CHAPTER 7

Conclusion: Melancholia, Depression, and the Politics of Classification

Opinion is not the same thing as evidence, of course. Yet how to read the evidence on affective illness has proven highly contentious, while the momentum of opinion is clear for all to see.[1]

Edward Shorter (2007)

The only things that one really knows about human nature is that it changes.[2]

Oscar Wilde (1891)

This book has sought to map the reconceptualisation of melancholia as a modern biomedical mood disorder in nineteenth-century psychological medicine. In the first half of the century, physicians began to draw on experimental physiology to explain mental phenomena, creating a language and conceptual framework with which to describe emotional functionality. Central to this framework was the concept of psychological reflex action, which allowed physicians to explain emotion as an involuntary act that was both physiological and psychological. Within this context, melancholia was reconstituted as a disorder of emotion, a pathological state that arose when the brain was subjected to repeated irritation, over time affecting the tone of the cerebral tissue, resulting in pathological reflexive action. At this time, the nosological status of melancholia in British literature was uncertain, as several medical writers sought to replace it with, or subsume it under, other categories such as monomania. Towards the end of the century, however, melancholia was one of the

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most frequently diagnosed conditions in British asylums, and the disorder was awarded considerable attention in diagnostic literature. Moreover, the internal biological model used to explain the disease, and the group of symptoms used to define and diagnose it, displayed remarkable coherence for its time.

The standardisation of melancholia in the second half of the nineteenth century occurred in a number of ways. First of all, the adoption by medical psychologists of a psycho-physiological framework for explaining mental disease facilitated a coherent internal model for this modern disease concept. Secondly, the argument that mental disease did not necessitate intellectual derangement but could be purely or largely affective became almost universally accepted within mid-century British medicine. Thirdly, following the creation of centralised bodies to oversee the implementation of lunacy law and the management of asylums, and the rapid growth of lunacy administration that followed, diagnostic and recording practices were increasingly standardised. Despite continued disagreement over nosology among Britain's asylum physicians, a de facto standardised system of classification emerged in which melancholia held a prominent position as an independent disease category. Finally, as a corollary of centralised lunacy administration and management, a large body of statistics was created containing every conceivable piece of information about Britain's asylum population. Statistical tables from around the country repeatedly suggested that melancholics were overwhelmingly suicidal, contributing to a homogenous symptom picture for melancholia in which suicidality was a defining criterion.

The story of how nineteenth-century biomedical melancholia was created and reified illustrates some of the inherent tensions within the psychiatric discipline, tensions that persist in the twenty-first century: on the one hand the conflict between biological disease models and descriptive nosologies, and on the other the uneasy relationship between neat medical categories and eclectic human life. The story of melancholia in this period constitutes only one small corner of psychiatric history, but it offers a window into the ways in which such medical knowledge about people is created and operates. As we saw in the final chapter, the people who were diagnosed with melancholia did not always fit so easily and neatly into this medical category. Rather, a multitude of different acts and expressions were merged into single keywords such as 'depression', 'mental pain', 'suicidal tendencies', and 'religious delusions'. Victorian physicians themselves acknowledged the difficulty in labelling

and categorising with accuracy the vast array of human emotionality with which they met on asylum wards and in hospitals and private practices. Nevertheless, they repeatedly emphasised the necessity of psychiatric classification, no matter how flawed any such system was. In this way, they set the trend for psychiatric epistemology ever since.

Alternative Models of Melancholia

In 1901 psychiatrist Bernard Hollander published a lengthy article in the *Journal of Mental Science* titled 'The Cerebral Localisation of Melancholia' in which he argued that recent neurophysiological data suggested a specific location in the brain for this emotional disorder.[3] Hollander's theory of mind was in part based on a revised version of Franz Joseph Gall's early nineteenth-century phrenological system, which enjoyed a period of popularity among the reading public, but which had been widely discredited by scientists. A decade earlier Hollander had presented a paper to the Royal Anthropological Institute in which he argued that recent neurophysiological experiments, especially those conducted by David Ferrier, provided ample support for a revised, 'scientific', version of Gall's phrenology. Drawing upon Charles Darwin's *The Expression of the Emotions in Man and Animals* (1872),[4] Hollander suggested a strong link between facial expressions and emotional states. Following from this, he held that galvanic experiments on animals eliciting various muscular contractions in the face normally seen to correspond to specific emotions indicated that different feeling states could be induced by exciting different parts of the brain.[5]

This view was, Hollander argued, clearly supported by Ferrier's experiments in which electric currents had been applied to 'the ascending frontal convolution' in monkeys, dogs, and cats 'with the effect of elevating the cheeks and angles of the mouth with closure of the eyes'.[6] Hollander proceeded to quote a substantial section from Darwin's *Expression*, suggesting that when men and animals alike are experiencing 'high spirits' the corners of the mouth will inevitably and universally be drawn upwards. This observation in conjunction with Ferrier's physiological experiments led him to conclude that 'pleasurable emotions produce a nerve current, which takes its start in this region'.[7] Ferrier attended the session and partook in the discussion that followed from Hollander's presentation. According to the notes from the debate, Ferrier was generally in favour of the idea of localisation of various mental functions, but

cautioned against conjectural leaps, suggesting that while Hollander's thesis begged consideration, present scientific research could not support his claims. However, Ferrier and the other attendants were in agreement that there may certainly be a future for more detailed and exact brain localisation of mental functions. The problem was how to proceed from the present vantage point to sound scientific explanation. Ferrier, in particular, suggested that while 'scientific phrenology might one day become possible', the route by which one could arrive at such a system must be staked out with care and precision.[8] Hollander's views on the localisation of melancholia were not widely appropriated at the time, but the attempts to locate emotion in specific parts of the brain have continued into the present.

