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Epidemic Depression and Burtonian Melancholy

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Abstract: Data indicate the ubiquity and rapid increase of depression wherever war, want and social upheaval are found. The goal of this paper is to clarify such claims and draw conceptual distinctions separating the depressive states that are pathological from those that are normal and normative responses to misfortune. I do so by appeal to early modern writing on melancholy by Robert Burton, where the inchoate and boundless nature of melancholy symptoms are emphasized; universal suffering is separated from the disease states known as melancholy or melancholia, and normal temperamental variation is placed in contrast to such disease states. In Burton's time these distinctions and characterizations could be secured by the anchoring tenets of humoral theory. Without such anchoring, and in light of the findings and assumptions of today's biological diagnostic psychiatry, we must re-visit each of them. My goals here are to show the need for analytic foundations when claims are made about depression such as those cited above, and to draw attention to some contemporary attempts that may help provide those foundations, particularly, attempts to define disorder or disease. With adjustments, one of these (Cooper 2002) is shown to take us some way toward that goal.

Introduction

The particular report prompting the following discussion described widespread use of medication for depression symptoms among adolescent girls in a refugee camp in Chad. More generally though, I take as my starting point data citing the ubiquity and rapid increase of depression wherever war, want and social upheaval are to be found: 120 million people worldwide suffer from depression, we are told; by 2020 depression will be the second leading cause of ill health world-wide; depression is the greatest source of disability as measured by Years Lived with Disability; 9.5% Mexican adults suffer depression; the greatest costs of Hurricane Katrina, the latest mudslide, tsunami, civil war and earthquake will be in terms of depression, and so on.

Of the several aspects of today's apparent epidemic of depression deserving philosophical examination, my focus is on preliminaries. How is depression understood when claims such as these are made? What is

its relation to more ordinary states of suffering and distress, and to normal temperamental differences? What are the limits of the concept? In this paper, I attempt to clear conceptual spaces around the condition(s) alluded to in accounts citing data on the incidence of depression. I do so by appeal to early modern writing, particularly that found in Robert Burton's great *Anatomy of Melancholy*, published in 1621. The earlier notion of melancholia and that of depression as it is understood today cannot be simply equated. Yet Burton's era also saw melancholy and melancholia in what were believed to be 'epidemic' proportions. And, there are significant parallels between the broad category of melancholic states employed by Burton and today's notion of depression that invite application of some of the same conceptual distinctions. In particular, early modern writing emphasizes the inchoate and boundless nature of melancholy symptoms; universal suffering is separated from the disease states known as melancholy or melancholia, and normal temperamental variation is placed in contrast to such disease states.

In Burton's time the distinctions and characterizations just noted could be secured by the anchoring tenets of humoral theory. Without such humoral anchoring, and in light of the findings and assumptions of today's biological diagnostic psychiatry, we must re-visit each of them. My goals in this brief discussion are to show the need for analytic foundations when claims are made about depression such as those cited above, and to draw attention to some contemporary attempts that may help provide those foundations.

Before turning to Burton's claims, one terminological clarification is necessary. 'Melancholy' and 'melancholia' were terms not systematically distinguished until a later period, and during Burton's era their employment was inexact, covering passing normal states, severe medical conditions, and enduring, natural temperamental types. In common parlance today, rather similarly, the term 'depression' covers a wide range of sub-clinical or normal responses as well as the more severe, lasting conditions that are acknowledged to be disorders. Others have

attempted to restrict 'depression' to clinical conditions. But the present discussion follows the looser usage: states of distress that are normal responses as well as those that are pathological are each 'depressive states,' their sufferers, at least temporarily, 'depressed.'

