical example of these treatment methods was the case of King Charles II of England (1630–1685), who suffered an attack of convulsions and was treated by draining first 16 ounces of blood (approximately half a litre). This was followed by a further eight ounces of bloodletting. When this produced little response, he was subjected to an intensive course of enemas, poultices, herbal remedies and vomit-inducing emetics. He endured a total of 24 ounces of bloodletting before succumbing to his illness (Greenstone 2010).

The case of the US President George Washington was equally dramatic. When he deteriorated dramatically after an initial cold, his physicians treated him by drawing half a pint of blood (approximately a quarter of a litre), followed by a further 20, 20, 40 and 32 ounces. As his condition continued to deteriorate, bloodletting was combined with other treatments, including mercury salts, poultices, vesicants and an emetic tartar. He was then subjected to another 32 ounces of bloodletting before his death, at the age of 69, on the 14th of December 1799. His illness had lasted <2 days. During the most intense period of his treatment, a total of 3.75 litres of blood was drawn over 9–10 hours (Vadakan 2004).

These excesses show just how far therapeutic practices had strayed over the years from the original Hippocratic principles, which encouraged interventions that were respectful towards both the patient and the *vis medicatrix naturae*, or the “healing power of nature”. Early Hippocratic physicians even believed that the body had natural healing mechanisms that could deal with serious illnesses. The role of medical interventions was just to trigger these mechanisms: they were never meant to be excessive or cause harm (Grube 1954; Neuburger 1944). There was also the equally respectful principle of *primum non nocere*, or “first, no harm to the patient”, which has been maintained in various different forms down to the present day (Smith 2005).

Both of these principles helped to lay the foundations for the modern Darwinian evolutionary understanding of disease: namely that it is caused by an unfavourable combination of environmental and genetic-molecular factors, and that these same evolutionary drivers have also caused the development of healing mechanisms, which are normally very effective against illness (Nesse and Williams 1996).

These principles also helped to found the modern theory of “the natural history of disease”, which examines the spontaneous evolution of serious conditions, how they are often overcome without treatment, and what this means for the efficiency and safety of therapy.

Returning to the theme of melancholy, the first description of this condition appears in the time of Greek Hippocratic medicine (fifth–fourth century BC). It was described as causing prolonged fear and discouragement and associated with the dry cold of autumn and the earth. It was attributed to an excess of the black bile (*melaina chole*) from which it takes its name. Since this time, terms such as “black mood” and “melancholia”—with its linguistic variants *melanconia* and *malinconia*—have become common terms for a depressed state. Because bloodletting was often associated with the administration of laxatives and emetics, this gave rise to the idea of “catharsis”, or purification by releasing the moods or toxic substances causing suffering. The term was then extended to symbolic and psychological catharsis (Mattern 2011).

When considering the history of depression, it should be noted that, for many centuries, very little attention was paid to the mental illnesses and mood disorders of people from more disadvantaged classes who found themselves facing physical hardships such as wars and terrible epidemics. After the dawn of the Enlightenment, however, physical conditions began to improve for many, and more attention was paid to mental suffering. In English society at the end of the seventeenth century, the term “melancholia” was increasingly approaching the status of the milder conditions usually associated with the Victorian period, such as “hypochondria”, “hysteria”, “spleen”, “vapours”, the “English malady” and the “nervous breakdown” (Shorter 2013). This paved the way for the distinction between serious depressive disorders and milder but more widespread personal suffering. This latter category is associated with emotional and existential distress, and is a cultural, anthropological and medical construct which has changed continuously through the years (Shorter 2013). This is largely because the socially and medically accepted ways of describing personal suffering derived from familial and social hardship have changed many times (Shorter 1993).

Between the eighteenth and nineteenth centuries, different frameworks developed across England, Germany and France, largely because

of the emergence of a contradiction between the somatic and functional theories of mental suffering. The first framed mental illness as a disease of the body, akin to many illnesses that were treated with internal medicine. This school of thought believed that mental illness was caused by a range of anatomical, functional and pathological factors that could be traced back to the nascent neurology of Willis and his followers. The second theory, however, traced mental disorders to a functional discomfort or disturbance. In the hands of Sigmund Freud and Emil Kraepelin, this theory would later develop into the fields of psychology and psychoanalytics on the one hand, and psychiatry on the other.

The psychoanalytical work of Freud has unquestionably played an enormous part in explaining how the mind functions, and is still hugely influential today, particularly at a cultural level. Freudian thought had a particularly strong influence on North American psychiatry after the Second World War, largely because of a number of eminent Jewish psychiatrists who fled to the USA from Nazi Europe. The influence of psychoanalysis on US psychiatry declined after that, however, giving way to the irrepressible rise of biological psychiatry, which relegated psychoanalysis to a secondary role.

Psychiatry, faced with the advance of biological psychiatry, seemed set to lose even its limited remaining role in medicine. It was largely only practised in mental hospitals, and played a small part in patient care in the absence of effective therapeutic tools. It thus became essential to create a system that would allow the effective definition and diagnosis of mental illnesses. In the event, this system was based on vital work by Kraepelin: his nosographic classification.