Towards the end of World War I, Sigmund Freud published an article on 'mourning and melancholia' that offered a striking contrast to the biomedical model of the late nineteenth century, and to Hollander's neo-phrenological argument for the localisation of melancholia. Freud compared melancholia to mourning, noting that the two states of mind broadly shared the same features, but only the former was generally regarded as a form of illness. Mourning was for Freud a response to 'object-loss' and he conceptualised melancholia along the same lines, with one significant difference—in mourning, the loss of object was clear and the sufferer aware of it, but in melancholia the loss was unconsciously experienced. In other words, '[i]n mourning it is the world which has become poor and empty; in melancholia it is the ego itself'.[9] In this way, Freud brought attention to what had been perceived by Victorian physicians as their patients' (incorrect) assessment of their suffering—i.e. that it was without cause. The argument that pathological low mood could be distinguished from ordinary sadness or grief in part due to the absence of external cause was equally part of early-to-mid-twentieth-century descriptions of clinical depression. It must be noted, however, that this criterion was always an ambiguous one, an emotional trauma such as bereavement were often perceived to trigger disorder. On the question of causation, then, the boundary between ordinary and pathological sadness was never clear. And as will be seen momentarily, it was further obscured with the reconstitution of depressive illness as Major Depressive Disorder in the last quarter of the twentieth century.

From Melancholia to Depression

Where, then, does the history of melancholia end and the history of depression begin? In the first decades of the twentieth century the use of melancholia as a diagnostic category rapidly declined. However, whether one writes the history of melancholia as a word, or as a concept or concepts, no clear-cut end point exists—as we saw in the Introduction, melancholia is inextricably linked to depression in contemporary literature, both psychiatric and historical. Moreover, the term melancholia has continued to feature peripherally in medical language throughout the twentieth and early twenty-first centuries, and both melancholy and melancholia appear with some regularity in the language and imagery of popular culture, literature, and philosophy.[10] However, the biomedical model of melancholia that reached its apex in British psychological medicine in the last three decades of the nineteenth century did not retain this prominent position for long, nor did it remain aetiologically and symptomatologically stable. With the emergence of an increasing number of conceptual frameworks for explaining the mind, and a growing separation of asylum and outpatient psychiatry, focus began to shift. Maudsley's argument in favour of bringing medical attention to bear upon what might be perceived as non-pathological emotional states came to inform practice and theory within the psy disciplines to an ever greater extent, particularly in the realm of psychoanalysis.

Two events at the turn of the twentieth century had significant repercussions for the classification and diagnosis of low mood. The first of these was the nosology introduced by Emil Kraepelin in 1899, in which he divided mental disorders into dementia praecox and manic-depressive insanity, that is, into a broadly cognitive illness and a broadly affective one. European psychiatrists had been gradually moving towards this kind of classification for some time. As we saw in Chapter 4, Maudsley had divided insanity into affective and ideational in 1867. In the early 1890s, Krafft-Ebing suggested that most forms of mental disorder could be separated into 'psychoneuroses' and 'psychic degenerations'. The former category included melancholia and mania, which he perceived as largely curable and with later onset, while the latter, which included constitutional affective insanity and paranoia, often appeared earlier in life and were more likely to become chronic. Kraepelin's subsequent division was, then, in part a rearticulation of existing knowledge. However,

dementia praecox and manic-depressive insanity were classified as individual conditions with subtypes rather than as umbrella categories. This had important consequences for melancholia, which was largely done away with as a stand-alone category. Its symptoms were subsumed under manic-depressive insanity as a depressive stage, with the exception of 'involutional melancholia', a particular type of mood disorder that Kraepelin saw as affecting the elderly.[11]

Kraepelin's nosology proved hugely influential, both in the immediate years following its initial publication, as well as for the reform of psychiatric classification that occurred in the last quarter of the twentieth century with the arrival of *DSM-III*, the third edition of the APA's diagnostic manual. *DSM-III*, first published in 1980, has been referred to as 'neo-Kraepelinian'.[12] It endorsed a clear separation between affective and cognitive disorders, and presented a version of depressive illness in which many symptoms of melancholia, in particular delusions and hallucinations, were marginalised. 'Depression' had eclipsed (rather than replaced) melancholia as the major non-cyclical mood disorder by this point, a development that was set into motion in the first decade of the twentieth century. Kraepelin's dichotomy had threatened to all but erase melancholia from diagnostic literature, but the concept of a unitary depressive disorder was retained with the shift to a new term for this type of illness: depression.

