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The Origin of Our Modern Concept of Depression—The History of Melancholia From 1780-1880
A Review

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The modern concept of depression arose from earlier diagnostic formulations of melancholia over the hundred years from the 1780s to the 1880s. In this historical sketch, this evolution is traced from the writings of 12 authors outlining the central roles played by the concepts of faculty psychology and understandability. Five of the authors, writing from 1780 through the 1830s, including Cullen, Pinel, and Esquirol, defined melancholia as a disorder of intellect or judgment, a "partial insanity" often, but not always, associated with sadness. Two texts from the 1850s by Guislain, and Bucknill and Tuke were at the transition between paradigms. Both emphasized a neglected disorder—melancholia without delusions—arguing that it reflected a primary disorder of mood—not of intellect. In the final phase in the 1860s to 1880s, 5 authors (Griesinger, Sankey, Maudsley, Krafft-Ebing, and Kraepelin) all confronted the problem of the cause of delusional melancholia. Each author concluded that melancholia was a primary mood disorder and argued that the delusions emerged understandably from the abnormal mood. In this 100-year period, the explanation of delusional melancholia in faculty psychology terms reversed itself from an intellect to mood to a mood to intellect model. The great nosologists of the 19th century are often seen as creating our psychiatric disorders using a simple inductive process, clustering the symptoms, signs, and later the course of the patients. This history suggests 2 complexities to this narrative. First, in addition to bottom-up clinical studies, these nosologists were working top-down from theories of faculty psychology proposed by 18th century philosophers. Second, for patient groups experiencing disorders of multiple faculties, the nosologists used judgments about understandability to assign primary causal roles. This historical model suggests that the pathway from patient observation to the nosologic categories—the conceptual birth of our diagnostic categories—has been more complex than is often realized.

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Before the rise of modern psychiatry in the late 18th century, the concept of melancholia differed substantially from our modern view of depression,[1-6] which did not emerge until the late 19th century.[1,2,7,8] By examining key texts published from 1780 to 1880, I document the nature and timing of this shift through 3 phases. Two theories play important roles in this story: faculty psychology[9-13] and understandability.[13-16] Faculty psychology is defined as

> The theory, in vogue particularly during the second half of the eighteenth and first half of the nineteenth centuries, that the mind is divided up into separate inherent powers or "faculties."[17(p253)]

I focus on 2 of these inborn faculties, one predominant at the initiation of this story (intellect, understanding, or judgment), and the other whose rising influence I track across the 19th century: mood, affect, or moral (ie, psychological) sentiment.

Given the frequency of patients apparently experiencing disorders both of intellect and mood, the theory of faculty psychology posed a problem. To give a proper diagnosis, clinicians needed to distinguish between 3 hypotheses about such patients. Did they have 2 independent disorders, a primary disorder of intellect with a secondary mood disorder or a primary disorder of mood with a secondary disorder of intellect?[13] A dominant approach to this problem, later popularized by Karl Jaspers,[14,15] was that with careful observation and empathy, the clinician could discriminate between these hypotheses, for example, determining if a delusion (a disorder of intellect) could arise understandably from a disordered mood.

Phase 1: 1780-1830

In the first historical phase, all major authors emphasized that melancholia was primarily a disorder of intellect, often—but not always—accompanied by sadness.

I begin with the medical nosology of William Cullen (1710-1790), a physician and leading figure in the Scottish enlightenment. In his highly influential 1780 nosology,[18,19] melancholia was placed within the class of neuroses (nervous disorders), and the order of *vésanie*

(mental diseases/insanity) characterized as "a disorder of the functions of the judging faculty of the mind, without fever or sleepiness."[19] Melancholia was defined as "partial insanity without dyspepsia," with the phrase "without dyspepsia" included to distinguish it from hypochondriasis. By partial insanity, Cullen meant that the delusions were limited to a single subject, leaving the affected individual with intact areas of intellectual functioning.

