# Introduction

## 1 The persistence of melancholia

Lars von Trier's 2011 feature film *Melancholia* tells the story of two sisters, the incorrigibly chaotic, selfish, and depressed Justine, played by Kirsten Dunst, and the organized, calm, and caring Claire (Charlotte Gainsbourg).[1] Or that is how they behave in the first half of the film, titled 'Justine'. In the second half, 'Claire', they seem to swap characters, and it is Claire who is erratic, anxious, and self-centred. A mysterious planet Melancholia is menacingly approaching the Earth. Governments and scientists have assured the public that Melancholia will fly past harmlessly, but Justine believes what she reads in the wilder reaches of the internet: that the planets will collide and Earth will be destroyed. Sure enough Melancholia passes close by and then whips back in a 'slingshot' orbit on a collision course with Earth. In the face of catastrophe the previously calm and rational Claire becomes agitated, erratic, and self-obsessed. The melancholic Justine, on the other hand, attains a state of calm and is able to comfort Claire's young son Leo at the end of all things. Von Trier has suggested that the film developed out of his own experience of depression, and in particular the insight that those who, like Justine, suffer from depression are able to respond calmly to crises, perhaps because their pessimism has prepared them for the worst.[2] But von Trier chose the title *Melancholia*, not *Depression*. The word *depression* never occurs in the film, though the diagnosis of depression would surely be part of the ordinary lexicon of the film's educated, wealthy characters – educated, but seemingly in denial. Perhaps the word *depression* is absent because the characters are set on denying its existence, in the same way as most of them will deny that Melancholia is on a collision course with Earth. The planet Melancholia thus has a metaphorical function in von Trier's film, both standing for depression and standing in an oddly oblique relation to it.

[1] *Melancholia*, film dir. by Lars von Trier (Zentropa, 2011).
[2] www.dfi.dk/Service/English/News-and-publications/FILM-Magazine/Artikler-fra-tidsskriftet-FILM/72/The-Only-Redeeming-Factor-is-the-World-Ending.aspx.

The idea of melancholia is around 2,500 years old at least. Its earliest surviving appearance is in the writings of Hippocrates of Cos (*c.* 460–*c.* 370 BC) and his school. After Hippocrates melancholia enjoyed a long and unchallenged reign within the terminology, nosology, and practice of mental medicine, until it was eclipsed by depression in the early twentieth century. Von Trier's *Melancholia* is one of a number of recent works that return to the ancient idea of melancholia in order to find new ways to talk about what we now call depression. Indeed, one of the functions of melancholia in von Trier's film is to disturb our common-sense, folk-psychological understanding of depression, to show us that there is more to depression than just low mood and self-loathing, and that melancholia can have positive attributes. In current psychiatry too, there is evidence of unease with depression and a desire to return to melancholia, albeit for quite different reasons. In their 2006 book *Melancholia: The Diagnosis, Pathophysiology, and Treatment of Depressive Illness*, the American neuro-psychiatrists Michael Alan Taylor and Max Fink propose that melancholia be reinstated as a medical diagnosis.[3] In a 2007 article Edward Shorter, a leading historian of psychiatry, argues that the diagnosis of major depressive disorder should be replaced by two separate forms of depressive disorder, 'melancholic mood disorder' and 'non-melancholic mood disorder', a distinction introduced by the Australian psychopathologist Gordon Parker.[4] In June 2010 a group of psychiatrists, including Parker, Taylor, and Fink, published an editorial in the *American Journal of Psychiatry* arguing that the American Psychiatric Association's taxonomy of mental disorders should recognize melancholia as a separate major disorder, alongside and distinct from depression.[5]

How do we explain this continuing interest, both cultural and scientific, in an idea that seemed to have passed into obsolescence a hundred years ago? The Hippocratic writings give several accounts of the illness. It was a grave mental and physical affliction, with profound effects on emotion, cognition, and physical health. For instance, in a case recorded in the Hippocratic *Epidemics*, a woman of Thasos was said to be suffering from 'coma ... aversion to food, despondency, sleeplessness, irritability,

[3] Michael Alan Taylor and Max Fink, *Melancholia: The Diagnosis, Pathophysiology and Treatment of Depressive Illness* (Cambridge University Press, 2006).