At a 1905 meeting of the New York Neurological Society, Adolf Meyer had suggested that melancholia was not particularly useful as a diagnostic category, since the name 'implied a knowledge of something' that medicine 'did not possess'. He proposed to do away with it entirely, to be replaced by a symptomatic term that described one of the most tangible features of this illness:

> If, instead of melancholia, we applied the term depression to the whole class, it would designate in an unassuming way exactly what was meant by the common use of the term melancholia; and nobody would doubt that for medical purposes the term would have to be amplified so as to denote the kind of depression. In the large group of depressions we would naturally distinguish our cases according to aetiology, the symptom-complex, the course of the disease and the results.....The distinction had best be made according to the intrinsic nature of the depression. From that point of view we might distinguish the pronounced types from the simple insufficiently differentiated depressions.[13]

One must be careful not to suggest that melancholia became depression. There was no simple transition from one to the other, and the field of emotional disorders was further confounded by a focus on the 'war neuroses' of WWI.[14] There are many overlaps between the two categories, but they are not, and have never been, interchangeable. Kraepelin's and Meyer's classifications of low mood were influential and durable, and many early twentieth-century diagnostic texts incorporated elements of both. In this way, depression became cemented as an independent category alongside manic-depressive insanity. When the first edition of the *DSM* was published in 1952, a fusion of the two systems produced a nosology that echoed Maudsley's 1867 division of melancholia, whereby depression was divided into two types, a neurotic and a psychotic version. A similar division of depression had been presented in the WHO's *International Classification of Diseases (ICD)* in 1949. In the early post-war period, then, it was widely accepted within Anglo-American psychiatry that two types of depressions existed: a simple or neurotic form, and a melancholic or psychotic. *DSM-III* did away with this division with the introduction of 'Major Depressive Episode' (later also 'Disorder'). Today this ubiquitous mood disorder reigns supreme, but melancholia or melancholic depression has continued to exist alongside, and in an increasingly uneasy relationship with, the now more mainstream depressive illness favoured by the major diagnostic manuals. Standard depression is defined as low mood, loss of interest or pleasure, fatigue, bodily retardation, guilt or feelings of worthlessness, insomnia or hypersomnia, changes to appetite and body weight, and suicidality (symptoms must be present for at least two weeks). The most marked difference between depression so defined and melancholia is the absence of psychotic symptoms in the former. Since the arrival of *DSM-III*, these are retained only for a minor subtype, depression 'with melancholic features'.

This way of classifying low mood, which was maintained in the fifth (2013) edition of the *DSM*, has been subject to much critique both from within and outside the field of psychiatry.[15] One major criticism is that the category Major Depressive Disorder is too broad, and that its criteria blurs the boundary between normal and pathological low mood. The *DSM-III* task force did away with a previous 'bereavement exclusion' qualifier, meaning that depression was no longer distinguished from ordinary low mood by the absence of cause. Moreover, the period for which symptoms had to manifest for a diagnosis was shortened from one month to two

weeks. These decisions led critics to argue that the category depression has been expanded to the point of becoming largely useless.[16]

The second criticism of Major Depressive Disorder concerns the decision of the APA to endorse a single unitary depression instead of the two types referred to above. Edward Shorter argues that this was not a decision based on scientific evidence. Rather, he suggests, the *DSM-III* task force had originally intended to include a 'minor' and 'major' depression in the new manual, but felt under pressure to drop the former as 'insurance companies would never pay for anything "minor"'.[17] As discussed in the Introduction, advocates of the two depressions model continue to argue for the reinstatement in diagnostic literature of a second, more severe form of psychotic or melancholic depression, which is defined both in terms of mental and physical symptoms and specific biological markers. Shorter and colleagues argue that the key to such a definition of melancholia—one that is both clinically and biologically reliable—lies with a combination of symptomatological descriptions (a statistically based system) and measurable biological markers (a physiological foundation). Shorter has contributed a historical perspective as one of the key building blocks of the case for the resurrection of melancholia. His narrative is one in which 'biological psychiatry' was founded in the nineteenth century and has continued to develop along a progressive (albeit bumpy) path ever since.[18] In 2007, the year after the Copenhagen conference discussed in the Introduction, Shorter published a book together with Conrad Swartz on 'psychotic depression', which presented a more detailed version of the argument for an endocrine-based definition of melancholia. The marginalisation of endocrinal research in psychiatry, they argue, has occurred to the detriment of this branch of medical science, as it holds the key to a greater understanding of mental disorders.[19] Shorter and colleagues are far from alone in the desire to—finally—make psychiatry truly biological. When work on the fifth edition of the *DSM* was still ongoing, the head of the US National Institute for Mental Health argued that such a reconstitution of psychiatric classification is essential because '[p]atients with mental disorders deserve better'.[20] This line of argument is significant; a system of classification that recognises the biological (neurological, genetic, endocrinal) basis of mental disorders is in the best interest of the people who are perceived to be suffering from such conditions.

