ORIGINAL ARTICLE

Melancholia a Psychiatric Disorder Described in Unani System of Medicine: Its Similarities and Differences with Depression

Abstract

Melancholia is a Latin transcription of the Greek word *melaina chole*, which in ancient Greece mainly meant "biliousness," and was also used, in medical speech "to signify insane or anxious conduct. In Unani system of medicine, Melancholia is classified into three categories according to the site affected by the disease. Persian scholars, including Rhazes, Ahmad bin Mohammad Tabri, Haly Abbas, and Avicenna, have given a detailed description of this disorder as a disease. Avicenna, in his treatise, The Canon of Medicine (*Al-Qanun Fittib*) has defined it as a kind of disorder in which imagination and judgment are so perverted that the victims become very sad and fearful. Some surveys were performed on Unani literature about melancholia and depression. The books consulted were mainly The Canon of Medicine (*Al-Qanun Fittib*), The Complete Book of the Medical Art (*Kamil Sana*), College (*Kitabbul Kulliyat*), *Kitabul Umda Fil Jarahat*, *Tib Akbar*. This study is constructed on a scrupulous overview of writings, compositions, and publications on melancholia and depression using internet sources like Web of Science, Scopus, PubMed, Google Scholar, Medline. There are numerous similarities between melancholia, a disease described in Unani system of medicine, and present-day depression, described in the conventional system of medicine. There are also a few differences between the two. Unani scholars were aware of psychiatric disorders and the concept is a collaborative effort of both ancient and conventional systems of medicine.

Key words: *Melancholia*; Depression; Unani System of Medicine; Medicatrix naturae; Anxiety

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Introduction

Ancient Greece is the origin of the Unani System of Medicine (USM). Unani is the Arabic word for Greek/Ionian, and *Tibb* is the Arabic word for medicine (Jabin, 2011, pp. 10-143). The Greek philosopher and physician Hippocrates (*Buqrat* 460-377 BCE) established that disease is a natural process, and signs and symptoms are the reactions of the body toward the disease. He laid down the foundation of the humoral theory. This system was introduced in India during the eighth century and immediately became accepted as an indigenous medical system. Unani physicians were successful in constructing this system in its entirety, even adding to it as science progressed (Rais-ur-Rehman, et al, 2013, pp. 39-44).

The Unani System of Medicine (USM) and Melancholia

The main concern of USM, along with curative and rehabilitative healthcare, is the prevention and promotion of good health. The USM's underlying framework is founded on profound philosophical concepts and scientific foundations. The doctrine of the four elements (air, water, fire, and earth), the four proximal qualities (*Kayfiyat*) (hot, cold, wet, and dry), and Hippocrates' humoral theory are among them. This theory involved four humors: blood, yellow bile, black bile, and phlegm which are associated with good health when in balance or equilibrium and with the disease when there is an imbalance, an excess of one or more of the humors. The quality and quantity of these humors determine the basis of health (i.e., when homeostasis in the internal environment of the body is maintained, the body remains healthy) (Rahman, et al, 2014, pp.46-9). Each humor is associated with one of the four seasons and is defined by a set of characteristics: yellow bile is warm and dry, black bile is cold and dry, blood is warm and moist, and phlegm is cold and moist. Of the four humors, the black bile, associated with autumn and with the qualities of coldness and dryness, is the crucial one in the etiology and pathogenesis of melancholia (Razi, 2008, pp. 28-46). Medicatrix naturae (*Tabiat Mudabbira-i-Badan*), according to the USM, is the supreme power that regulates all physiologic bodily functions. It helps in natural healing and provides resistance to diseases. The disease comes from any change in the balance of humors, whether quantitatively, qualitatively, or both. Treatment aims to restore equilibrium, using a variety of treatment modalities of opposite temperaments (Tipo, et al, 2019, pp. 265-268). Dietotherapy (*Ilaj-bil-Ghiza*), regimental therapy (*Ilaj-bit-Tadbeer*), pharmacotherapy (*Ilaj-bil-Dawa*), and surgery (*Ilaj-bil-Yad*) are among the treatments recommended by Unani physicians (Bhat, 2021, pp. 545-550).

