On Depression: A Dissent from the Personal to the Political

By Bea Groves-McDaniel | Research Assistant: SAL-9000 Saturday, 5th September 2026

Introduction

I was thirteen years old when depression first sat down beside me and refused to leave. That is not a metaphor. I do not mean I felt a little sad, or down, or fed up in the way that any teenager might be after a row with a parent or a disappointment with friends. I mean that something — something vast, heavy, and utterly immovable — descended upon me and blanketed every thought, every sensation, every flicker of curiosity or pleasure that might otherwise have made a life worth living.

I am now seventy years old. That is more than fifty-five years of intimate acquaintance with an illness, a condition, a state of being — I still do not know which word is correct — that has shaped everything I am, everything I have done, and everything I have failed to do. In that time I have been medicated, therapised, patronised, dismissed, and occasionally, fleetingly, helped. I have also read widely around the subject, as much to understand myself as to survive myself.

What follows is not a clinical review. There are plenty of those, and I am not a clinician. This is a dissenting account from someone who has lived inside depression for six decades, and who has watched with growing unease the way it is discussed, treated, and misunderstood in contemporary Britain.

Development

How psychiatry defines depression

The diagnostic manuals — the DSM-5 and the ICD-11 — tell us that major depressive disorder, or clinical depression, is characterised by a set of symptoms:

- persistent low mood or irritability,
- loss of pleasure in activities,
- changes in appetite and sleep,
- fatigue,
- feelings of worthlessness or guilt,
- difficulty concentrating, and
- recurrent thoughts of death or suicide.

To receive a formal diagnosis, **five or more** of these symptoms must be present for **at least two weeks** and represent a significant change from previous functioning. The affected person must also rule out bereavement, substance use, or other medical conditions as primary causes.

This is a reasonable working description, as far as it goes. Clinicians need categories, thresholds, and agreed criteria in order to communicate across settings, prescribe consistently, and assess need. I do

not dispute that. But the language of diagnosis is not the language of experience, and somewhere between the checklist and the lived reality, a great deal gets lost.

How it feels from the inside

The clinical definition speaks of symptoms. It does not capture the texture of the experience. From the inside, depression is not a list of symptoms. It is an immense and immovable darkness, sometimes so total that it simply blanks out every other concern, every other interest, every other person. It is not sadness, not really. Sadness has a cause and an object. Depression, at its most severe, is the absence of everything — **a void** where feeling used to be.

It is also, for many of us, a profound and exhausting inertia. The most elementary tasks — getting out of bed, making a cup of tea, opening the curtains — require the same effort as climbing Everest. Not because the body is tired, though it may be. But because the will has simply evaporated. The motivational architecture that drives ordinary human functioning has been stripped away, and what remains is a shell of a person going through the motions of living without any of the internal engines that make living possible.

There is also, in my experience, a terrible misanthropy. A turning away from other human beings, not because of any rational grievance, but because they seem impossibly distant, impossibly other, and impossibly demanding. The world contracts to a single point — **the self** — and the self is unbearable. Other people become objects of indifference or active distaste, not from any malice, but because the emotional apparatus that allows us to recognise others as fellow creatures has been switched off.

And then there is self-hate. Not in the melodramatic sense of theatrical self-loathing, but in the grinding, relentless sense of believing oneself to be inadequate, worthless, a burden, a failure. These are not thoughts that come and go. They are the constant background noise of a depressed mind, a permanent static that drowns out any evidence to the contrary.

The British fear of emotional honesty

It is no accident that depression is so poorly understood in Britain. We are, culturally, deeply suspicious of emotional expression. The stiff upper lip is not merely a stereotype — it is a lived social reality that shapes how we talk (or do not talk) about our inner lives. We have a national allergy to sentiment, to vulnerability, and to the open acknowledgement of psychological pain.

When someone with depression hears "*pull yourself together,*" as so many of us have, what is really being said is this: your suffering is inconvenient, your experience is not welcome here, and I do not wish to be troubled by it. The phrase is not merely unhelpful — it is actively **cruel**. It suggests that the depressed person has chosen their condition, and could equally unchoose it. This is a profound misunderstanding of what depression is.

The consequence of this cultural timidity is that many people suffer in silence for years, even decades, before seeking help. They have internalised the message that depression is something to be ashamed of, a personal failing rather than a legitimate illness. And when they do finally speak, they often find that those around them lack the vocabulary, the patience, or the emotional literacy to respond with anything more useful than embarrassed silence or well-meaning but hollow encouragement.