However, advocates for the 'resurrection' of melancholia as a distinct mood disorder with biological markers also point to historical evidence in making their argument, suggesting that melancholia is a universal,

timeless condition that has always existed. The temptation to draw on history to legitimise current psychiatric knowledge is obvious, but it is both unhelpful and unnecessary. The question is not so much whether or not we *can* plausibly diagnose people in the past with current conditions and vice versa, but rather, whether we should. What is gained by doing so? Does it serve its intended purpose, that is, if we can show that people have suffered from the same illness throughout history, does this affirm that the condition is real? It is difficult to see how it does. Historical records tell us nothing about the experience, psychopathology, or biological reality of people in the present. The current empirical data that forms the basis of arguments for a distinct melancholic depression is convincing, and if the APA and the WHO agreed to formally recognise melancholia as presently described, this could potentially benefit people suffering from severe low mood with psychotic and pronounced bodily symptoms, in terms of swifter access to more appropriate treatment. One might argue, then, that there is an urgent need to formally accept the validity of a melancholic depression as a distinct diagnosis. But it does not follow that this is done by demonstrating universality across time. The idea that this is a possible and plausible approach to scientific knowledge echoes a Baconian perception of 'nature' as something that human beings can observe, intervene with, and learn from, and about which universal truths can be demonstrated. But this idea of nature is itself historically specific. And moreover, the scientific method cannot be applied to long-dead historical subjects whom we believe to have suffered from melancholia, nor to the documents they have left behind.

Current medico-scientific knowledge about melancholia does not gain its validity and legitimacy from its presumed timelessness and universality. Rather, if it is a valid and legitimate diagnosis reflecting the experience of living subjects in the present, it is precisely because it is real right now. Projecting it onto past and long gone individuals who are only names on papers does not help to make it more 'true' in the present. What it does, however, is threaten to demote history from its place as a rich, constructive, and critical human science, a science that offers a different kind of insight, by showing how things change, and how knowledge is produced, instead reducing it to a one-dimensional discipline, the main task of which is to lend legitimacy to current knowledge within the natural sciences. When it comes to medical knowledge about the emotional life of humans, we might do better to distinguish the past from the present. Much can learnt about each from the other, but there is little to be gained from

attempting to equate the two. This does not diminish current knowledge about melancholic depression. What we know today is not any less valuable or helpful because it applies only to the present and not the past. When it comes to treating people, to alleviating severe and debilitating low mood, it is our actions in the present and the future that matter. This is the real value of medical knowledge—what we can do with it right now.

The real value of history is not as a legitimising tool for such knowledge, rather it is to show how present knowledge (medical or any other) was created, and in this way help us gain a broader, deeper, and richer understanding of the human condition. This should not be taken as a rejection of biological claims about human beings. The aim here is not to replace scientific conceptions of self, of mind and emotions, with historical ones. The division between the human and the natural sciences is equally historically constituted[21]; these different 'sciences' represent different ways of knowing ourselves and our world, a multitude of 'partial perspectives'.[22] Rather than foregrounding one as the source of truth, a more hopeful approach would be to consider the wealth of knowledge at our disposal when we are able to allow for multiple epistemologies. The antagonistic relationship often perceived between the natural sciences and the humanities is both unnecessary and unhelpful. What we might better strive for is an 'affirmative relationship' between these spheres, a relationship that, in the words of Nikolas Rose

> seeks to identify and work with those arguments that recognize, in whatever small way, the need for a new and non-reductionist biology of human beings and other organisms in their milieu, and which can thus be brought into conversation with the evidence, concepts and forms of analysis developed in the social and human sciences.[23]

The Politics of Pathological Emotionality

There are further reasons for promoting a more flexible, multidisciplinary, and multifaceted view of what it means to be human and of our emotional life. Medical approaches to low mood have undergone a number of significant shifts over the last two hundred years, one of which has been the focus of this book. Another was the rise of social models of depression in the mid-twentieth century,[24] which emerged in the context of the construction of the post-war Keynesian welfare state. In contrast to this, twenty-first-century biological approaches to emotion

and its disorders can be seen as closely wedded to a neoliberal worldview. The link between socio-economic inequality and psychological distress such as depressed mood is widely acknowledged,[25] yet the dominant treatment for depression relies on the perception of pathological low mood as an individual problem of neurochemistry and emotional dysregulation. Clinical guidelines favour functional and cost-effective and/or profitable treatment approaches geared towards getting people back to work, specifically Cognitive Behavioural Therapy (CBT) and antidepressant medication.[26] Much has been written on the relationship between contemporary models of depression and the rise of antidepressants on the one hand, and neoliberal capitalism on the other.[27] The central aim of CBT and its sister therapy Dialectical Behaviour Therapy (DBT), emotion regulation, must equally be understood within the context of political economy.[28]