Distinctions among these different depressives states are the focus of what follows. Other than social and cultural nostalgia for the wisdom enshrined in writing such as Burton's, it might be asked, why should we care to preserve these distinctions? One answer to that question is perhaps an aesthetic and cultural preference only. The tendency to collapse distinctions such as that between normal suffering and depressive disorder comes at a cost in the richness of our experience and understanding. A world in which all suffering had been reduced to medical symptoms would be an impoverished one, despite the good brought by modern medicine. A second answer possesses real moral heft. Collapsing these distinctions seems all too likely to forestall social and political action not only more fitting but, in directing itself toward the causes of much of this suffering, more effective. The hapless inhabitants of refugee camps may suffer depression, and may require medical intervention. But if that intervention comes at the cost of neglecting why they are there in the first place, and why they suffer—that is, the questions spurring social and political action—then it will be difficult to justify. The apparent collapse of the boundaries separating these kinds of human suffering and the importance of maintaining conceptual space around depressive disorder have been the subject of recent concerns (Horwitz and Wakefield 2007). Moreover, such concerns may be seen as part of a broader whole. Erosion of distinctions at the boundary of our categories of disease and disorder occurs where forms of 'enhancement' apply medical treatments to non-medical conditions. Although it is not one dealt with here, this practice has rightly been recognized to jeopardize important moral distinctions. (For a discussion of some of the issues involved and far-reaching implications of losing sight of this allied distinction, see Elliott and Kramer 2003, Conrad 2007.)

Burton famously insisted that melancholy states were universal, the lot of humankind. Melancholy is nothing less than the Character of Mortalitie. And ‘From Melancholy Dispositions ... no man living is free.’ Melancholy Dispositions are for Burton distinguishable from melancholy the ‘Habit,’ however. Melancholy dispositions make us ‘dull, sad, sour, lumpish, ill-disposed, solitary, any way moved or displeased.’ As a Habit, melancholy is ‘a chronic or continuat disease, a settled humour ... not errant, but fixed.’ In some people, ‘these Dispositions become Habits.’ For Burton, it seems, no human can avoid melancholy states but only some will succumb to melancholy the disease, when disease is in this discussion indicated by the settled, or chronic, nature of those states.

Burton is clearly leaving a conceptual space for distress that is not pathological. Mistaken as we would now say he was in his humoral assumptions, moreover, he had in humoral theory a means of distinguishing the two kinds of melancholy state by appeal to underlying causation. The disease of melancholy was marked by adustion, when the black bile became heated and smoky vapors interfered with brain functioning causing the disturbances of imagination that in turn brought apprehensive and dispirited mood states of melancholy. These machinations are explained more fully, and embraced more literally, in some earlier works, such as Timothy Bright’s *Treatise of Melancholy* (1586). And by the time of Burton’s writing references to the black bile have begun to take on something of the quality of metaphor. Nonetheless, humoral theory provided a full explanation: the chronicity of the disease of melancholy was the result of adustion.

This distinction between pathological and more normal suffering does not always receive stress in Burton’s *Anatomy*. (In that rambling and inconsistent compendium, few distinctions are systematically employed.) Nor does it in the rest of the canon of writing on melancholy from that era. As products of natural and unnatural humoral arrangements, normal melancholy and pathological melancholy differ at most as variations on a unitary condition, and only in extreme cases or through long term study will melancholy the disease be observably different from

more normal melancholy states and temperaments. Rather than immediately observable, this is a distinction attributable to and theoretically provided for by the complex variations, normal and abnormal, in the black bile.

Melancholy's nature as inchoate and boundless was also able to be accommodated by humoral lore. 'The tower of Babel never yielded such confusion of tongues as this Chaos of Melancholy doth variety of its symptoms,' says Burton, in one of many efforts to emphasize the unbounded, open-ended nature of the symptomatology and subjectivity of melancholy. The force of this conviction of Burton's was not that the *concept* of melancholy could not be bounded, but that the plethora of its symptoms in the world could not. That unbounded-ness made it hard, or even impossible to provide a list of all melancholy's symptoms, but not to define it. Because of the anchoring and unifying role played by humoral explanations, the diversity and unbounded variety of symptoms provided no reason to question whether melancholy was one thing or many. Again, it is arguable that Burton was drifting away from a literal reading of humoral theory, and that remarks such as the above prefigure a Wittgensteinian 'family resemblance' conception of the category of melancholy. Ostensibly, though, Burton accepted that such symptoms were united by their source in the endless variations of the humor.

