Melancholic Mysteries

by Theodore Dalrymple

When I was a young doctor, getting on for half a century ago, depression was a rare condition, or at least a condition that was rarely diagnosed, which is not quite the same thing. In its severe forms it was unmistakable. Patients who might to all appearances have everything to live for would turn their faces to the wall, almost literally if their beds were adjacent to a wall; they might even suffer from Cotard's syndrome, the delusional belief that they had or were nothing, that their bodies had rotted away, that they were in the last stages of impoverishment even when they had millions in the bank. I remember a patient who told me that he was already dead and that all that remained of him was the gangrenous tip of his nose. No logical argument could convince him that he was mistaken. Electro-convulsive therapy (ECT) returned him very quickly to his normal state, that of a successful and prosperous businessman.

It was impossible not to conceive of him as having been ill, pure and simple. But what about lesser forms of depression and

human misery? When did misery, understandable in the patient's circumstances, become illness? There was at the time a lively polemic between those who thought that depressed mood had a bimodal, and those who thought it had a unimodal, distribution. Those who thought that there was a bimodal distribution divided depression into *endogenous* (that is to say, arising from the sufferer's constitution) and *reactive* (that is to say, arising from the patient's reaction to his circumstances). The former tended to be, but was not necessarily, more severe, extreme and bizarre than the latter; they admitted that circumstances, in some circumstances, could lead to profound depression, to an understandable disgust with life and even to suicide.

Interestingly, there was a similar lively polemic between those who thought that high blood pressure was bimodally distributed and those who thought it was unimodally distributed. In the bimodal model, there were a separate group of people who suffered from an as yet undiscovered illness that led to exceptionally severe high blood pressure, while everyone else had blood pressures that were distributed around a mean.

It is now generally accepted that those who believed in unimodal distributions, both of depressed mood and blood pressure, won the argument. Personally, I think this is right in the case of blood pressure, but wrong in the case of depression. Once you have seen melancholia, as it used to be called, you cannot mistake it for depression of mood, however prolonged. But I am very old-fashioned.

In the last forty to fifty years, diagnosis of depression has become so common that up to a sixth of adults in western countries are taking antidepressants—or alleged anti-depressants, as critics might say. The word *unhappiness* has almost been excluded from the lexicon, and no one complains of it; if they complain at all, it is of *depression*. Deviation from happiness and contentment, at least for more than two

weeks, is now an illness: the default setting of Man, so to speak, is happiness.

Clearly, anyone who attends to the history of Rasselas, Prince of Abyssinia will not agree, but few people do attend to it. The question remains, addressed in this book without definitive answer (because none can be given), as to whether the increased number of people diagnosed, or self-diagnosed, as suffering from depression represents a real increase in the prevalence of the disease, better recognition of a condition that was always there but ignored, or perhaps a cultural fashion.

Jonathan Sadowsky's *Library of Law and Liberty*.