The pre-twentieth-century origins of emotion regulation have received scant attention by historians. As this book has shown, in the Victorian period a belief that most forms of insanity commenced with emotional disturbance was widely held among British physicians. Related to this was the view that many lunatics could not be held responsible for their actions.[29] The disordered emotions of the insane and the acts resulting from these (such as suicide) were not to be morally condemned, but biologically explicated and medically treated. Yet at the same time, physicians such as Henry Maudsley held that the development of pathological emotionality could be prevented through conscious individual effort. Persistent practice to monitor and master one's emotions would over time result in the formation of a healthy mind and moral conduct.[30] The idea that insanity could be prevented and that the development of a healthy mind was an individual duty was underpinned by a cultural framework where self-help and individual responsibility were celebrated virtues, and where 'freewill' was a powerful philosophical and political concept.[31]

This cultural framework has seen a resurgence in the age of neoliberalism.[32] The efficacy of the neoliberal programme is in part resulting from the ability of its proponents to successfully promote it as a non-ideological, rational, 'common sense' approach to economics and the organisation of society.[33] Over the last four decades, the core principles of neoliberalism have come to permeate every facet of human existence. Rose explains the subtle and effective ways in which what he refers to as 'advanced liberalism' has become an integral part of contemporary life, creating a society in which 'the regulation of public conduct' is closely

linked to and underpinned by 'the subjective emotional and intellectual capacities and techniques of individuals, and the ethical regimes through which they govern their lives'.[34] Psychiatric and psychological strategies aimed at regulating pathological emotion and behaviour are one such ethical regime. In Britain today, the programme of individual self-help promoted by cognitive behavioural strategies is situated within a Conservative approach to welfare that measures an individual's health or illness in terms of their ability to perform productive work.[35] Both CBT and DBT are seen as functional and cost-effective strategies,[36] and a key goal of these at present is to return the individual to active society—and to paid labour—by treating the symptoms of mental distress in isolation from their wider social causes. Meanwhile, illustrating the paradoxes of the present system, government policies aimed at incentivising people to return to work have been shown to be a major cause of psychological distress, at times so profound it causes individuals to take their own lives.[37]

How are we to make sense of and address depression and melancholia in this context? In the first instance, the presently dominant way of classifying low mood sits well within the current economic framework. Major Depressive Disorder, as currently defined, constitutes a collection of symptoms that are perceived to respond well to standard antidepressant medication and CBT. Melancholic depression, which is seen as requiring different and more comprehensive psychiatric care and treatment, fits less comfortably in this context. This brings us to the problem of 'correct' classification in psychiatry, which has been a central theme of this book. As the present story illustrates, there is nothing natural or inevitable about how psychiatry defines, labels, and classifies human emotionality. Many of the decisions made about the classification of melancholia in the nineteenth century were the result of administrative concerns and the need to make diagnostic practices more efficient in the context of expanding asylum populations and limited resources. Similarly, the decision by the *DSM-III* task force to do away with a more severe, melancholic depression was at least in part motivated by financial concerns. It is perhaps unavoidable that nosological decisions will be driven not only by a desire for correct diagnosis and suitable treatment, but also by various political factors. There is no conclusive evidence regarding the former, and the latter includes many powerful forces, such as insurance providers and pharmaceutical companies.

While persistent conflicts and disagreement over how to classify mental disorders have plagued the psychiatric profession since its infancy, there has nevertheless been overwhelming support for the argument that classification is necessary. Critique of the usefulness and benevolence of classification is, however, growing, both from within and outside the psy disciplines. It has been suggested that the 'poor validity' of psychiatric diagnostics and the expansion of diagnostic categories to include an increasingly wide range of human behaviour cause more harm than good to the people whom psychiatry is meant to help, and that the current system of classifying psychological distress as specific mental disorders would be better replaced with an 'operational definition of different experiences and phenomena' without denoting clusters of these as specific disorders.[38] Callard and Bracken have highlighted some of the ways in which psychiatric labelling can be harmful. These include 'diagnostic overshadowing', whereby an existing psychiatric diagnosis can lead to the patient's physical symptoms being automatically attributed to that diagnosis, precluding a full medical investigation of those symptoms, as well as the long-term institutionalisation that can result from some types of psychiatric diagnoses. They conclude that diagnosis in psychiatry on the whole does more harm than good, and that 'the [mental health] interventions that have arguably empowered people the most, such as innovative community services, have not been diagnosis specific'.[39] Cooke and Kinderman have furthermore drawn attention to the problem of stigmatisation. Their critique centres on the schizophrenia diagnosis and the stigma attached to this psychiatric label, which in their view renders an already vulnerable group of people even more so. Adding to this are the 'feelings of hopelessness' that can result from being diagnosed with what is largely seen as a 'chronic' mental illness.[40]

