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Commentary on 'Depression: why drugs and electricity are not the answer': We have created a public health disaster

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It's clear that the medical 'treatments' we use for something we label as 'depression' are simply enhanced placebos. Read and Moncrieff's thorough review of the evidence demonstrates this persuasively.

We should not be surprised by the lack of evidence for anything tangible that we can biologically connect to 'depression' or its treatment. This is because we don't know how to identify cases that have something essential and universal that characterises them. Depression is a diagnosis only in the cultural sense. Diagnosis is a system of categorisation pointing to a proximal cause. We define diabetes as blood sugar levels that are too high and we can evaluate treatment by measuring its effects on blood sugar. A scientific ontology and epistemology are thus appropriate for developing technical knowledge on diabetes.

With depression all we have are experiences. Experiences can't be measured or empirically captured and so we use language (such as questions) to try and capture something about them and language again to try and make sense. Experiences of suffering have been known for millennia and many cultures, far from seeing suffering as a sign of something going badly wrong, recognise not only its ubiquity, but also its potential value for deepening our experiential knowledge of the human condition.

With depression we thus encounter a different ontology, for which a different epistemology (relational meaning making) is required. Saying your low mood is caused by depression is like saying the pain in your head is caused by a headache.

What common sense?

However, Read and Moncrieff do not appear to appreciate the depth and breadth of the mental health behemoth we have created, that is hoovering up all in its path. They contend that, '*understanding depression and anxiety as emotional reactions to life circumstances … demands a combination of political action and common sense.*' Political action I get, but what do they mean by 'common sense'?

Surely part of the problem is the colonisation of 'common sense' by an individualised medicalised discourse such that psychiatric propaganda has invaded the common-sense meanings we attach to our experiences. In a marketized consumer culture creating typologies of experience opens up prodigious markets for selling cures and well-being products that promise to correct our defects or enhance our wellness. Medications, therapies, books, courses, experts, institutes and so on, for what we call diagnoses like depression, function more as brands that ultimately inflict semantic violence on an unsuspecting public, saturating them in the McDonaldised mental health market place. Like most consumer products they never quite deliver what you hoped, so you search for better, consume more and become trained to be suspicious of your feelings, seeing in them monsters lurking under the surface waiting to take over your mind, sometimes succeeding, and leading to more consumption.

Common sense is always constructed by those that have the power to shape which narratives become popular. There have been decades' long drives, under the mis-guided banner of reducing stigma, to popularise the idea that human suffering, difference, and diversity are signs of illnesses, disorders, dysfunctions, and dysregulations. It's hard nowadays for anyone to know what ordinary or even just understandable suffering is meant to feel like.

The UK Royal Colleges of Psychiatrists' and General Practitioners' 'Defeat Depression Campaign' in the early 1990s is an example of this common-sense colonialism (Paykel et al., 1997). Using medicalised language, it sought to educate GPs and the general public to better 'recognise' and manage depression. Surveys had found that the public seemed to be sympathetic to those with depression, but reluctant to consult about it. Evaluations of this campaign found no evidence that it led to any significant improvements in clinical outcomes, but instead was associated with a rapid increase in antidepressant prescribing (Croudace et al., 2003).

Campaigns like that have been a great success. Common sense shifted. People started talking about feeling 'depressed' rather than down or miserable. They became suspicious of how they felt and a collective delusion that some chemical manipulation can change the material realities of our lives and the dilemmas we face, was introjected.

For young people this meant a disastrous tsunami was about to sweep them away. Young people, their parents, and their teachers developed an awareness that 'illnesses' like depression are all around us, and you could be one of those affected (Timimi & Timimi, 2022). You start to notice how bad you feel sometimes and wonder why you feel like this. Could it be that you are developing a mental disorder?

And so, like a viral pandemic, young people's common sense became infected with mental health ideology. A survey in 2019 of 1000 young people found that 68% thought they have had or are currently experiencing a mental health problem and of those 62% thought that 'de-stigmatisation' campaigns helped them identify it (Wright, 2019). These are dizzying numbers, but not that far off a 2019 academic paper that, using a child self-report questionnaire methodology, came up with a prevalence figure for mental health problems in 11- to 15-year-olds, of 42% (Deighton et al., 2019). This alienation from, and fear of, the emotional turmoil that growing up involves is the terrifying result of this moral panic about mental health.

The scene has been perfectly set up for transforming the challenges, confusions, intensity, and changes that happen as we grow and develop, particularly in our adolescent years, into potential obstacles, dysfunctions, dysregulations, and disorders, that can be neatly packaged and given 'treatments' to get rid of them. This is 'common sense' in late capitalism.

We all suffer

We all suffer as a result of this cultural process. Most GPs and psychiatrists I talk to report feeling under intense pressure to prescribe even when they don't feel this is the best course of action. The idea that we doctors have these magical pills that should at least be 'tried' is woven deeply into our everyday cultural narratives. In our desire to be helpful and avoid a complaint, we often feel powerless to resist. Thus, despite the lack of evidence for effectiveness, year on year we prescribe more and more of the snake oils we erroneously label using their marketing term – 'antidepressants'.

The perseverative call for more resources is the standard juvenile political response to the chaos our incoherent logic has caused. Such a response will only aggravate the problem unless it is accompanied by a recognition that depression isn't a diagnosis, low mood isn't a symptom – it's an experience – and that the evidence for what we refer to as 'treatment', as Read and Moncrieff correctly surmise, is that the risks outweigh any meagre benefits. Such a genuine paradigm shift would allow for the rediscovery of psychiatry that is aware that distress and suffering are meaningful human experiences. We can then help families and communities in the process of facing up with courage and compassion to the human frailties we carry, as well as recognising our innate resilience and capacity for helping that we all possess. Until we do this, we will continue trying to tread water in an ontological sea where every time we think we have found a shore to climb up on, it dissolves back into sea.

Conflicts of interest

ST has received royalties for a number of books that he has authored, co-authored or co-edited, that are critical of current models of psychiatry.

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