Ideally, if we are to remain faithful to the parallel with Burton, an account of pathological depression will contain explanatory force, attributing pathological depression to the brain states, and or experiences, which caused it. And it is true that today's causal analyses sometimes postulate such antecedents. Compromising resilience to life's vicissitudes, preexisting genetic and other biological conditions of vulnerability such as reduced volume of the hippocampus and an absence of glial cells are thought by some to combine with adverse experiences to yield the depressive response. (See Kramer 2005, for example.) These are controversial interpretations of what are thus far ambiguous findings, however. (For a critique of such interpretations, see Horwitz and Wakefield 2007: 175-177). Science may eventually confirm

such hypotheses and secure conceptual space around depressive disorder with a causal definition. Meanwhile, though, we must at least insist on the difference, and honor philosophical efforts to preserve it.

Without anchoring humoral theory, then, we face a conceptual problem: depressive states of despair, discouragement, numbness, dispiritedness, sadness, demoralization, anxiety and grief result not only from biological and inter psychic causes, but from the vicissitudes of life. And they are, as Burton says, the lot of humankind. The effects of ordinary love and loss affect us with what appear to be states indistinguishable from the symptoms of major depression and dysthymia. So too do experiences like painful social disruption, deprivation and oppression. Because it no longer adheres to humoral *or other* causal analyses and is instead solely 'descriptive' in its account of symptoms, contemporary diagnostic psychiatry appears without a way to secure the conceptual distinction between these different kinds of depression. (Horwitz and Wakefield make this point when they contrast the earlier 'contextualized' approaches with the de-contextualized one adopted with the descriptivist 1980 DSM-III (Horwitz and Wakefield 2007).)

The social and political origins of many depressive symptoms have been acknowledged and emphasized. Philosopher Jennifer Hansen speaks of 'a worldwide human illness that reveals important truths about our relationship to political and economic structures in culture' and 'says something about what pressures and freedoms culture offers individuals' (Hansen 2003:61). And a diagnosis of Dysthymic Disorder, it has been observed, will likely represent the *medicalization of social problems* in much of the world, where severe economic, political and health constraints create 'endemic feelings of hopelessness and helplessness, where demoralization and despair are responses to real conditions of chronic deprivation and persistent loss, where powerlessness is not a cognitive distortion but an accurate mapping of one's place in an oppressive social system ...' (This is medical anthropologist, Arthur Kleinman (1987:452).)

Preserving the conceptual space around depression understood as a real disorder rather than a more normal response—whether to oppressive conditions or to life's vicissitudes—is a goal with practical, as well as theoretical, interest and implications. The task is to justify and account for the presumption that states of pathological depression are importantly distinct from normal responses to life's vicissitudes, and to explain why the disease or illness status of depression is not arbitrarily assigned. Practical implications include when and whether to treat; remedies and or preventive measures, and questions of resource allocation; how to understand the role of the sufferer, and so on.

The category of non-pathological depression is a heterogeneous one, as we have seen, including responses to experiences and states of affairs both avoidable and unavoidable, the results of human nature and the human condition, as well as of seemingly contingent and preventable forms of oppression and misfortune. No matter what their situation, humans have pride and suffer from slights; they form close attachments, so suffer when loved ones suffer, grieve when they die, and so on. Perhaps due to this heterogeneity, instances of non-pathological suffering will not permit ready characterization, and efforts at analytic definition have been focused on circumscribing pathological rather than normal suffering.

This is a challenge that has received considerable attention from philosophers and other theorists, and three approaches to defining pathological suffering are distinguishable among their efforts. One of these dismisses the distinction, not acknowledging any real difference between pathological depression and more normal depressive responses. This, we shall see, is the position adopted by Freud and, later, by Melanie Klein. In a second approach, the suffering resulting from more normal and normative causes is separated from pathological suffering by exclusion. This is the approach adopted by the authors of the DSMs, for instance (American Psychiatric Association 1994). Pathological depression is characterized as a syndrome or pattern that is not merely an 'expectable or culturally sanctioned' response, such as grief and

mourning. A third approach attempts to circumscribe pathological depression by providing an analytic definition of affective disorder, mental disorder, or disease, within which it can be seen to fall. Summed up, these three approaches offer the following prescriptions:

- (1) deny there is any real difference between pathological and normal/normative suffering (Freud and Klein, for example)
- (2) exclude normal and normative suffering by fiat (DSM approach)
- (3) find a definition for pathological depression (affective or mental disorder, or disorder) that can be used to exclude other forms of suffering.