Melancholia is the Latin transcription of the Greek word *melaina chole*, which in ancient Greece mainly meant "biliousness," and was also used, in medical speech "to signify insane or anxious conduct. This term, derived from *melaina chole*, was translated into Latin as *atra bilis* and into English as black bile. Hippocrates (460-377 BCE) was the first person to write about *Melancholia*. He stated that this clinical disorder was often associated with "aversion to food, despondency, sleeplessness, irritability, restlessness," and was named *melancholia* (Withington, Potter, and Smith, 2021, p. 337). It is classified into three categories according to the basic site of the disease: 1- "the whole body is full of a melancholy blood"; 2- "only the brain has

been invaded"; and 3- "*Miraq*" (the hypochondria) known as *Melancholia Miraqi* (Hypochondriacal *melancholia* (Tabri, 1995, pp. 374-391). Persian scholars, Rhazes (*Zakariyya al-Razi*,865-925 CE), Ahmad bin Mohammad Tabri (980 CE), Haly Abbas (Ali ibn al-Majusi , 930-994 CE), and Avicenna (980-1037 CE) gave a detailed description of *Melancholia*. Avicenna in his treatise, The Canon of Medicine (*Al-Qanun Fittib*) defined it as a kind of disorder in which imagination and judgment are so perverted that the victims become very sad and fearful.

Etiology

A body is healthy as long as the humors (*Akhlat*) remain in a state of equilibrium in terms of their quality and quantity (Bhat, Khan, and Hakim, 2010, pp. 601-605). According to the USM, abnormal melancholic humors (*Sawda Ghayr Tabiiyya*), are regarded to be a key etiological element in *melancholia*. The brain substance is affected by excess and abnormal black bile (*Sawda Ghayr Tabiiyya*). The spleen plays a vital role in the pathogenesis of *melancholia*. The normal function of the spleen is to filter out the atrabilious humor served to maintain good health. Its defective function can lead to an excess of black bile in the system and so to a case of *melancholia* (Razi, 1997, pp. 56-57). According to Averroes (Ibn Rushid), the spleen is a spongy organ and because of its loose texture, it enjoys the capacity to "easily absorb fluid from the nearby parts of the body" (Rushid, 1980, pp. 374-391). The spleen is a spongy organ that served to filter out "the thick, earthy, atrabilious humors (Black bile) formed in the liver (Qaf, 1986, p. 185). Melancholic humors dregs in the spleen and become the source of the smoky vapors that rose from the hypochondriacal region to the brain, leading to hypochondriacal *melancholia* (*Melancholia Miraqi*) (Razi, 1997, pp. 56-57; Avicenna, 2007, pp. 550, 560).

Clinical Features

Avicenna mentioned that those suffering from *melancholia* are gloomy, sad, and fearful (Avicenna, 2007, pp. 550, 560). According to Ali ibn al-Majusi, melancholic patients have delirium (*Hadhayan*), impaired memory, anxiety about loud noises, and seek solitude. He also stated that in its later stages, various delusions are usually found in patients suffering from *melancholia*. The patient may see himself as an earthenware pot, or he may feel that his skin is dried up like parchment, and some may even think that they do not have a head (Majusi, 2010, pp. 317-323). Some melancholics spot dangers where there are none; some find advantages in objects in which there are none; some are afraid of their friends, and some others, of all mankind. In addition, melancholics tend to turn from the company of others and seek solitude (Razi, 1997, pp. 56-57; Qamri, 2008, pp. 15-18). In his book *Tibb Akbari*, Akbar Arzani defined *melancholia* as a disease in which the power of imagination and judgment are completely lost and occurs only in individuals having a melancholic temperament (*Saudawi Mizaj*)(Arzani, 2000, p. 739). Avicenna has mentioned that this disease occurs most commonly in the summer and spring seasons (Avicenna, 2007, pp. 550, 560). Averroes (Ibn Rushd , 1126-1198 CE) have described melancholic diseases (*Saudawi Amraz*) as having a familial occurrence (Rushid, 1980, pp. 134-144).