Phillipe Pinel (1745-1826),[20,21] a major reformer and one of the founders of modern psychiatry, provided the following definition of melancholia in 1801:

> Delirium (ie, delusions) exclusively upon one subject ... free exercise in other respects of all the faculties of the understanding: in some cases, equanimity of disposition, or a state of unruffled satisfaction: in others, habitual depression and anxiety, and frequently a moroseness of character ... and sometimes to an invincible disgust with life.[21(p149)]

Like Cullen,[18,19] Pinel's definition emphasized intellectual dysfunction (eg, partial insanity), but he added a range of associated mood states. Some of the states reflect depression but another described emotional equanimity.

In his 1804 treatise on madness and suicide,"[22] the English physician William Rowley (1742-1806) gave a succinct definition of melancholia that agrees in essential points with his predecessors, with the disordered intellect here termed "alienation of the mind":

> Madness, or insanity, is an alienation of the mind, without fever. It is distinguished into two species; melancholy, or mania.... The former is known by sullenness, taciturnity, meditation, dreadful apprehensions, and despair.[22(p1)]

Rowley differs from his predecessors in associating melancholia only with the moods of sadness and anxiety.

In his 1817 monograph on melancholia,[23] Maurice Roubaud-Luce's description of melancholia resembled that of his French predecessor, Pinel,[20,21] including its possible association with elevated mood states:

> Melancholy is characterized by an exclusive and chronic delirium focused on a single object, or on a particular series of objects, with a free exercise of intellectual faculties on everything that is foreign to these objects. This condition is often accompanied by a deeply concentrated sadness, a state of dejection and stupor, and an ardent love of solitude. Sometimes also it excites, for no apparent reason, immoderate joy.... [23(p1)]

Jean Esquirol (1772-1840), Pinel's student and successor as leader of French psychiatry, coined the term *lypemania* as a synonym for melancholia.[24,25] Like Rowley, in his 1838 textbook, he removed the association with mania-like partial insanities:

> We consider it well defined, by saying that melancholy ... or lypemania, is a cerebral malady, characterized by partial, chronic delirium, without fever, and sustained by a passion of a sad, debilitating or oppressive character.[25(p203)]

Phase 2: 1850-1860

In phase 2, the dominant view of melancholia as a primary disorder of intellect came under challenge.

Joseph Guislain (1789-1860), a Belgian alienist and director of the psychiatric hospital at Ghent, took a first step toward the modern view of depression. He described, in his 1852 text,[26] 6 elementary forms of mental maladies, one of which was mélancolie, defined as "mental pain—augmentation of sentiments of sadness.[26(p94)] He then described the relatively novel category of nondelusional melancholia, calling it

> exclusively an exaggeration of affective feelings; it is a pathological emotion, a sadness, a grief, an anxiety, a fear, a fright, and nothing more. It is not a state which appreciably weakens conceptual faculties.[26(p112)]

He continues:

> The description that the [prior] authors gave us of this disease [melancholy] leaves something to be desired; almost all spoke of delusional melancholy, and none, to my knowledge, describes melancholy in its state of greatest simplicity: there are melancholies without delusions ... without noticeable disturbance of intelligence or ideas. Melancholy without delusion is the simplest form under which the suffering mode can occur; it is a state of sadness, dejection ... without notable aberration of imagination, judgement or intelligence ... a despair dominates him; he is absorbed into this painful feeling.[26(p186)]

In their influential 1858 textbook, John Bucknill (1817-1897) and Daniel Tuke (1827-1895) took a further step away from the view of melancholia as primarily a disorder of intellect. In the section on melancholia, written by Tuke, he begins with the quotation above from Esquirol[25] to which he adds a critical comment (italics added):

> "We consider it well-defined," he observes "by saying that melancholia or lypemania, is cerebral malady, characterized by partial chronic delirium, without fever, and sustained by a passion of a sad, debilitating, or oppressive character." A definition sufficiently accurate, if we except *the "chronic delirium," disorder of the intellect not being, as we shall presently see, an essential part of the disorder*.[27(p152)]