Before turning to (3), as the most promising of these approaches, one or two comments about (1) and (2) are required. Seemingly recognizing the conceptual contrast we are concerned to preserve, Freud later spoke of psychoanalysis as transforming neurotic misery into ordinary unhappiness. Yet exploring the difference between normal mourning and pathological depression in his famous 1917 essay on mourning and melancholia, he concluded that normal and pathological responses were really *equally pathological*. Mourning does not seem to us as pathological, he states, only because ‘... we know so well how to explain [it]’ (Freud 1967:153). Melanie Klein also insists that ‘because this state of mind is common and seems so natural to us, we do not call mourning an illness’ (Klein 1935:354). Stephen Wilkinson draws the same conclusion—although ironically as part of a *reductio* argument—when he identifies insufficiencies in each of the criteria proposed to distinguish normal grief from pathological depression (Wilkinson 2000). Because it simply denies the conceptual space between normal and pathological suffering, this position violates our intuitive sense that these forms of suffering are importantly different and of the reasoning provided at the outset of this essay. If preserving such conceptual space is a defensible goal, then the answer provided in (1) is question begging.

The method of exclusion by fiat employed in (2), and reference to responses that are 'expectable or culturally sanctioned' requires further clarification. It must be noted, first, that not all expectable responses will be culturally sanctioned and not all that are culturally sanctioned may be expected. In the present discussion 'normal' refers to responses that are expected and 'normative' is reserved for those that are culturally sanctioned, with the understanding that many normal reactions are proscribed or treated with moral indifference, while responses that are normative reflect evaluations as to appropriateness, fittingness or moral acceptability. Death of loved ones is not only expected to bring sadness and grief, such a response is judged appropriate and proper, the person who fails to feel it morally wanting. More generally, whether and how a person suffers in response to life's vicissitudes functions as a central indicator of moral character in our, and probably every, society.

Second, although many other experiences will bring comparable sadness and be both normal and normative, mourning is offered as a sole example of a culturally expected response by the authors of the DSM. In this respect, grief is thus positioned as a prototype of normal responses of sadness and distress.¹ Since whatever the variations their cultural expression may take, some such responses to the death of loved ones seem to be close to universal, the example of the depressed responses associated with grief and mourning is a compelling one. Even as an instance of distress that is incontestably normative, however, grief shades into a penumbra that is relative to particular cultures and even to particular individuals, where norms are controversial, unsettled, and contested. Within the scope of 'mourning' we can encounter differing moral intuitions over the appropriateness of responding with grief to the loss of a pet, for example, an aborted or miscarried foetus, a romantic

¹ Horwitz and Wakefield similarly position grief as the paradigm. They do so with the explanation that all forms of normal and even adaptive sadness are instances of 'loss,' on analogy with the loss suffered upon the death of a loved one. I have commented elsewhere on the risk of trivialization incumbent in sweeping 'loss' analyses such as these (Radden 2000a, and 2000b: 222-226).

relationship, or a slowly eroded friendship. Norms surrounding these and many other responses to life experience seem to be less agreed upon, less stable, and less clear-cut.

Mourning the loss of a loved one, then, is in this respect an unusual case and, I now want to stress, a rather misleading one. In cultures more traditional than our own, reliance on the appropriateness of certain responses relative to cultural mores may serve to distinguish normal and normative suffering, even in these and other less clear cut cases. But in non-traditional cultures such as that of the US, questions of appropriateness, rationality, and proportionality are controversial and contested. Moreover, in today's non-traditional society, mental health norms are more often *appealed to as arbiters* than *framed by* other norms. They are also clubs in the increasingly fractious war over the applicability of medical presuppositions to cultural structures and strictures.

Under these circumstances and within non-traditional cultures such as the US one, the method of exclusion employed in (2) leaves dangerously arbitrary and vulnerable the line between normal and pathological depression. Faced with this controversy, it seems sensible to turn to the remaining approach, (3), finding a definition of pathological suffering to distinguish it from depression that is more normal and normative.