The latter concern speaks to the complex and sometimes harmful relationship between psychiatric diagnosis and identity. Arguments for parity between physical and mental health often turn to current biological models of psychiatric illness to suggest that these two areas of pathology should be treated the same because they are the same—in this way, depression is no different from cancer or a broken leg. However, parity does not have to be based in sameness. On the contrary, such arguments are potentially harmful. In the first instance, psychiatric illness concerns the part of us that is most central to our personhood—the mind. While we continue to debate social and biological causes of mental

distress, the ways in which such distress manifests are primarily (but not only) psychological and consequently also relational and identity-based, in ways that a broken leg is not. Attempts to frame mental disorders in strictly biological terms carry the risk of imprinting human beings in all their complexity with simplistic, reductionist biological stamps, which can potentially have a self-perpetuating effect. Secondly, as people internalise their diagnoses, this can feed back into, and reinforce, psychiatric labels (what Ian Hacking called 'looping effects'[41]). And finally, following from this, attempts to destigmatise 'mental illness' by framing psychiatric conditions as chiefly biological and to be equated with other medical conditions can lead people to feel 'less optimistic about their ability to get better' and increase public 'perceptions of dangerousness and unpredictability' of such disorders.[42]

At the same time, we must be careful not to simply reject existing diagnoses as not 'real' or 'true'. If depression exists in psychiatric literature as a mental illness, if people are diagnosed with this condition, and if they consequently experience themselves as 'having depression' or 'being depressed', then depression is inevitably a real thing. Moreover, framing one's suffering in medico-scientific terms is undoubtedly helpful for many people, especially in terms of alleviating feelings of guilt, shame, and personal responsibility. A more helpful and nuanced approach then, as we think about the future of psychological distress and psychiatric diagnostics, is to accept and validate both the concept and experience of 'depression' or 'melancholia' and other diagnoses as legitimate medical conditions, while at the same time allowing equal space for other explanations for and ways of naming difficult psychological experiences. And finally, it is imperative that we continue to argue forcefully for a comprehensive and multifaceted model of psychological distress that places human suffering in the context of material reality. A strict framing of severe and debilitating low mood as an internal problem, with the pathology located solely in the individual, marginalises critical approaches to the social and economic causes of emotional distress, and excludes political solutions to a problem that is increasingly shown to at least in part be the product of ideological decisions.

Conclusion

This book has mapped the reconstitution of melancholia as a modern biomedical mental disease in Victorian psychological medicine. It has tried to show how this medical category was created and reified through a combination of ideas and practices, which were specific to their temporal and cultural context. At the same time, however, many of the concepts that emerged through the creation of biomedical melancholia continue to inform current perceptions of emotion as a biological event that is subject to pathologisation. There are undoubtedly many similarities between nineteenth-century melancholia and our time's depression, as well as between these two conditions and earlier forms of melancholy and melancholia. But similarities across time should not be mistaken for inevitability. One must be careful to avoid falling into teleological traps when approaching historical events. When stories of people in the past appear familiar to the twenty-first-century reader, such familiarity is at least partly read into past accounts by those who are doing the reading. History is made now, in the present. By arguing for universality of human experiences based on current knowledge frameworks, the possibility for different accounts not just of the past but also of the present and the future are potentially foreclosed. As this book has aimed to show, the idea of pathological emotionality, of 'mood disorders', is historically specific. It was once created, made—which consequently implies that it can be unmade. This is where history becomes more than storytelling or academic pursuit. It shows that things can change, including the possibilities and limits of human experience. History, then, holds the promise of hope, of a future different from both the present and the past.

Notes

1. Edward Shorter, "The Doctrine of the Two Depressions in Historical Perspective," *Acta Psychiatrica Scandinavica*, 115, S43: 5.
2. Oscar Wilde, *The Soul of Man under Socialism* (The Floating Press, 2009 [1891]), 51.
3. Bernard Hollander, "The Cerebral Localisation of Melancholia," *Journal of Mental Science* 47 (1901): 458–485.
4. Charles Darwin, *The Expression of the Emotions in Man and Animals* (London: J. Murray, 1872).