Tuke argues that delusions have been incorrectly understood as the primary melancholic symptom. Following Guislain,[26] Tuke operationalizes this change by defining a simple form of melancholia in which "there is here no disorder of the intellect, strictly speaking; no delusion or hallucination.[27(p158)] Bucknill and Tuke are then more explicit about their new conceptualization of melancholia: "it can be shown that the disorder at present under consideration, may coexist with a sound condition of the purely intellectual part of our mental constitution.[27(p159)]

Tuke provides his rationale for this conceptual shift in his earlier chapter on classification. After reviewing prior nosologic systems, he writes of the importance of faculty psychology in psychiatric nosology: "The writer thinks there is much to be said in favor

of the attempt to classify the various forms of insanity, according to the mental functions affected."[27(p95)] He then quotes his coauthor, "Dr Bucknill observes that insanity may be either intellectual, emotional, or volitional."[27(p95)] We cannot, he argues, base our nosology on the "physiology of the organ of the mind," because we do not know it. But, he continues, "in the absence of this knowledge it would seem reasonable to adapt them to the affected function."[27(p95)] We could then, he concludes, "speak of disorders of the intellect, sentiment, etc. instead of basing our classification exclusively on prominent symptoms."[27(p95)] He formalizes the conclusion:

> In bringing the phenomena of diseased mind into relation with such classification, we should endeavor to refer every form of disease to that class or group of the mental faculties which the disease necessarily, though not exclusively, involves in its course.[27(p98)]

In his ideal nosology, idiocy, dementia, and monomania, which commonly manifests delusions and hallucinations, are disorders of the intellect while melancholia is considered a disorder of "moral sentiment," that is, mood.

Phase 3: 1860-1883

Phase 3 continues the shift from the view that melancholia was predominantly a disorder of intellect to one of mood. But these authors also confronted the problem of delusional melancholia. If it too is primarily a disorder of mood, how can the emergence of delusions be explained? Their response to this question will incorporate the concept of understandability.

The first professor of psychiatry in Germany and a strong advocate for a brain-based psychiatry, Wilhelm Griesinger (1817-1868), early in his 1861 textbook,[28,29] adopts a faculty psychological approach to psychiatric nosology in his chapter entitled "The Elementary Disorders in Mental Disease":

> In those cerebral affections which come under consideration as mental diseases, there are, as in all others, only three essentially distinct groups.... Thus, according to this threefold division, we have to consider successively each of the three leading groups of elementary disturbances—intellectual insanity, emotional insanity, and insanity of movement.[29(p60)]

Although like Guislain[26] before him, Griesinger viewed melancholia as typically forming the first stage of a unitary psychosis: both of their descriptions are of relevance. Griesinger begins, "The fundamental affection in all these forms of disease consists in the morbid influence of a painful depressing negative affection—in a mentally painful state."[29(p209)] That is, he clearly emphasized the affective nature of the disorder. He elaborates:

> In many cases, after a period of longer or shorter duration, a state of vague mental and bodily discomfort ... a state of mental pain becomes always more dominant and persistent.... This is the essential mental disorder in melancholia, and, so far as the patient himself is concerned, the mental pain consists in a profound feeling of ill-being, of inability to do anything, of suppression of the physical powers, of depression and sadness.... The patient can no longer rejoice in anything, not even the most pleasing.[29(p223)]

Earlier in the book, Griesinger sought to explain how disordered mood can produce delusions.