[4] Edward Shorter, 'The Doctrine of the Two Depressions in Historical Perspective', *Acta Psychiatrica Scandinavica* 115, suppl. 433 (2007), 5–13. See also Shorter, *Before Prozac: The Troubled History of Mood Disorders in Psychiatry* (Oxford University Press, 2009), 165, and Gordon Parker, 'Editorial: Commentary on Diagnosing Major Depressive Disorder', *Journal of Nervous and Mental Disease* 194 (2006), 155–7.

[5] Gordon Parker *et al.*, 'Issues for DSM-5: Whither Melancholia? The Case for Its Classification as a Distinct Mood Disorder', *American Journal of Psychiatry* 167 (2010), 745–7.

restlessness [*dysphoriai*], the mind being affected by melancholia'.[6] Another case mentions strange and terrifying dreams.[7] The symptoms of Hippocratic melancholia bear comparison with the diagnosis of major depressive disorder in the latest edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5, 2013). DSM-5 gives the following symptoms for major depressive disorder: depressed mood; diminished interest in otherwise pleasurable activities; significant weight loss or gain; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or guilt; diminished ability to think or concentrate; recurrent thoughts of death.[8] If we allow for their different modes of expression and for different cultural norms, Hippocrates and DSM-5 show several similarities: both refer to low mood, disturbances of sleep and diet, agitation, and lethargy. This has led Stanley Jackson to conclude that there is a 'remarkable continuity' in the psychological symptoms of ancient melancholia and modern depression.[9] To be sure, the contrary case can also be made; even from this purely descriptive perspective, in other words without considering the ontology of the disease, we might conclude that the differences outweigh the similarities.[10] Jackson acknowledges that the disorders labelled melancholia and depression have changed in significant ways over time. For instance, the range of conditions covered by melancholia up to the early modern period was far greater than that covered by modern depression.[11] And he acknowledges that in the modern period numerous very different physiological models have been used to explain the phenomena – 'a parade of theories', as he puts it.[12] But having acknowledged these changes, he sticks to his thesis of a 'remarkable continuity'.

## 2 Psychiatric realism and constructivism

The most obvious, and I think the most compelling, way of accounting for Jackson's continuity would be a form of psychiatric realism. We

[6] *Epidemics*, iii, 17, 2, in *Hippocrates I*, trans. W. H. S. Jones, Loeb Classical Library (London: Heinemann, 1948), 263.
[7] Hippocrates, *De morbis*, cited by Helmut Flashar, *Melancholie und Melancholiker in den medizinischen Theorien der Antike* (Berlin: de Gruyter, 1966), 51.
[8] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th edn (DSM-5) (Arlington, VA: APA, 2013), 160–1.
[9] Stanley Jackson, *Melancholia and Depression: From Hippocratic Times to Modern Times* (New Haven, CT: Yale University Press, 1986), *passim*.
[10] Jennifer Radden, 'Is This Dame Melancholy? Equating Today's Depression and Past Melancholia', *Philosophy, Psychiatry, &Psychology* 10 (2003), 37–52.
[11] Jackson, *Melancholia*, 399. [12] *Ibid.*, 386–90.