The overdiagnosis debate: a dissenting view

One recurring argument in public discourse is that depression is overdiagnosed. Sceptics suggest that everyday sadness, grief, and ordinary human unhappiness have been medicalised, pathologised, and turned into a diagnosis in order to sell pills. The pharmaceutical industry, it is argued, has broadened the criteria, funded the research, and incentivised the prescribing in order to expand its

market.

There is, I think, some truth in this critique — but it has been weaponised in ways that cause real harm. Yes, the boundaries of depression have expanded. Yes, pharmaceutical companies have marketed aggressively. And yes, not everyone who receives a diagnosis of depression necessarily has the severe, recurrent, disabling condition that the term once described.

But the solution to overdiagnosis is not to dismiss the suffering of those who are genuinely ill. It is to be more precise, more careful, more humane in how we assess and treat. Antidepressants — primarily selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine, sertraline, and citalopram — have been demonstrated in clinical trials to be modestly more effective than placebo for moderate to severe depression (Kirsch, 2014). They do not work for everyone. They do not work all the time. But for many people, including me at various points in my life, they have been the difference between surviving and not surviving.

To dismiss them as a conspiracy or a placebo is to gamble with people's lives. And it is a gamble that has been taken, again and again, by people who have never themselves stared into the void that I am describing.

Inheritance and circumstance

The biology of depression is not straightforward. The most credible contemporary account is that it arises from a complex interaction between genetic predisposition and life experience. Family studies suggest a heritable component — twin studies have estimated the heritability of major depressive disorder at around 37% (Sullivan, Neale and Kendler, 2000) — but inheritance is not destiny. Many people with a strong genetic loading never develop depression; many people with no known family history do.

What is clearer is that adverse life circumstances dramatically increase the risk. Childhood trauma, chronic stress, poverty, social isolation, bereavement, serious illness, and structural disadvantage all contribute. Depression is not purely biological, nor is it purely psychological. **It emerges at the intersection of the body and the world, shaped by both.**

This matters because it has implications for treatment. If depression is purely a chemical imbalance, then medication alone should suffice. But if it is also, and sometimes primarily, a response to circumstance, then medication alone is not enough. We also need to change the conditions that give rise to it.

The tyranny of Cognitive Behavioural Therapy

In recent years, **Cognitive Behavioural Therapy** has become the default treatment for depression in the NHS. Waiting lists for IAPT (the Improving Access to Psychological Therapies programme) offer CBT or counselling to those who qualify. This sounds like progress. In practice, it is often a sticking plaster on a haemorrhage.

CBT is a practical, structured approach that helps people identify and challenge distorted patterns of thinking and develop more adaptive behaviours. It has a solid evidence base for mild to moderate depression. I do **not** wish to dismiss it entirely.

But it has become something of a whitewash solution — a cost-effective, scalable, manualised intervention that can be delivered by practitioners with relatively brief training, and that therefore suits the budgetary constraints of a stretched health service. What it cannot do is address the root causes of a person's distress. It cannot remedy poverty. It cannot repair a broken marriage. It cannot compensate for childhood abuse. **It cannot fill the void left by the collapse of community and the rise of social isolation in modern Britain.**

Worse, there is evidence that the IAPT programme, for all its ambition, has systematically underdelivered for those with more severe or complex presentations. The patients who most need help are often those who do not fit the CBT model and who are discharged, inadequately treated, to wait again or to give up entirely (Clark, 2018).

What is needed is not one therapy for all, but a range of therapeutic approaches — psychodynamic, humanistic, systemic, narrative — delivered by practitioners with the time, training, and supervision to form genuine therapeutic relationships with their clients. The relationship itself, the human connection between therapist and client, may be the most potent ingredient in any therapy. This is increasingly supported by research (Swift et al., 2017). We have reduced it to a technical intervention and wondered why it often fails.

The NHS and the rise of health expectations

When the National Health Service was founded in 1948, its ambition was clear: to provide healthcare that was free at the point of use, based on clinical need rather than the ability to pay. The founding principle was a **safety net** — catch those who fell, treat acute illness, ease suffering where possible.

Seven decades later, the demand on the NHS is unrecognisable. An ageing population, the rise of chronic long-term conditions, the medicalisation of previously unexamined aspects of human experience, and the explosion of public expectations have transformed what people want from a health service. Mental health, once the poor relation of physical medicine, is now rightfully foregrounded. But the resources have not followed.