> As to their contents, two leading differences are particularly to be observed in insane conceptions [one of which is] ... somber, sad, and painful thoughts .... [which arise] from depressed states of the disposition, and gloomy ill-boding hallucinations, as language of abuse and mockery which the patient is always hearing, diabolical grimaces which he sees, etc. The false ideas and conclusions, which are attempts at explanation and vindications of the actual disposition in its effects, are spontaneously developed in the diseased mind according to the law of causality.... At first the delirious conceptions are fleeting ... gradually, by continued repetition, they gain more body and form, repel opposing ideas ... then they become constituent parts [of the "I"] ... and the patient cannot divest himself of them.[29(p71)]

Early in his 1866 text, William Sankey (1813-1889), an asylum director and lecturer at University College London, outlined morbid psychiatric conditions of the intellect, emotions, and volition. He turned to discussing the development of melancholia:

> The alterations in degree are such as an increase of grief, a depression of spirits going on to melancholy.... Such description of abnormal acts of mind belong to the emotions, and occur in the earlier stages, the later or more permanent alterations of kind may be manifested in the (a) intellect, (b) the disposition, (c) the manner, (d) temper, (e) habits, and (f) character of the individual.[30(p25)]

Therefore, primary alterations in emotions can lead to a range of developments in melancholia, including alterations in intellectual functioning including "in power of judgment, apprehension, imagination, argumentation, memory, or they may entertain distinct illusion [hallucination] or delusion."[30(p25)] He captures this point in a case history of melancholia which he summarizes:

> The progress of this case was therefore—simple depression, abstraction, forgetfulness, neglect of duties... religious fears, and morbid apprehensions and delusions... You see how closely nearly all these symptoms are connected with the emotions. Fear, apprehension, and dread are among the commonest phenomena.[30(p30)]

Early in his section on the varieties of insanity from his 1867 textbook,[31] Henry Maudsley (1835-1918) adopted a faculty psychological orientation:

> On a general survey of the symptoms of these varieties it is at once apparent that they fall into two well-marked groups one of these embracing all those cases in which the mode of feeling or the affective life is chiefly or solely perverted—in which the whole habit or manner of feeling, the mode of affection of the individual by events, is entirely changed; the other, those cases in which ideational or intellectual derangement predominates.[31(p301)]

He then outlines how the effects of the mood disorder spread through other faculties:

> Consequently, when there is perversion of the affective life, there will be morbid feeling and morbid action; the patient's whole manner of feeling, the mode of his affection by events, is unnatural, and the springs of his action are disordered; and the intellect is unable to check or control the morbid manifestations.[31(p302)]

He later continues:

> The different forms of affective insanity have not been properly recognised and exactly studied because they did not fall under the time-honoured divisions and the real manner of commencement of intellectual insanity in a disturbance of the affective life has frequently been overlooked.[31(p321)]

Maudsley then attacks the earlier views of melancholia—that the intellectual dysfunctions were primary and the mood disorder secondary (italics added):

> It is necessary to guard against the mistake of supposing the delusion to be the cause of the passion, whether painful or gay .... Suddenly, it may be, an idea springs up in his mind that he is lost forever, or that he must commit suicide, or that he has committed murder and is about to be hanged; the vast and formless feeling of profound misery has taken form as a concrete idea —in other words, has become condensed into a definite delusion, this now being the expression of it. *The delusion is not the cause of the feeling of misery, but is engendered of it, it is precipitated, as it were in a mind saturated with the feeling of inexpressible woe*.[31(p328)]

Richard von Krafft-Ebing (1840-1902), among the most important late 19th century German-speaking neuropsychiatrists,[32,33] wrote in his influential 1874 monograph on melancholia, "The basic phenomenon in melancholic insanity is simply mental depression, psychic pain in its elementary manifestation."[34(p1)] By analogy with a peripheral neuralgia, melancholia transforms normal psychological experiences into anguish and sorrow. Affected individuals have repeated "painful distortions" of their experiences, "all his relations to the external world are different ... he is unfeeling, homeless ... with unbearable despair."[34(p5)]

In his section on melancholy with delusions and hallucinations, Krafft-Ebing writes