would want to say that, having allowed for cultural differences in their forms of expression, Hippocratic melancholia and DSM-5-style depression represent the observable phenomena of one and the same disorder. Melancholia and depression have features in common because they both represent the structure of a single reality. Clearly things are not that simple. During their long history melancholia and depression have not always represented the same facets of that reality or represented it with equal clarity. We might also wonder what level of reality they represent. Are melancholia and depression labels for a set of commonly co-occurring symptoms (low mood, sleep disturbance, etc.)? In other words, is it a reality at the level of symptomatic phenomena? Or do they describe a deeper level of reality, like physiological diseases? Are they the psychiatric equivalent of diseases like influenza, each with its own specific causes, pathogenesis, physiological location, and course? The latter form of psychiatric realism might invoke an even stronger argument to the effect that melancholia and depression are 'natural kinds'. That is to say, individual instances of melancholia and depression are members of a stable and discrete set, all of whose members share the same significant properties. Questions of this kind – what exactly do we mean by *psychiatric realism*? – need not concern us just yet. (They are discussed at some length in sections 4 to 7 of this Introduction.) Whatever kind of realism they espouse, realists will argue that the theories of melancholia and depression have persisted because in some fashion and at some level they represent the structure of reality. This is indeed the view that Jackson himself takes. In spite of the theoretical variety he finds in the history of melancholia and depression, he maintains that melancholia and depression represent facts about human nature. The concluding words of his book are, 'with such distress, we are at the very heart of being human'.[13]

Psychiatric realism has been challenged by various forms of psychiatric constructivism (or constructionism). These have ranged from the radical antipsychiatry movement led by Thomas Szasz and historical constructivists such as Michel Foucault, to those who, like Ian Hacking and Mikkel Borch-Jacobsen, have positioned themselves somewhere between realism and constructivism.[14] We will return to the moderate styles of constructivism in due course. The more radical forms of constructivism centre on two

[13] *Ibid.*, 404.
[14] Szasz's publications in this field are too numerous to list here. Key works by other writers include Michel Foucault, *History of Madness* (London: Routledge, 2006); Mikkel Borch-Jacobsen, *Making Minds and Madness: From Hysteria to Depression* (Cambridge University Press, 2009); Ian Hacking, *Rewriting the Soul: Multiple Personality and the Sciences of Memory* (Princeton University Press, 1995), and *Mad Travellers: Reflections on the Reality of Transient Mental Illness* (Charlottesville, VA: University Press of Virginia, 1998).

arguments. The first concerns the nature of truth claims in psychiatry. Foucault and Szasz have both maintained that psychiatry is not a true science. They do not deny the truth claims of other sciences (e.g. chemistry and biology), but because psychiatry is uniquely implicated in complex questions of human behaviour, it cannot be properly scientific.

Taking his lead from Heidegger, Foucault consistently argued that there is no such thing as an essence of human nature. What we call 'human nature' is formed by whatever self-interpretations and social practices happen to be current in a given period. Therefore, a *science* of human nature cannot exist; all we can have is a description of the structure of historical human self-interpretations. Szasz shares the view that psychiatric science is an impossibility. This is because the phenomena that mental disorders purport to explain are in fact socio-behavioural, and not medical problems. As Szasz writes of psychiatric diagnoses such as schizophrenia, 'each of these terms refers to behaviour, not disease; to disapproved conduct, not histopathological change'.[15] Szasz acknowledges that people suffer from real distress, but he would prefer that we talked about 'problems in living' rather than mental disorders.

The constructivism of Foucault and Szasz can be contrasted with the 'strong programme' in the sociology of science initiated by David Bloor. According to the strong programme, science is to be understood as a product of the social structure of scientific communities.[16] Foucault and Szasz, by contrast, have focused on wider political questions rather than the details of the sociology of scientific institutions. Broadly speaking, both are (or became) libertarians: they argue that the weakness and indeed the *danger* of psychiatry lie in its inability to liberate itself from the state. During the early modern period, while true sciences, like physics, were growing to full maturity and attaining a measure of autonomy, psychiatry continued under the tutelage of the state. Consequently, the state was able to exploit psychiatry as a means of social control. In his *Folie et déraison* (1961; translated as *History of Madness*, 2006) Foucault argued that in the early modern period the mad, along with the sick, idle, and unemployed, were lumped together under the category of 'unreason' and confined in asylums. Psychiatry was a means of policing undesirable elements in society. It was not really *psychiatry* in any proper sense at all, since it classed many behaviours as unreason that were patently not mental disorders. Psychiatry was therefore not concerned with treating the mentally ill, but with maintaining the social and political status quo.