5. Bernard Hollander, "A Demonstration of Centres of Ideation in the Brain from Observation and Experiment," *Journal of the Anthropological Institute of Great Britain and Ireland* 19 (1890): 13. Hollander's localisation theory was provided with further rationale in the form of changes observed in patients following surgery to treat brain injuries, which he suggested indicated the specific localisation of melancholia in the parietal lobe, confirming that it was chiefly an emotional rather than an intellectual disorder. Bernard Hollander, "Can Insanity Be Cured by Surgical Operation?" *The Phrenologist* 6 (1907): 53–59.
6. Hollander, "A Demonstration," 15. See also Tiffany Watt-Smith on how Darwin's concept of the 'flinch' as an 'emotional gesture' reflected wider Victorian perceptions of the external manifestations of feeling: "Darwin's Flinch: Sensation Theatre and Scientific Looking in 1872," *Journal of Victorian Culture* 15, No. 1 (2010): 101–117.
7. Hollander, "A Demonstration," 15.
8. Cited in Hollander, "A Demonstration," 24–25 ('Discussion').
9. Sigmund Freud, "Mourning and Melancholia," reprinted in *The Standard Edition of the Complete Works of Sigmund Freud, Volume XIV (1914–1916)*, eds. James Strachey and Anna Freud (London: The Hogarth Press, 1957), 243–246 (quotation p. 246).
10. For instance, Danish director Lars von Trier named his film about depression as a metaphorical Armageddon 'Melancholia'. See also e.g. Julia Kristeva, *Black Sun: Depression and Melancholia* (New York: Columbia University Press, 1989).
11. Emil Kraepelin, *Psychiatrie: Ein Lehrbuch für Studirende und Aertze*, II Band, 6 Aufl. (Leipzig: J.A. Barth, 1899), 317–318. In the (abbreviated) English version of the textbook, the subcategory is translated as 'involutional melancholia'. Emil Kraepelin, *Clinical Psychiatry: A Text-Book for Students and Physicians*, 6th ed. (New York: Macmillan, 1904), 254.
12. Tayla Greene, "The Kraepelinian Dichotomy: The Twin Pillars Crumbling?," *History of Psychiatry* 18, No. 3 (2007): 361–379.
13. Adolf Meyer, quoted in "Proceedings of the New York Neurological Society," *Journal of Nervous and Mental Disease* 32, No. 2 (1905): 114.
14. e.g. Rhodri Hayward, "Sadness in Camberwell: Imagining Stress and Constructing History in Post-War Britain," in *Stress, Trauma and Adaptation in the Twentieth Century*, eds. David Cantor and Edmund Ramsden (Rochester, NY: Rochester University Press, 2012); Christopher M. Callaghan and German E. Berrios, *Reinventing Depression: A History of the Treatment of Depression in Primary Care, 1940–2004* (Oxford: Oxford University Press, 2005).
15. E.g. Thomas Insel et al., "Research Domain Criteria (RDoC): Toward a New Classification Framework for Research on Mental Disorders," *American Journal of Psychiatry* 167, No. 7 (2010): 748–751; Andy

Coghlan and Sarah Reardon, "Psychiatry Divided as Mental Health 'Bible' Denounced," *New Scientist*, 3 May 2013, http://www.newscientist.com/article/dn23487-psychiatry-divided-as-mental-health-bible-denounced.html#.UhSi4z-1tBE. See also Mark Moran, "Continuity and Changes Mark New Text of DSM-5," *Psychiatric News*, 18 January 2013, http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=1558423.

16. Allan V. Horwitz and Jerome C. Wakefield, *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder* (Oxford: Oxford University Press, 2007), 95–103.
17. Edward Shorter, *How Everyone Became Depressed: The Rise and Fall of the Nervous Breakdown* (Oxford: Oxford University Press, 2013), 134–135.
18. Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: Wiley, 1997).
19. Conrad M. Swartz and Edward Shorter, *Psychotic Depression* (Cambridge: Cambridge University Press, 2007).
20. Thomas Insel, "Director's Blog: Transforming Diagnosis," National Institute for Mental Health, 29 April 2013, http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml.
21. Roger Smith, *Being Human: Historical Knowledge and the Creation of Human Nature* (Manchester: Manchester University Press, 2007), Chapter 3.
22. Donna Haraway, "Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective," *Feminist Theory* 14, No. 3 (1988): 575–599.
23. Nikolas Rose, "The Human Sciences in a Biological Age," *Theory, Culture & Society* 30, No. 3 (2013): 24. At a time when interdisciplinarity is all the rage, it is worth considering the practical, political, and ethical challenges of collaboration between the natural, human, and social sciences. Callard and Fitzgerald draw on their own experience of interdisciplinary collaboration to shed light on and interrogate the object that is interdisciplinarity, asking what is at work—and at stake—when researchers from different epistemological traditions come together. Felicity Callard and Des Fitzgerald, *Rethinking Interdisciplinarity across the Social Sciences and Neurosciences* (Basingstoke: Palgrave Macmillan, 2015).
24. Hayward, "Sadness in Camberwell".
25. A wealth of research across disciplines suggest a link between socio-economic inequality and depression (as well as other mental health conditions). See for instance: Vincent Lorant, et al., "Socioeconomic Inequalities in Depression: A Meta-Analysis," *American Journal of Epidemiology* 157, No. 2 (2003): 98–112.
26. See e.g. "Depression in Adults: Recognition and Management," National Institute for Health and Care Excellence (October 2009, last updated

April 2018). For a critique of policy approaches to depression in the age of neoliberalism (using Canada as an example), see Katherine Teghtsoonian, "Depression and Mental Health in Neoliberal Times: A Critical Analysis of Policy and Discourse," *Social Science & Medicine* 69, No. 1 (2009): 28–35.