> Let us look at the sources of these [symptoms]. Initially it is the altered sense of self of the patient, the consciousness of deep abasement ... the fractured strength and ability to work, which require an explanation and, with advancing disturbance of consciousness, does not find this in the subjective aspect of the illness, but in the delusional changes of relationship to the external world, from which we are after all used to receiving the impulses for our feelings, ideas and ambitions. This formation of delusions is supported significantly by the deep disturbance of the perception of the world.[34(p32)]

He then gives examples of how delusions of poverty, persecution, and impending punishment can emerge "in a psychological manner ... from elementary disturbances of mood"[34(p34)]:

> Thus, deep depression of the sense of self, and the consciousness of mental impotence and physical inability to work, lead to the delusion of no longer being able to earn enough, of being impoverished, of starvation.[34(p33)]
>
> Mental dysesthesia thus causes hostile apperception of the external world, as presumed suspicious glances, scornful gestures, abusive speeches from the environment join, leading to persecutory delusions.... Precordial anxiety and expectations of humiliation lead to the delusion that an actual danger is threatening [where] ... a prior harmless action which is not even a crime ... is formed into an actual crime.[34(p34)]

Emil Kraepelin's views of melancholia, unencumbered by his later development of the category of manic-depressive illness, can be found in the first edition of his textbook published in 1883. He saw this syndrome as arising from "psychological anguish" when "the feelings of dissatisfaction, anxiety and general misery gains such strength that it constantly dominates the mood."[35(p190)] He describes the emergence of depressive delusions:

> ... in milder cases ... there is insight into his own illness. As a rule, however, critical ability becomes overwhelmed by powerful mood fluctuations, and the pathological change is transferred to the external world. It does not merely seem to be so dismal and bleak, but really is so. A further progression ... can then give rise to formal delusions and a systematic distortion of external experiences.[35(p191)]

The writings of Krafft-Ebing[32,33] and Kraepelin[35] reflect a culmination in the development of the modern concept of depression, an illness resulting primarily from a disorder of mood, which can manifest delusions that do not reflect an independent disorder of judgment or intellect but rather a rise, in an understandable manner, from the affective disturbance. We see a clear continuity from these authors to *DSM-III*[36] in the signs and symptoms of what we now call major depression.[7,8]

Discussion

In this historical sketch, which could not examine all relevant authors or provide helpful background materials, I document that, during the rise of modern psychiatry in the late 18th and early 19th century, the concept of melancholia was closely wedded to earlier views that it was fundamentally a disorder of intellect—a partial insanity—often, but not always, accompanied by sadness. This concept was seen, with modest variation, in writings from 1780 through the 1830s from both England (Cullen[18,19] and Rowley[22]) and France (Pinel,[20,21] Roubaud-Luce,[23] and Esquirol[24]).

In this narrative, the first movement away from this paradigm was by Guislain,[26] writing just after the mid-19th century, who defined elementary melancholia as a disorder of mood and then focused on the neglected but illustrative category of nondelusional melancholia. Such patients demonstrated no abnormalities of intellect or judgment. This form of melancholia was, he suggested, a disorder primarily of mood.

In 1858, 2 British authors, Bucknill and Tuke,[27] went further, declaring explicitly, in the language of faculty psychology, that a disorder of the intellect was not an essential part of melancholia. However, this assertion left a key problem. How could the common

occurrence of melancholia with delusions be explained if melancholia was primarily a disorder of mood?

Our final 5 authors—Griesinger,[28] Sankey,[30] Maudsley,[31] Krafft-Ebing,[32,34] and Kraepelin[35]—each accepted the primacy of mood in the cause of melancholia and addressed the problem of the origin of melancholic delusions. Griesinger argued that "the false ideas …are attempts at explanation."[29(p71)] Sankey noted "how closely nearly all these [psychotic] symptoms are connected with the emotions."[30(p30)] Maudsley stated, "The vast and formless feeling of profound misery has taken form as a concrete [delusional] idea.... The delusion is not the cause of the feeling of misery but is engendered of it."[31(p328)] Krafft-Ebing presented a compelling explanation of the psychological origin of melancholic delusions including the nature of "delusional changes of relationship to the external world"[34(p32)] and sketched how melancholic symptoms could lead, understandably, to delusions of poverty, persecution, or punishment. Kraepelin described how "critical ability becomes overwhelmed by powerful mood fluctuations."[35(p191)]