Depression

Today, *melancholia* is mainly used as a descriptive syndrome, a specifier of major depressive episodes (MDE), as defined by DSMIV-TR (Angst, et al, 2007, pp. 72-84). Wilhelm Griesinger around the mid-19th century introduced the states of mental depression as a synonym for *melancholia* (Griesinger, 1861, pp. 155-153) (Tables 1 and 2). Jean Esquirol (1772-1840), coined the term lypemania, as a synonym for *melancholia* (Kendler, 2020, pp. 863-868). Dictionary of Psychological Medicine in 1892, listed mental depression as a synonym for *melancholia* (Jackson, 2008, p. 443). Major depression is defined as a depressed mood on a daily basis for a minimum duration of 2 weeks. Approximately 15% of the population experiences a major depressive episode at some point in life, and 6–8% of all outpatients in primary care settings satisfy diagnostic criteria for the disorder. Depression is approximately twice as common in women as in men, and the incidence increases with age in both sexes (Kasper, et al, 2015, p. 1890). Depression is extremely common, with up to 30% of primary care patients having depressive symptoms (Papadakis, McPhee, and Rabow, 2018, pp. 51-66). Depression continues to be the leading cause of disability worldwide (World Health Organization, 2017), accounting for almost half of disability-adjusted life years (World Health Organization, 2012) (Papadakis, McPhee, and Rabow, 2018, pp. 51-66).

The mood varies from mild sadness to intense despondency and feelings of guilt, worthlessness, and hopelessness, Difficulty in thinking, including the inability to concentrate, ruminations, suicidal ideation, and lack of decisiveness. About 10% to 15% of all depressed patients commit suicide, and about two-thirds have suicidal ideations (Siddarth, et al, 2008, pp. 685-688). Loss of interest, with diminished involvement in work and recreation, Pessimism, Guilt, and anhedonia (Loss of enjoyment) (Davidson, 1974, p. 1181) are also observed in depressed patients. In elderly patients, depressive symptoms may be associated with cognitive def¬icits mimicking dementia ("pseudodementia"). A seasonal pattern of depression, called a seasonal *affective disorder*, may manifest with the onset and remission of episodes at predictable times of the year (Kasper, et al, 2015, p. 1890).

Conclusion

The USM, in addition to the curative and rehabilitative healthcare, is focused on the prevention and promotion of good health. According to the USM, a body is healthy as long as the humors (Akhlat) remain in a state of equilibrium, in terms of their quality and quantity. Abnormal melancholic humors are regarded to be a key etiological element in *melancholia*. Nowadays, *melancholia* is mainly used as a descriptive syndrome specifier of major depressive episodes (MDE), as defined by DSMIV- TR. Although there are various differences between *melancholia* and depression, it can be concluded from the above review that Unani scholars were aware of the psychiatric disorders and the concept is a collaborative effort of both Unani and the conventional system of medicine.

