Everything Causes Depression and Nothing 'Causes' Depression

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1 INTRODUCTION

The causal story that depression arises from problems in brain chemistry in general and perhaps low levels of serotonin in particular does not hold up to scrutiny in clinical practice. This idea, proliferated by the introduction of a new class of antidepressants in the 1980s (Selective Serotonin Reuptake Inhibitors or SSRIs), has contributed to a rise in diagnosis of depression and an increase in the use of these drugs [1], [2]. Meta-analysis of drug trials shows that in some cases improvements in wellbeing are no better than placebo [3]. I suggest that this is because we are ignoring the systemic nature of the problem. Using examples from clinical practice I argue that a person becomes depressed when certain complex combinations within the brain/body/world system (BBWS) break down in particular ways. For example, a person might have problems with feeling anxious, being unable to sleep or unable to concentrate; she might also have problems with relationships with others or with her environment; she might have practical problems about housing, finance or feeding herself. I also argue that this is already understood through folk psychology and the use of the bio-psycho-social model. This makes it all the more puzzling that research and treatment centre around pharmacology.

Depression is understood in folk psychological terms to happen at person level. *People* are depressed. Brains are not. If we take psychological realism to be true [4] then what depression is can be readily understood by the (non-medical) lay-person to include many complex overlapping factors relating to the brain, the body and a person's relationships within her lived environment. Emphasis on brain chemistry means that other constitutive factors are neglected and opportunities for intervention are missed. If a person seeks help for her depression she normally has a narrative to recount which seems to explain (to herself and to others) the circumstances of her depression. I now illustrate this using a case example from my practice.

2 CASE EXAMPLE

A client recently came to see me after becoming depressed and being prescribed anti-depressants by her GP. The client has been evicted from her house and is living with her parents. She does not get on well with her parents as they continue to treat her as if she is a teenager (she is in her 30s) and she has to conform to 'house rules'. The consequences of not conforming mean that she is constantly rowing with her parents. She thinks that being evicted from her house is evidence that she has not 'grown up'.

Her best friend from school had just bought a flat and is moving in with her boyfriend. She complains of feeling stressed and is not sleeping well. The lack of sleep is affecting her mood. She says she is more irritable than normal and recently had a row with a work colleague. She is ruminating on how her life might have been different if she had finished university. She also regrets splitting up with her boyfriend two years ago and wonders whether it was her fault. Her perceived 'failures' seem to be highlighted when her friend got her new flat.

Whilst one could argue that this client is not strictly speaking severely or clinically depressed[2] as she is still functioning relatively well (going to work/spending time with friends etc.) it is clear that both she and her GP would described her as depressed - she uses this language when talking about herself and her GP has prescribed antidepressants. Yet the 'treatment' does not seem to address the problems. Given her narrative it is hard to see how the 'cause' of her depression can simply be a problem with her brain chemistry. It is therefore difficult to understand how a pill that increases the serotonin available to her brain can be an appropriate treatment. I now examine how a systemic (embodied embedded enactive) conceptualisation of the person better fits the narrative of the case example than the notion of depression as a problem with brain chemistry.

3 EMBODIED, EMBEDDED, ENACTIVE

Depression is extremely complex and it would be a difficult, if not impossible task to establish and describe all the factors that have an impact on the system. For example, such factors as a person's response to the people around them and the way this is reciprocated all have an impact on the wellbeing of that person [6]. However, one can see, broadly speaking how the system works with reference to a much simpler example.

Take a person who has a pin stuck through her hand and complains of feeling pain. Whilst we ordinarily talk about the pin 'causing' the pain and a neuroscientist might talk about the pain being 'caused' by tissue or nerve damage leading to pain areas in the brain responding, I suggest that these kinds of explanations are over-simplified. One can better describe what is happening in the following way:

A pin/person combination responds in this way (with an expression of pain) because it is a system that has these properties. If one were to significantly change part of the system (for example train the person in mindfulness meditation) then she might find that the pain experience is reduced or disappears altogether. Similarly, if the person had a de-nerved/paralysed

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[2] For clinical criteria see F32/33 Depressive Episodes/Recurrent Depressive Disorder [5]

hand she would not experience the pain. If she lived in a 'stoic' culture where expressions of pain were unheard of she might experience something entirely different. All the elements and interactions of the pin/person system are needed for the experience to occur. Whilst one could argue that this is (still) an oversimplified description it is certainly more accurate than one that just states that the pin causes the pain.[3]

4 CONCLUSION

A depressed person is embodied and embedded in the world such that the brain, the body and the world interact systemically and are constitutive of the depression. To this extent 'everything' causes depression and at the same time there is no single 'cause' of depression. This conceptualisation has implications for treatment and research.

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[3] I am grateful to Sanneke De Haan for this example explored in conversation [7]