

Depression: Rebalancing Neuroessentialist Data

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Abstract

Health care provision for those suffering from depression is gaining momentum with local and international initiatives to destigmatize mental disorders; an example is the global mental health day. Still, depression remains the leading cause of ill health and disability, over 300 million people living with depression. There is a prevailing paradigm in the field to describe depression in the realm of brain disorders. Such a position tends to prevent individual values from clinical treatment, particularly those patients suffering from depression. I aim to claim in this paper that reducing the numbers mentioned above will require us to adopt the conception of depression that is beyond neuroessentialism, highlighting the importance of neuroessentialism data in the discourse.

Key-words: depression, neuroessentialism, mental health, community care, mental disorders, recovery

Introduction

Depression is a global illness, according to world health organization data, more than 300 million people are now living with depression [1]. Neuroessentialism research has contributed a series of studies on brain-chemical compositions of self-awareness, brain imaging techniques application in psychopharmacological research. The goal of neuroessentialism account of depression lies in the explanation that proceeds to assert that depression is best understood as a brain disorder. To discard this evidence from the outset, would be to reject the biological factors which are crucial in the pathogenesis of certain disorders. Breaking this down will require us to look at the evolutionary theories of depression.

Method

Theoretical analysis is employed to address the conceptual structure of depression drawing from the contemporaneous research findings in the field and the results obtained from this approach will help us develop a concept of depression that accounts for the valuational dimension of the disorder.

Evolutionary Theories of Depression

In current medical settings, very few would say that the evidence provided within the neuroessentialism movement suffice to account for what depression is. Mental health practitioners must have enough tools in their toolkit to deal with heterogeneity concerns when diagnosing depression given that mental health practitioners are beginning to operate in pluralistic settings where individual values might clash with mental health practitioner's values. Delving into the evolutionary theoretical terms is cardinal to the aims of this paper. Wakefield defines the disorder such as depression as a design failure extending to harmful dysfunction [2]. Wakefield sees disorder as a dyad expression, that is, the scientific establishable aspect and the valuational aspect which is outside of our empirical grasp.

If one domain of the dyad that Wakefield suggests is outside the realm of neuroessentialism, how then is it possible

for neuroessentialism to give a complete account for the conceptual understanding of depression? We have to assume two things here; firstly, there is another avenue to gain new understanding; secondly, Wakefield accepts that additional research is required as to how these two domains can be consolidated. Wakefield rejects the notion that depression is purely a scientific concept [2]. His claims that depression, as a design failure, is the unsuccessful attempt of a system to function as previously designed, this account struggles to address secondary adaptations. I must admit that Wakefield's account addresses the importance of combining the contextual and subjective account of the patient's experience with the evidence of neuroessentialism.

Nonetheless, it fails to sufficiently account for the definition of function or dysfunction considering we have dysfunction which is unrelated to evolutionary systems. Lilienfeld and Marino put it this way; the weakness of Wakefield's argument lies in his conceptualization that all physical and mental processes establish themselves via evolutionary processes [3]. However, Wakefield's adherence to the logic of essentialism pertaining to dysfunction makes his description inconclusive. Point also emphasized by Lilienfeld and Marino saying that Wakefield adopted an essentialistic view of what depression as a disorder means, elucidating that function and dysfunction are parts of a natural separation based on evolutionary mechanisms. For example, kidneys perform several functions in the body, supporting fluid balance and filtering toxic substances, one's kidney is still within the normal range if the GFR number is 90 or greater. However, we understand that GFR decreases with age, so for a particular older adult, the functional range would still be considered normal, and a lesser values of the GFR could be enough to live the good life. Gene variants might also prove adaptive, increasing performance and maladaptive in some instances, with increased risk of development of chronic kidney disease.

Wakefield's account is essential but fails to accommodate conflicting human values with evolutionary accounts of function. While Wakefield's account is useful in helping us understand the concepts and understanding of these phenomena but in depression as a disorder in dysfunctionality terms, this

leads to oversimplification of the terms. Fulford tends to see function, dysfunction, disease, illness and disorder as inter-linked terms [4]. The move to address the function and dysfunction terms of humans dated back to Aristotle [5].