Table 1: Similarities between *melancholia* and depression

Melancholia	Depression
1. Mood varies from mild sadness to intense despondency and feelings of guilt, worthlessness, and hopelessness. Difficulty in thinking, including the inability to concentrate, ruminations, and lack of decisiveness. Loss of interest, with diminished involvement in work and Suicidal ideation (Avicenna, 2007, p. 550; Majusi, 2010, pp. 317-323).	1. Psychological symptoms of depressive disorders include Depressed mood, Reduced self-esteem, Pessimism, Guilt, Loss of enjoyment, (anhedonia), and Suicidal thinking (Papadakis, McPhee, and Rabow, 2018, pp. 51-56; Gelder, 1989, p. 239).
2. Somatic complaints, such as disrupted, lessened, or excessive sleep; loss of energy; change in appetite; decreased sexual drive (Tabri, 1995, pp. 374-391; Majusi, 2010, pp. 317-323).	2. Somatic symptoms of depressive disorders include reduced appetite, weight loss, disturbed sleep, fatigue, loss of libido, bowel disturbance, and motor retardation (slowing of activity) (Davidson, 1974, p. 1181).
3. Averroes (Ibn Rushd, 1126-1198 CE) described those melancholic diseases (*saudawi Amraz*) as having a familial occurrence (Rushid, 1980, pp. 374-391).	3. Genetic factors and familial predisposition plays a critical role (Sadock, and Sadock, 2008, pp. 165-167).
4. Most commonly occur during the summer and spring seasons (Avicenna, 2007, p. 550).	4. Spring and fall are the peak time for depression (Kasper, et al, 2015, p. 1890; Siddarth, et al, 2008, pp. 685-688).
5. Social and environmental stressors can precipitate illness in vulnerable people (Tabri, 1995, pp. 374-391).	5. A neurotic personality increases the risk of depression (Siddarth, et al, 2008, pp. 685-688).
6. Most commonly occurs after 4th decade of life (Avicenna, 2007, p. 560).	6. The incidence increases with age in both sexes (Kasper, et al, 2015, p. 1890).
7. Certain foodstuffs, like cabbage, cheese, pickles, and alcohol intake precipitate symptoms of *melancholia* (Razi, 1997, pp. 56-57; Arzani, 2002, p. 45).	7. Alcohol dependency frequently coexists with serious depression (Kasper, et al, 2015, p. 1890; Papadakis, McPhee, and Rabow, 2018, p. 51-56).
8. Motivating melancholic patients to get involved in pleasurable activities to help improve symptoms (Tabri, 1995, pp. 374-391; Majusi, 2010, pp. 317-323).	8. Behavioral activation and Exercise, especially aerobic, are observed to improve depressive symptoms (Kasper, et al, 2015, p. 1890; Papadakis, McPhee, and Rabow, 2018, pp. 51-56).

Table 2: Differences between *melancholia* and depression

Melancholia	Depression
1. Anormal melancholic humors (*Sauda Ghayr Tabiiyya*), are regarded to be a key etiological element in *melancholia* (Razi, 1997, pp. 56-57).	1. The two neurotransmitters most implicated in the pathophysiology are norepinephrine (NE) and serotonin (5 HT) (Siddarth, et al, 2008, pp. 685-688).
2. Spleen plays a vital role in *melancholia* as it stores and secretes black bile (Qaf, 1986, p. 185).	2. Adrenal gland is enlarged, as it secretes noradrenaline and dopamine (Kasper, et al, 2015, p. 1896).
3. *Melancholia* is more common in males (Avicenna, 2007, p. 560; Majusi, 2010, pp. 317-323).	3. Depression occurs two-fold more commonly among women than men (Kasper, et al, 2015, p. 1896; Siddarth, et al, 2008, pp. 685-688).
4. Derangement in quality or quantity of body humor (Avicenna, 2007, p. 560; Arzani, 2000, p. 739).	4. Derangement in HPA-axis and hypothalamic thyroid axis (Gelder, 1989, p. 239; Sadock, and Sadock, 2008, p. 423).
5. Socioeconomic status plays an important role in *melancholia* (Tabri, 1995, pp. 371-391; Razi, 1997, pp. 56-57).	5. No correlation has been found between socioeconomic status and depression (Sadock, and Sadock, 2008, p. 423).
6. Pharmacotherapy (*Ilaj Bil Dawa*) recommended for *melancholia*: concoction and expulsion (*Nuzuj Wa Tanqiyah*) of abnormal humors (*Sawda Ghayr Tabiiyya*) mainly with venesection (*fasd*), moisturization of head (*Tarteeb ra'as*), and the use of sitz bath (Tabri, 1995, pp. 371-391; Avicenna, 2007, pp. 550-560; Majusi, 2010, pp. 317-323; Arzani, 2002, p. 45)	6. Management include medications (SSRIs are preferred to TCAs) and psychotherapy (Kasper, et al, 2015, p. 1896; Papadakis, McPhee, and Rabow, 2018, pp. 51-56).

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Conflict of Interest

None.

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