This review provides the historical context for our modern concept of mood-congruent psychotic features, which was first introduced in the research diagnostic criteria as "typical depressive delusions such as delusions of guilt, sin, poverty, nihilism, or self-deprecation,"[37(p16)] and then incorporated with modest changes in *DSM-III*[36] and all subsequent *DSM* editions. Echoing the writings of authors reviewed herein, this list reflects delusions whose content can be understandably derived from the primary mood disturbance in major depression.

These historical observations have important implications for how we understand the nature of our psychiatric categories. A prominent narrative is that the great psychiatric nosologists of the 19th century acted as simple inductivists, seeing large numbers of patients with psychiatric disorders and, based initially on symptoms and signs and later also on course of illness, then sorting them into diagnostic categories. This inquiry suggests a more complex process.

First, as illustrated herein and described elsewhere,[13,38,39] across Europe during the 19th century, systems of faculty psychology, innate functions of the human mind, were propounded by a range of philosophers, including Kant, Reid, and Stewart.[10,38] These faculties provided influential a priori categories for psychiatric nosologists. As articulated explicitly by Tuke, absent a knowledge of pathophysiology, diagnostic categories should at least be based on the "affected function" (eg, "disorders of the intellect, sentiment, etc"[27(p95)]) rather than exclusively on symptoms.

Second, given the adoption of faculty psychology, nosologists had to confront the problem of the classification of patients apparently experiencing disorders of 2 faculties, such as individuals with delusional melancholia. Did these patients have 2 disorders or only 1 and, if so, which one? The creation of our modern concept of depression arose from an argument about the primacy of disordered intellect vs disordered mood in explaining the cause of delusional melancholia. The early model, consistent with the then dominant intellectualist view of insanity,[40,41] assumed that disordered judgment was the essence of melancholia, which was first and foremost a disorder of intellect. Over the 19th century, this opinion was reversed. By the 1870s, it became widely accepted that melancholia was primarily a mood disorder. The argument that fueled that major diagnostic change appealed to understandability—that clinicians could empathically grasp how disordered mood could lead to particular kinds of delusions.

Rather than naive inductivism, a more realistic model for the development of psychiatric nosology in the 19th century would reflect a mixture of bottom-up and top-down processes. Psychiatric neuroscientists and geneticists working today are not studying the biological substrate of illnesses in patients classified from raw clinical experience. Rather, our diagnostic categories reflect clinical observations translated through mentalistic constructs from philosophers who divided the major functions of the human mind into faculties. An obvious question then is whether these faculties have a coherent biological substrate. In an 1857 essay, Henry Monro expressed concerns exactly on this point: Can we relate the metaphysical structure of mental faculties to brain structures? He wrote

> Physiology points further than to the general truth that brain as a whole is the instrument of the mind as a whole, and gives us good reason to believe that the great faculties, the emotions, the sensations, and the intelligence, have distinguishable ganglia, sensoria, or spheres of action.[42(p196)]

The success of our efforts at understanding the biologic characteristics of major psychiatric disorders might therefore depend, in part, on how successfully the faculty psychology of 18th century philosophers reflected brain structure and function. Furthermore, our nosologic categories are influenced by empathy-based insights into the nature of psychological causation. When can a delusion be understood to derive from disordered mood rather than from a primary disorder of intellect? The degree to which these empathy-based mentalistic processes translate into a discernable neurobiology is not well known.

This history suggests that the path from patient observation to our nosologic categories and from there, hopefully, to a detectable pathophysiologic nature is more complex than is commonly realized.

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