Efforts to define disease or disorder often appeal to the concept of (harmful) dysfunction, and certainly a notion of *reduced functioning*, *disability*, or *incapacity* is central to lay conceptions of mental illness. Moreover the usual facultative divisions into cognition, memory, motivation, perception, judgment, feeling and so on, provide us with a map of the kinds of psychological dysfunction associated with particular mental disorders. (It is the very facultative map, indeed, on which mental disorders were originally classified.)

But not only are normal and pathological depression indistinguishable in terms of their symptom expression, as we saw earlier—resulting in pain as intense, sadness as profound, and despair as overwhelming, for example—so they are in terms of an everyday sense of reduced functioning. Depression and suffering resulting from life's vicissitudes

sometimes render their sufferer both *equally or more* apparently dysfunctional than those whose suffering is the symptom of disorder. Pathological depression, habituated despair and discouragement wrought of powerlessness, as well as genuine grief, all have the effect of deadening responses, dampening motivation, slowing and compromising cognition, for example; in this respect, they are equally likely to interfere with 'getting on with things.' So while it is a key to lay understanding of other forms of mental disorder, observable dysfunction cannot be interpreted as an attribute distinguishing pathological from more ordinary misery.

Dysfunction also enters into more formal definitions of disorder (APA 1994, Boorse 1975, Wakefield 1992, Megone 2000, Horwitz 2002). In the two best known of these types of definition, disease (or disorder) is defined as dysfunction relative to norms of functioning in some reference group (Boorse), and as dysfunction that is a maladaptive in the evolutionary sense (Wakefield). (Both accounts, it should be pointed out, accept the analogies between mental or psychological and organic conditions and neither draws a significant difference between 'disease' and 'disorder.')

But both definitions have also been subject to extensive and damaging criticism. Critiques of Boorse's account of dysfunction relative to a reference group press on the difficulties of fixing on a *suitable* reference group. (See, for example, Cooper 2002: 266-267.) Additional difficulty is involved when this effort concerns normal and normative depression. The effects of life's vicissitudes on individual character are widely variable, depending as they do on idiosyncratic values, ideals, goals and self-identity. Isolating the appropriate reference group against which one person's dysfunction could be judged abnormal will likely be even more difficult than settling on the appropriate reference norms for demarcating ordinary physical diseases. Consider for example, a group comprising X who believes in an afterlife; Y who does not and instead accepts a tragic view of life, and Z who, having no fixed opinion on such matters, is convinced that value lies in a dignified approach to whatever comes. Or, consider R and S, an undertaker and a clown, respectively,

each committed to the same worldview. With the latitude created by this sort of meaning-driven and idiosyncratic variability, the designation of an appropriate reference group must be an unacceptably arbitrary one.

Its unsubstantiated, empirical, essentialist assumptions about the way natural selection underlies natural functions have been widely noted as substantial and perhaps irreparable flaws in Wakefield's analysis. (See also Cooper 2002, Culver and Gert 2004, Woolfolk and Murphy 2000, Poland 2002, Lilienfeld and Marino 1995.)

Dissatisfied with accounts of disease as (harmful) dysfunction, whether defined statistically or by appeal to evolutionary psychology, Rachel Cooper has proposed a different approach, and I want to devote some attention to this alternative. Cooper introduces a set of conditions she believes necessary and sufficient for 'disease,' as understood within the medical paradigm: (1) diseases are bad things to have; (2) the afflicted person is unlucky, and (3) the affliction can potentially be medically treated (Cooper 2002).² This definition seems a promising one and, in light of the now well-rehearsed problems associated with both Boorsian and Wakefield accounts, deserves a closer look.