[15] Thomas Szasz, *Schizophrenia: The Sacred Symbol of Psychiatry* (Syracuse, NY: Syracuse University Press, 1988), 10.
[16] David Bloor, *Knowledge and Social Imagery* (London: Routledge & Kegan Paul, 1976), 7.

In a similar vein, Szasz has argued that psychiatry has become a tool of the modern 'therapeutic state'.[17] The state has used psychiatry to define, psychologize, and correct behaviours of which it disapproves – 'problems in living' such as suicide, unhappiness, anxiety, and shyness. For both Foucault and Szasz, then, behind psychiatry's apparently scientific diagnoses lies a complex covert web of socio-political motivations.

At this point it is helpful to distinguish between two meanings of social construction: the social construction of beliefs, and the social construction of facts.[18] By socially constructed beliefs I mean beliefs that for whatever reason cannot be tested against reality and can therefore only be explained in terms of the interests of the people who hold them. According to Foucault and Szasz, mental disorders are socially constructed beliefs. People may have had compelling social or political reasons for thinking in terms of, say, melancholia – Foucault certainly thinks this is the case – but these reasons were not rational, and the resultant beliefs were not empirically verifiable. By socially constructed facts I mean real entities that are the product of human activity. They include such things as money, the English language, and the law. No one denies that such socially constructed facts are facts. What we mean by calling them socially constructed is that they are the way they are because humans have made them so. And they might conceivably have been made quite differently; indeed, they evidently have been made differently at different times and in different places. The dispute between psychiatric realists (Jackson) and psychiatric constructivists (Foucault and Szasz) is not a dispute over whether mental disorders are socially constructed facts. Realists and constructivists should be able to agree that the phenomena covered by the psychiatric label *depression* are socially constructed facts. Cases of depression may have been caused by social factors, and the symptoms may be expressed through socially dysfunctional behaviour. For these reasons depression might indeed have been different in different places and times, depending on the different causal factors that were in play. The disagreement between realists and constructivists concerns whether depression and other psychiatric kinds are socially constructed beliefs, beliefs that are by their very nature untestable and unverifiable. The constructivists maintain that psychiatric kinds are untestable socially constructed beliefs. The realists believe that they can be tested and shown to be real.

[17] Thomas Szasz, *Law, Liberty, and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices* (New York: Macmillan, 1963).
[18] Paul A. Boghossian, 'What Is Social Construction?', *Times Literary Supplement* 5108 (23 February 2001), 6–8.

## 3 Are psychiatric natural kinds possible?

Faced by the radical constructivist challenge, psychiatric realism needs to demonstrate the possibility of psychiatric natural kinds. Natural kinds play an important role in scientific realism. A realist view of science holds that, when all goes well, science is able to reveal the ways nature organizes itself into kinds such as chemical elements or biological species. It is by isolating natural kinds that science is able successfully to theorize and make inferences. The theories and inferences might involve law-like statements about causal properties of kinds. Natural kinds also form the basis of any scientific taxonomy, such as the periodic table of elements or the Linnaean taxonomy of biological species. In denying scientific status to psychiatry, Foucault and Szasz imply that there are no natural kinds in psychiatry. They insist on a contrast between psychiatry, which cannot have natural kinds, and other sciences, such as chemistry and biology, which can.