27. See e.g. Joanna Moncrieff, "Psychiatric Drug Promotion and the Politics of Neoliberalism," *British Journal of Psychiatry* 188 (2006): 301–302.
28. Åsa Jansson, "Teaching 'Small and Helpless' Women How to Live: Dialectical Behaviour Therapy in Sweden, ca 1995–2005," *History of the Human Sciences* 31, No. 4 (2018): 131–157. DBT was developed specifically to treat (primarily women) diagnosed with Borderline Personality Disorder who were perceived to engage in suicidal and self-harming behaviour. It places significant emphasis on self-help and individual responsibility, and has been framed as a cost-effective strategy to treat a group of patients among whom the prevalence of in-patient care was traditionally high. In this context, it is also important to note, as Chris Millard does, that 'neoliberalism's stress on individual actors' radical freedom to make choices for their own benefit fits well with a model of self-harm that emphasises the individualistic, private feelings of tension, and the self-regulation of these through cutting'. Chris Millard, *A History of Self-Harm in Britain: A Genealogy of Cutting and Overdosing* (London: Palgrave Macmillan, 2015), 205.
29. This view, which remained controversial and contested throughout the Victorian period, formed the basis of the insanity defence, institutionalised following the M'Naghten trial of 1843. The argument was, however, subject to much disagreement both within and outside of the medical community. For an excellent look at the discussions on insanity and legal responsibility, see Roger Smith, *Trial by Medicine: Insanity and Responsibility in Victorian Trials* (Edinburgh: Edinburgh University Press, 1981), esp. pp. 14–17 for the M'Naghten rules.
30. See e.g. Henry Maudsley, *Body and Will* (New York: D. Appleton & Co, 1870), 93.
31. Roger Smith, *Free Will and the Human Sciences in Britain, 1870–1910* (London: Pickering and Chatto, 2013).
32. By this I mean the period from the late 1970s/early 1980s onward, when Keynesian economics were gradually abandoned in the West in favour of a neoliberal approach, which also came to be reflected in the policy orientation of international institutions such as the IMF, and forced upon much of the Global South through Western economic dominance both within and outside of institutional frameworks.
33. Stuart Hall in part attributes this to British pragmatism: Stuart Hall, "The Neo-Liberal Revolution," *Cultural Studies* 25, No. 6 (2011): 705–728.

See also Nick Srnicek and Alexander Williams, *Inventing the Future: Postcapitalism and a World without Work* (London: Verso, 2016), 60–64, who refer to neoliberalism as 'the single most successful hegemonic project of the last fifty years'.

34. Nikolas Rose, "Government, Authority and Expertise in Advanced Liberalism," *Economy and Society* 22, No. 3 (1993): 286–287.
35. For a critical analysis of the Work Capability Assessments see Benjamin Barr et al., "'First, Do No Harm': Are Disability Assessments Associated with Adverse Trends in Mental Health? A Longitudinal Ecological Study," *Journal of Epidemiology and Community Health* 70 (2016): 339–345.
36. See e.g. Sandra Hollinghurst et al., "Cost-Effectiveness of Therapist-Delivered Online Cognitive-Behavioural Therapy for Depression: Randomised Controlled Trial," *The British Journal of Psychiatry* 197, No. 4 (2010): 297–304; Roy Krawitz and Erin M. Miga, "Financial Cost Effectiveness of Dialectical Behaviour Therapy (DBT) for Borderline Personality Disorder (BPD)," in *The Oxford Handbook of Dialectical Behaviour Therapy*, ed. Michaela A. Swales (Oxford: Oxford University Press, 2018); Franske J. van Apeldoorn et al., "Cost-Effectiveness of CBT, SSRI, and CBT + SSRI in the Treatment for Panic Disorder," *Acta Psychiatrica Scandinavica* 129, No. 4 (2013): 286–295.
37. "Mental Health Discrimination 'Built into' Work Capability Assessment," Heriot Watt University, 23 February 2017, https://www.hw.ac.uk/news/articles/2017/mental-health-discrimination-built-into-work.htm. For a comprehensive analysis and critique of the link between suicide and austerity driven policies underpinned by neoliberal ideology see China Mills, "'Dead People Don't Claim': A Psychopolitical Autopsy of UK Austerity Suicides," *Critical Social Policy* 38, No. 2: 302–322.
38. Peter Kinderman, John Read, Joanna Moncrieff, and Richard Bentall, "Drop the Language of Disorder," *Evidence-Based Mental Health* 16 (2013): 2–3.
39. Felicity Callard, Pat Bracken, Anthony Davies, and Norman Santorius, "Has Psychiatric Diagnosis Labelled Rather Than Enabled Patients?" *BMJ*, 347 (2013): 4312–4313.
40. Anne Cooke and Peter Kinderman, "'But What About Real Mental Illnesses?' Alternatives to the Disease Model Approach to 'Schizophrenia'," *Journal of Humanistic Psychology* 58, No. 1 (2017): 58–59.
41. Ian Hacking, "The Looping Effects of Human Kinds," in *Causal Cognition: A Multidisciplinary Debate*, eds. Dan Sperber, David Premack, and Ann James Premack (Oxford: Clarendon Press, 1995).
42. Ashok Malla, Ridha Joober, and Amparo Garcia, "'Mental Illness Is Like Any Other Medical Illness': A Critical Examination of the Statement and Its Impact on Patient Care and Society," *Journal of Psychiatry & Neuroscience* 40, No. 3 (2015): 147–150.

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