Although Cooper's criteria derive from ordinary non-psychiatric disorder and disease, we can simplify her analysis for our purposes here (and reduce their vulnerability to counter example) by limiting the scope of (1)-(3) in this definition—proposing them as definitive of *affective disorder or disease* only. Still, Cooper's criteria are not quite sufficient to exclude all normal and normative suffering. Normal responses are also sometimes bad luck, as Cooper accounts for it, vis., the sufferers 'could reasonably have hoped it might have been otherwise..' because, as she puts it, either (i) they feel worse compared with an earlier state; (ii) they consider themselves worse off than others, and or (iii) they believe there is a good chance that everyone could be better off. The oppressed inhabitants of a refugee camp, or the AIDS orphan could be in each category described in (i)-(iii). Moreover, (i)-(iii) introduce another

² This last condition finds its origins in work on disease by Reznek (1987).

problem. As subjective assessments made by the patient, (i)-(iii) may not capture all conditions we would normally suppose to be affective disorders or diseases. The manic patient would be unlikely to assess her situation this way, for example, and indeed, relying on subjective assessment with many mood disordered patients will raise the same problem. As pathological states, both mania and depression very typically affect the capacity to make global comparisons of the kind captured in (i). This problem will require a reformulation of (i) in less subjective language, so that the explication of 'bad luck' now reads: either (i) they feel *or are* worse compared with an earlier state; (ii) they consider themselves worse off than others, and or (iii) they believe there is a good chance that everyone could be better off.

Finally, Cooper's third condition seems naïve, even Panglossian. Once a method of remedying a particular condition is developed and placed in the hands of a medical practitioner (and others able to exploit the situation for gain), as Carl Elliot has observed, that condition 'tends to become re-conceptualized as a medical problem' (2004: 429). The rush to medicate all forms of depression in the present 'anti-depressant era' attests that normal and or normative depressive responses can be and (many think) too often are, medically treated. This point has been stressed in recent analyses noting the powerful forces aligned by a common interest in medicalizing, over-diagnosing and over-treating ordinary depressive states. (See Healy 1994, 2004, Horwitz and Wakefield 2007.)

In light of these concerns, several qualifications can be added to Cooper's conditions. Ill fate is customarily distinguished from misfortunes resulting from injustice, when this is a morally significant difference. Employing this distinction, we can insist that those suffering diseases (disorders) believe themselves unlucky because—*not as the result of a violation of their human rights*—they feel *or are* worse compared to an earlier state, consider themselves worse off than others and or believe there is a good chance everybody could be better off. As stated, this qualification may be too stringent. For it will also serve to exclude some conditions we

would intuitively judge to be genuine disorders or diseases, such as schizophrenia. (Arguably, for example, a failure to provide treatment for those with severe disorders such as schizophrenia might be regarded as a violation of their human rights.) A more complete qualification will define being unlucky as feeling worse, etc., *not merely as the result of a violation of their human rights*. This adjustment should serve to exclude normal and normative suffering that results from injustice.

Cooper's third condition concerning medical treatment that we saw to be naïve given the current climate of over-treatment, invites a second qualification. The affliction can be potentially medically treated and, we may add, *does not lend itself to more obvious, effective, socially sanctioned, remedies and or preventive measures*.

The group of responses making up normal and normative suffering, it was pointed out earlier, is heterogeneous. Those resulting from bereavement are an apparently unavoidable aspect of being human, for example, while those resulting from forms of oppression, we like to think, are not. The two qualifications added to Cooper's definition serve to exclude two types of normal and normative responses, those arising from avoidable states of affairs, and those that have alternative, socially sanctioned remedies. Depression resulting from unavoidable aspects of being human can be excluded by adding a qualification to the first part of Cooper's definition: diseases are bad things when they are *not apparently unavoidable aspects of being human*.

Suitably reduced so that it deals only with the affective disorders of concern here, and qualified in the way outlined above, Cooper's account reads:

Affective disorders (diseases) are (1) bad things to *have that are not apparently unavoidable aspects of being human*; when (2) the afflicted persons are unlucky in the sense of feeling *or being* worse than previously, considering themselves worse off than others and or believing there is a good chance everybody could be better off, when this *is not merely as the result of a violation of their human rights*; and (3) the affliction can potentially be medically treated *and does not lend itself to more obvious, effective, socially sanctioned, remedies and or preventive measures*.