Constructivist challenges to psychiatric realism have generally aimed to show that on four key points psychiatric classifications are fundamentally unsatisfactory compared to the true natural kinds of chemistry, biology, etc.:

1. Psychiatric taxonomy is arbitrary, because psychiatry is undecided about which sets of facts constitute the basis for a diagnosis. Is diagnosis based on a disorder's symptoms or its causes or its course or its method of treatment? Each of these approaches is currently used in psychiatry, with no agreement about which of them is the decisive one.
2. In contrast with, say, chemical natural kinds (elements), psychiatric classifications are not distinguished from one another by clear boundaries. Chemical elements occupy a taxonomic space called the periodic table. Any given element has a determinate place within this space, by virtue of its atomic number. There can be no boundary disputes in the periodic table. Psychiatry by contrast is plagued by seemingly endless and irresolvable boundary disputes.
3. Psychiatry is historically mutable. As human behaviour has changed, so too psychiatric diagnoses have changed. But natural kinds ought to be more or less immutable.
4. Psychiatry studies human behaviour, which is a product of human actions. Psychiatric kinds, whatever they are, are human-made kinds, not naturally occurring ones, like nitrogen, say.

Sections 4 to 7 address these charges, outlining some of the responses psychiatric realists have made to constructivism. The aim is to show that in contrasting, say, chemical or biological kinds with psychiatric kinds the radical constructivists create a falsely binary picture of science and an

unwarrantedly pessimistic view of the status of psychiatry. The distinction drawn by radical constructivism between psychiatry and 'real' science is much less clear than the constructivists suppose. This argument takes two forms. It aims to demonstrate that kinds in psychiatry are more robust than the constructivists imagine. And it aims to demonstrate that natural kinds in biology and chemistry, while possible, are less robust than the arguments of the constructivists imply. In combination these two arguments aim to show that the kinds found in chemistry, biology, and psychiatry exist on a continuum of difference. The differences between chemical, biological, and psychiatric kinds are differences in the degree of their stability. In psychiatry, as in chemistry and biology, kinds are able to support reliable inference and law-like statements. In each science, kinds possess this power to the extent that the systems in which they operate are stable ones. Gold behaves like gold, and not like nitrogen, always and everywhere in any system created by the big bang. Wolves behave like wolves, and not tigers, always and everywhere within any system containing the wolf genome and a suitable and stable ecological niche. The same applies, *mutatis mutandis*, for mental disorders.

Sections 8 to 10 address the second type of social construction: socially constructed facts. If mental disorders are natural kinds, does this not imply that they cannot be socially constructed facts? Must psychiatric natural kinds not be organic pathologies rooted in, say, brain chemistry and quite unaffected by social causation? I will follow those who, like Dominic Murphy, have argued to the contrary that the dichotomy between mental disorders as natural kinds and mental disorders as socially constructed facts is another false dichotomy.[19] To argue that mental disorders have an organic component is not to argue for complete biological reductionism. A mental disorder with an organic component can very well have social causes too. As Murphy puts it, 'debates about whether mental disorders are natural or social kinds are beside the point: they can be natural kinds even if part of their explanations is social'.[20] Sections 8 to 10 will sketch a model for combining organic and social understandings of mental disorders. Most of the argument in sections 4 onwards is unoriginal; it draws on recent work in the philosophy of psychiatry by Murphy, Ian Hacking, and others.[21] The original and distinctive part of the argument

[19] Dominic Murphy, *Psychiatry in the Scientific Image* (Cambridge, MA: MIT Press, 2006).
[20] *Ibid.*, 279–80.
[21] In particular I draw on Murphy, *Psychiatry in the Scientific Image*; Rachel Cooper, 'Why Hacking Is Wrong About Human Kinds', *British Journal of the Philosophy of Science* 55 (2004), 73–85; Peter Zachar, 'Psychiatric Disorders Are Not Natural Kinds', *Philosophy, Psychiatry, &Psychology* 7 (2000), 167–82, and 'Psychiatry, Scientific Laws, and Realism About Entities', in Kenneth S. Kendler and Josef Parnas (eds.), *Philosophical Issues in*

comes in section 10. There I propose a new way of understanding the socio-historical 'niche' in which melancholia developed in Europe.

For the purposes of the following sections, I am going to make three assumptions that will help to bring the realism debate into sharper focus. These assumptions are questionable, and I make them only for the temporary purposes of this Introduction.