Although Kraepelin's work observing mentally ill patients in Munich at the end of the nineteenth century was hugely influential, he is nevertheless decidedly less well known than Freud. In fact, Kraepelin's work laid the foundations for essential psychiatric diagnostic tools like the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM). As the name suggests, it is a hefty manual that enables diagnosis by listing the assessment criteria for patients' symptoms. It was first published in 1952, had its fifth edition in 2013, and has been a notable success for the American Psychiatric Association (APA). In fact, it has sold almost half a million copies to date.

In Europe, the *International Classification of Diseases* (ICD) was compiled by the World Health Organization (WHO) and published for the first time in 1948. It reached its tenth edition in 1992.

Over the years, the various editions of the DSM—including the recent DSM-5—have received much substantial, authoritative and well-founded criticism (Frances 2013a, b). The various editions of the ICD—which, unlike the DSM, cover *all* illnesses rather than just those of a psychiatric nature—have been embraced as useful classification and communication tools, aside from certain unresolved issues to do with creating diagnostic categories of psychiatric disorders.

At this point, however, it is perhaps useful to return to melancholy and depression to analyse how the relatively rare condition of serious melancholic depression became more frequent mild or moderate mood disturbances, and eventually became the modern “major depressive disorder” epidemic described by the DSM.

The creation of modern psychiatric diagnostic criteria was accompanied by significant changes to the definition of depressive mood disorders. Kraepelin’s definition of mental illness categories was based on the careful observation of a large number of clinical cases between the nineteenth and twentieth centuries. It was a time when many people were waiting for the joint work of neurologists and psychiatrists to prove that mental illnesses were caused by organic lesions of the brain. Kraepelin’s categories were based on the progression of the disease and the regularity of sets of symptoms (syndromes): these formed the basis for the subdivision of mental illnesses into two large groups. The first was made up of conditions characterised by thought disturbances that deteriorated over time, such as schizophrenia, then labelled *dementia praecox*. Conditions in this category required constant treatment, which could only be provided in mental hospitals.

The second category was made up of emotional and affective disorders, which typically manifested themselves episodically and could therefore go into temporary remission, allowing patients to return to everyday life. This condition was formerly labelled “manic depression”, meaning depressive episodes that alternate with episodes of manic excitement. It has been given various names over the years, including “manic depression” and “cyclothymia”, but it is now termed “bipolar disorder”. Kraepelin initially defined a unipolar depressive disorder,

“involuntional melancholia”, as separate from manic-depressive disorders, but abandoned the theory later. Kraepelin saw mania (characterised by elation, hyperactivity and tumultuous conception) and melancholy (characterised by a lowered mood and the inhibition of thought and bodily processes) as part of the same single morbid identity, the manic-depressive illness. He also saw that the depressive state could have different manifestations and degrees of severity, from the retardation of “melancholia simplex” and the psychotic symptoms of “melancholia gravis”, to the rarest and most serious form, “delirious melancholia”, which involved clouded consciousness and even catatonia (Bynum and Bynum 2011; Decker 2004; Engstrom 1991; Kraam 2002).

Sigmund Freud, a contemporary of Kraepelin, laid the foundations for an interesting alternative perspective. For Freud, mental suffering did not necessarily have physical causes, and was due to intra-psychic conflicts in the unconscious. Freud also saw that depression was often associated with anxiety, and it could be accompanied by physical ailments as well, such as a drop in a person’s libido and energy. The idea that a depressive mood disorder could have external causes—which today we might call a *reactive* theory—originates from Freud’s psycho-analytical studies, particularly those on mourning. Mourning is generally accompanied by transitory depression, which does not usually require intervention and is dealt with physiologically. This contrasts with melancholy, which is characterised by sadness, loss of pleasure and energy and a withdrawal from the external world. It is also endogenous and, unlike mourning, cannot be traced to unconscious psychodynamic adaptation mechanisms (Carhart-Harris et al. 2008; Flynn 1968; Lawlor 2012; Robertson 1979a, b; Shorter 1994; Spiegel 1976).

Overall, it seems that melancholy has gradually been relegated to a sort of theoretical and operational limbo, while the theory of two distinct, psychiatrically defined forms of depression has grown up in its place. In bipolar patients, depression is one of the two faces of manic depression and the patient passes from a state of manic excitement, which can entail dangerous behaviour if left untreated, to a state of depression, which in serious cases can even cause suicidal tendencies. These phases can vary in frequency and severity, and are interspersed with periods of quiescence. The severity of unipolar depression can also

range from mild—characterised by a lowered mood and anxiety, which is often a reaction to life events—to serious, which is endogenous, cannot be traced to external events, and is often accompanied by suicidal tendencies (Craddock and Owen 2010; Paykel 2008).

The first half of the twentieth century saw the creation of a diagnostic framework for illnesses, which gave rise to diagnostic manuals that classified mental illnesses in social, clinical, medical, legal and insurance terms. The various versions of the ICD have not met with particular scientific or methodological criticisms, and have enabled the adoption of a shared terminology to define morbid entities across all areas of health. The various editions of the DSM have also been hugely influential because they have helped to transform psychiatry from a marginal branch of medicine into a modern specialism, which could forsake brutal and inefficient treatments and adopt therapeutic approaches based on new drugs. The development of the DSM made all of this possible, so its evolution merits a closer examination.

## Note

1. An ancient Eastern practice in which small heated cups are placed on the skin. The subsequent loss of heat creates suction, which was meant to result in a curative action.

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Unhappiness, Sadness and 'Depression'

Antidepressants and the Mental Disorder Epidemic

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