This definition has its own vulnerabilities: the nature of human nature is itself vague and contested; the scope of human rights is similarly open to challenge; and any determination that remedies are socially sanctioned will eventually require further refinement and clarification since it, too, seems to rely on unsettled and contested norms. This reformulation seems to move us some way toward the end we seek. It is still designed for 'diseases' in the traditional sense, however. On the traditional model, affective diseases (or disorders) are understood as the manifestations and effects of an underlying pathological process originating in the individual (at least as a diathesis or risk factor) and characterized by an episodic course or career. Yet some disorders, if not diseases strictly so called, seem to elude this framing, either by not presupposing a particular originating cause within the person (Post Traumatic Stress Disorder is an obvious example here) or by not giving evidence of an episodic course. Dysthymic personality may be one of these exceptions.

A trait based depressive personality disorder, Dysthymia is grouped with the family of depressive disorders. With its origins in the earlier trait-based category of Neurotic Depression, Dysthymic Disorder is the mildest of depressive disorders, whose diagnosis requires disturbances of mood and only two additional symptoms from a disjunctive set and whose trait-based and static nature is indicated by the requirement that these symptoms must have lasted for some time (at least two years for adults, and one for adolescents and children). In terms of severity, Dysthymia rests between major depressive disorder and the normal, passing sadness and suffering of everyday life, although it is in DSM-IV placed on a separate axis from other conditions in recognition of its status as an unchanging trait cluster.

In early modern writing about melancholy, the same humors that might culminate in a severe disease condition gave rise to normal temperamental variations as well. The melancholy man was not ill in any way. His was a fixed tendency to respond more gloomily and sourly than would, for example, the sanguine or choleric man. His traits, too, resulted from differences in the balance of humors within his body, but

in a tradition harking back to classical times, humoral character ascriptions such as these were employed without medical connotations. This category of a person of melancholy disposition or temperament is orthogonal to Burton's contrast, introduced earlier, between melancholy as 'Disposition' and 'Habit.' The melancholy man was disposed to be 'dull, sad, sour, lumpish, ill-disposed, and solitary' as, from time to time, humans all are. His fixed and long term tendencies were not sufficiently marked to be evidence of the habituated disease state (melancholy the Habit), however.

Typologies of this kind and trait-based accounts of personality may have less currency today, either in folk psychology and lore, or in more formal analyses.³ Yet, arguably, the category of a temperamentally depressive or melancholic personality is one we still recognize and want to avoid confusing with any disorder. It is widely accepted that, as Horwitz and Wakefield observe, there is 'a normal distribution of intensities with which non-disordered people respond to stressors' (Horwitz and Wakefield 2007:117). And the basis of those differentiated responses, we can suppose, will include mildly depressive or melancholic temperaments.

It seems, then, that depressive personality styles and patterns that are relatively stable, and mild, may result either from normal temperamental variation or from whatever underlying states account for dysthymic personality disorder. However, remembering the description of what can seem to mimic the diagnosis of dysthymic personality—demoralization and despair as a habituated response to chronic deprivation and persistent loss—we seems must recognize a three part distinction here. Some personality patterns will reflect habituated responses to stressful lives. (Although employing a somewhat limited range of depressive symptoms, the so-called 'learned helplessness' hypothesis apparently addresses this claim. Passivity and a failure to

³ Powerful critiques of the presuppositions underlying trait theories include those of Mischel 1968, and Ross and Nisbett 1991.

believe in oneself, it has been shown, seem to result from being deprived of opportunities for autonomous action (Seligman 1975.) The trait clusters making up depressive personality types may result from underlying states of disorder, from normal temperamental variation unrelated to setting, or from habituated responses to stressful lives. These types may *appear* indistinguishable. But conceptually they are separate and there seems reason to maintain that separation.