1. I will assume that melancholia and depression are paradigmatic instances of mental disorders. This is questionable on two counts. As I suggested above, it might be more rational to think of melancholia and depression not as disorders but as symptoms – either symptoms of an underlying mental disorder or of several different disorders that share similar symptomatic profiles. If melancholia and depression turned out to be merely symptoms, it would not invalidate the search for natural kinds in psychiatry. It would only mean that we had been looking for natural kinds in the wrong place. Second, historians of antiquity will point out that in much of the medical writing melancholia has more in common with a physical disease than a mental disorder, and that in some of the ancient sources it has no mental symptoms at all.[22] While this is undeniably true, my argument concerns the *potential* of melancholia to be classified as a mental disorder, not whether all forms of it ought to be so classified.
2. Connected with the first assumption, I will also assume that a mental disorder is a discrete entity, like a disease in general medicine. Again this might be wrong. It might be that none of the disorder concepts in psychiatry (depression, anxiety, schizophrenia, etc.) are discrete entities, but instead are all the varied expressions of a single, very broad psychiatric malaise.
3. I will assume that Stanley Jackson is right in supposing that melancholia and depression are different representations of the same thing. So in the following sections melancholia and depression will almost always appear yoked together, or when I use one term the other can usually be taken as implied.

I should stress that these three assumptions do not hold good outside this introductory chapter. Their function is only to give clarity to the issues surrounding the realism debate. I should also stress that in using the term *depression* in these introductory pages I am referring to a composite object, not to a historically determinate understanding of depression. I am not referring specifically to the definition of major depressive episode or major

*Psychiatry* (Baltimore, MD: Johns Hopkins University Press, 2008), 39–47 (at pp. 39–42); Muhammad Ali Khalidi, 'Interactive Kinds', *British Journal for the Philosophy of Science* 61 (2010), 335–60.

[22] Jackie Pigeaud, '*Prolégomènes* à une histoire de la mélancolie', *Histoire, économie et société* 3 (1984), 501–10 (at p. 502).

depressive disorder in DSM-5, or the similar depressive episode and recurrent depressive disorder in the World Health Organization's *International Classification of Disease* (ICD-10, 1988), or the depression constructs of the rating scales most commonly used by clinicians and researchers (the Hamilton Rating Scale for Depression and the Beck Depression Inventory). I have in mind something rather broader, which encompasses these definitions – namely, the general usage of *depression* in modern psychiatric practice and research. The fact that the various constructs of depression listed above are not in complete agreement is not relevant to my argument, nor is the question of whether a composite concept such as I have just outlined here (as distinct from any particular depression construct) can be said to be meaningful. My argument concerns the *possibility* of psychiatric natural kinds, not what any actual psychiatric natural kind looks like. The same applies to my use of the term *melancholia* in this Introduction. In subsequent chapters I will be talking about historically determinate meanings of the term *melancholia*. But in this Introduction I have in mind a composite concept that includes a wide range of the term's historical meanings as well as its uses in contemporary psychiatry.

## 4 Taxonomy

How should the phenomena of melancholia and depression be classified? As I have already suggested, there is more than one factual resource on which we could ground a taxonomy of mental disorders, and the different factual resources can be made to generate quite different disease constructs. For instance, one might prefer a purely symptom-based taxonomy, and one might accordingly choose to remain agnostic about whether depression is a discrete disorder or merely a set of symptoms of some broader underlying disorder. In this spirit some researchers have argued that the medical model of discrete disease categories is inappropriate for psychiatry, and that instead we should think in terms of a smaller number of disorders which express themselves in diverse ways.[23] (This approach to classification is sometimes termed 'lumping', as opposed to 'splitting' into more and smaller categories.) Most attempts at psychiatric classification involve a higher degree of splitting. One approach is to define disorders in terms of stable sets of co-occurring symptoms that follow a regular course. This approach does not involve any claims about the causation and organic nature of the disease; it simply records the patterns of co-occurring symptoms and their course over

[23] See, for example, Richard P. Bentall, *Madness Explained: Psychosis and Human Nature* (Harmondsworth: Penguin, 2004).