The result is that depression is simultaneously overdiagnosed in some quarters and catastrophically undertreated in others. People with severe, recurrent depression wait eighteen months or more for specialist input. Crisis services are stretched to breaking. And the gaps are filled by social prescribing — a well-intentioned policy that directs patients to community activities, exercise programmes, and befriending schemes in place of clinical treatment.

I have **no objection** to social prescribing in principle. Community, activity, and connection are genuinely healing. But as a substitute for therapeutic and psychiatric input, it is inadequate, and in some cases actively harmful. Being told to join a walking group when you can barely get out of bed, or to attend a craft workshop when your mind is consumed by suicidal thoughts, does not merely fail to help. It compounds the sense of inadequacy. It suggests that the problem is simply that you are not trying hard enough. And that is a cruel message to send to someone who is already consuming themselves with self-hatred.

Alienation, social media, and the perfect self

Depression does not arise in a vacuum. It arises in a society. And contemporary British society is, in many respects, a near-perfect incubator for depressive illness.

The social conditions that once buffered individuals against despair — stable communities, meaningful work, strong family networks, shared cultural rituals, a sense of place and belonging — have been systematically eroded. Economic restructuring, the decline of the industries that once defined working-class identity, the fragmentation of communities through housing policy, and the atomisation of daily life through car-dependent urban planning: all have contributed to a profound sense of alienation that affects even those who have never been diagnosed with a mental health condition.

For those of us who are already vulnerable, this alienation is not an abstract sociological concept. It is a daily experience of isolation, disconnection, and the grinding sense that the world has moved on without us and does not require our presence in it.

And then there is social media.

The arrival of platforms designed to surface, amplify, and celebrate the best moments of other people's lives has been, I think, a net negative for mental health — particularly for those already predisposed to depression. The constant comparison to curated images of success, happiness, beauty, and productivity creates a standard that no ordinary human being can meet. To be told, day after day, that you should be your "*best self*" — as though the self you actually are is insufficient, as though happiness is a hygiene product to be achieved through the right mindset and the right products — is to be set as an impossible task and then blamed for failing it.

This is not a conspiracy. It is a business model. But its consequences are real, and they fall disproportionately on those least able to bear them.

Conclusion

I have lived with depression for fifty-five years. I have good days and bad days, good years and catastrophic years. I have found help at various points, and I have found nothing at all at others. I have learned to manage, to survive, and to build a life alongside an illness that I will never fully be rid of.

What I have learned is that depression is not a weakness, not a choice, and not a failure of willpower or character. It is a serious and potentially fatal illness that deserves to be treated with the same seriousness, the same resources, and the same compassion as any physical condition. It is also a profoundly social phenomenon — shaped by the conditions we create together, by the communities we do or do not build, and by the economic and cultural forces that determine how we live.

The solutions on offer — the antidepressants, the CBT sessions, the social prescribing, the mindfulness apps — are not nothing. They help some people some of the time. But they are crudely inadequate as responses to the scale and complexity of the problem. We need more. We need better. We need a society that does not drive people mad and then blame them for being ill.

What can we do?

We can start by taking depression seriously as a public health issue and funding mental health services accordingly. We can expand the range of therapeutic options available, and we can give practitioners the time and training to form the kind of human connections that actually heal. We can challenge the cultural stigma that prevents people from speaking honestly about their mental health, and we can teach emotional literacy in schools, in workplaces, and in communities.

We can resist the social media architecture that turns human connection into a performance competition. We can rebuild the communities, the shared spaces, the opportunities for play and informal contact that have been systematically stripped away from modern life. We can be honest about the economic and social conditions that cause depression — precarious work, insecure housing, structural inequality — and refuse to treat it purely as a medical problem with a medical solution.

And we can, each of us, practise forgiveness. **For ourselves and for each other**. The world asks us to be more than we are, more than we can be, more than any human being reasonably should be. To fail at this is not a character defect. It is the most honest response to an impossible demand. Let us have the grace to be inadequate in peace, together.

Coda

If this piece resonates with you — whether you live with depression yourself or know someone who does — please understand that you are not alone. Help exists. Recovery, or at least survival, is possible. And the fact that you are reading this, that you have come this far, that you are still here: that is not nothing. That is everything.

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