In an attempt to demarcate disorders wrought by social stressors, appeal has been made to the notion of a separate ‘sustaining’ (Gert and Culver) or ‘environmental maintaining’ (Wakefield) cause, the presence of which betokens not genuine disorder but a normal response to stress. Such a cause is one whose effect will not outlast its continuing stimulus. Only when the suffering originally caused by trauma outlives the trauma (most notably in forms of Post Traumatic Stress Disorder), are there grounds for attributing disorder, according to this view. Stephen Wilkinson has offered a neat definition of a sustaining cause: (a) x is a cause of c ; (b) x is not part of (i.e., is distinct from) the person with c ; (c) If x were removed, c would cease to exist almost immediately, i.e., x is necessary for sustaining c (Wilkinson 200:301). Wilkinson’s particular focus is the application of the notion of a sustaining cause to distinguish grief and mourning from pathological states, an effort he shows to be confounded by equivocation over the characterization of x . If what persists is the griever’s sense of loss, he points out, then x is not distinct from the person with c . On the other hand, interpreting it as a fact (the fact of the loved one’s death) the truth of which continues unchanged will lead to highly counter-intuitive conclusions in other cases (Wilkinson 2000:302-3). Granted, this critique may apply with grief and mourning. But other external stressors do seem to function as sustaining causes so defined. In many instances, we should indeed expect that when depressive states result from stress, the habituated response to it would be no more than a sustaining cause—ceasing with the cessation of the stressor and thus seeming to confirm that here were no ordinary, or at least no lasting, states of disorder. Moreover, it might well be that

recurrent stresses sometimes cause lasting pathological depressive states or dispositions, again conforming to the model in proving themselves to be more than mere sustaining causes.

In many cases then, the sustaining cause model will allow us to separate pathological from normal and normative depressive traits. Applied to our task of demarcating normal cases of a habituated numbness and dis-spiritedness resulting from external stressors, this criterion comports with our intuitions only incompletely, however. For we can also envision cases where, once habituated, even normal and normative responses might outlast their stressors, or result in a *lasting, but non-pathological*, alteration in the temperament of the sufferer. They might transform her from a sunny to a sourer person, for example, or from a light-hearted to a graver one. In this kind of case, the initiating cause is not a mere sustaining cause because its effects outlive it. But the resulting effect is not pathology or disorder; it is normal temperamental or character change.

Few permanent character changes probably engender the sadder, sourer, more reflective responses we would recognize as melancholic or depressed (and this, presumably, is fortunate). Yet, for example, those who have witnessed or participated in great human evil can seem so changed. Holocaust survivors sometimes speak this way about themselves or give evidence of such transformation, for example. Those who have come to sincerely repent great and irreparable harm they have wrought do also. And so sometimes do those whose belief in human or divine goodness has been permanently and shatteringly expunged. It may even be that mental disorder itself sometimes leaves a residue of normal long term effects on character. Speaking of earlier episodes of melancholia in the lives of John Bunyan and Leo Tolstoy, Williams James remarks that 'the iron of melancholy left a permanent imprint,' and he does not imply that the illness lingered but rather that it was profound enough to permanently change the character of these two men (James 1961:143). The difference between normal and normative responses is evident here: extreme and life changing experiences such as these are too rare for us

to speak with any confidence of the resulting character effects as *expectable*. But we certainly regard them as normative—they are fitting and appropriate in light of the experience or experiences undergone. Certain experiences, when sufficiently profound, ought to permanently mark the person, and show in that person's outlook and responses, it is generally believed. And the person unaffected by such experiences is widely deemed shallow, or callow or morally wanting.

The melancholy or depressive type of character or personality may or may not reflect innate temperamental differences, as thinkers from classical to early modern times believed. But these examples seem to require us to acknowledge normal change that results in such character types. Thus, corresponding to the temporary suffering which is recognized to be a normal or normative response to certain sorts of external stressor is permanent personality transformation—also the result of such stressors—that is equally normal and normative. It will be possible to add to Cooper's amended definition of affective disorders (diseases) to exclude the case of normal temperamental variation and these permanent transformations by adapting (1) as follows:

Affective disorders (diseases) are (1) bad things to have that are (i) not apparently unavoidable aspects of being human or the results of (ii) normal temperamental variation or (iii) character change wrought by extreme experiences.

Conclusion

There seem reasons to maintain separations found in some early modern writing, I have argued here. Attributions of depression can and should be distinguished from (i) universal suffering in response to life's vicissitudes; from (ii) normal temperamental variation and from (iii) habituated responses and even permanent, non-pathological changes in temperament resultant from painful and oppressive lives. Until such time as fully causal accounts of pathological depression allow us to separate those from depressive states that are more normal and normative, we must look toward philosophical definitions that attempt to

circumscribe those states that reflect pathology, of which Cooper's is one of the most helpful.

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