Correspondingly, Scadding propounds mental disorders like depression in evolutionary theoretical terms. John Scadding defines illness as a non-physiochemical process that needs to manifest by its consequences [6]. The definition of illness as a condition in which one suffers is also not adequate because one can suffer without getting ill. Scadding describes the concept of biological disadvantage, that is, anyone suffering from a body illness or depression produces some biological disadvantage although he did not explicitly explain what he meant by "Biological Disadvantage". Kendell, who also subscribes to this notion of biological disadvantage to represent a mental condition is not the last word on the subject [7]. Biological disadvantage as a feature of disease as Kendell takes it is inconclusive and also problematic because the Dubin-Johnson syndrome, an abnormality of the liver enzymes without symptoms is not seen as a biological disadvantage. However, it is considered to be a disease; the legitimacy of asymptomatic diseases is predicated on classical diagnostic methodology. By contrast, the conceptual structure of depression is beyond neuroessentialism since the mental content of the patient influences the dynamics of the diagnosis.

For this reason, it would be sagacious to seek alternatives beyond algorithmic explanation as we can see that the construction of mental disorders such as depression is complex and continuously developing with global considerations playing a cardinal role. If depression as a disorder is not well-understood this can have a pernicious effect on society, considering the latest data on depression diagnosis mentioned in this paper coupled with undiagnosed cases due to stigma associated with mental disorders, it would be harmful to our collective way of life.

Nevertheless, the explanatory power of the evolutionary cannot be undermined, as Stein puts it.

An evolutionary perspective helps to explain why a handful of psychotropics have such powerful effects across behav-

iours and across species. The power of these agents resides not so much in their own structure as in the effect that they may have on complex, evolved, endogenous neurocircuitry [8].

Indeed, the questions arise of the implications of solely basing the conceptual understanding in evolutionary terms. We shall move next to the current evidence within the neuroessentialism movement.

Neuroessentialism Model of Depression

The acceptable paradigm within the neuroessentialism tradition is the belief that our brain will be able to tell us what depression is. One thing is sure from this assertion, that is, to assume that depression can only be explained via brain machination systems. This assumption is predicated on the chemical composition of our brain as solely responsible for depression. I must say the empirical basis of this assumption is not clear-cut. The issue is that there is a challenge in translating the data from the animal model to humans due to interpersonal networks in humans.

Still, recent research from Elizabeth S. Williams et al. might assist in clarifying those challenges. They found a switch in the brain showing a single circuit in mice that activates during stress and controlled by testosterone. According to the researchers, apart from locating this new circuit, its importance is enormous regarding our access to how we can observe and confirm how the activation of the circuit drives different behaviours in males and females. As they put it, testosterone tends to lessen activities in the circuit. They arrived at this insight by observing the effect of testosterone on the mice when testosterone was removed, depression-like behaviours were observed.

Conversely, in female mice, increased activity was registered, and when testosterone was given, the neurons in the brain quieted, and the female mice develop resistance to depression-like behaviours [9].

Consistent with a more critical perspective that emphasizes subjective and contextual understandings, three questions

will be logical to ask here, firstly is the source of the depression-like behaviour in the brain of the mice? Secondly, do external factors influence the activity of the single circuit in the mice? Moreover, can this research yield definitions of function and dysfunction that is sufficient if we were to translate the findings to humans? Sure this data is very crucial in assisting us to gain an in-depth understanding of what depression is. However, critics of neuroessentialists would argue that neuroessentialism explanations are too inconclusive to provide classical conclusions that one would consider comprehensive to meet the Popperian falsification criteria.

In practice, though, the latent content of particular depression is beyond neuroessentialism description. For example, this is how a patient describes her feeling.

“When depression takes over, and I cannot push through it, I have to close my door and shut the world out; it is the only way I know how to survive” [10].

The inference derived from this quote can be stated that there is a sense of detachment and altered “I” experiential account in depression, a point that I will get to later in this paper. It is worth considering the way artificial intelligence is changing the way we understand depression. I must have to say that further research is required on how to humanize the research findings in the area of artificial intelligence, brain imaging and depression. In a discourse relevant to the considerations of neuroessentialism, Cherise R. Chin et al. and Gregory A. Fonzo et al. illustrate how AI can be used to specify correlations between the efficacy of an antidepressant and how the brain processes emotional conflict. The researchers shift the analysis of the brain imaging results to AI; machine learning technique is employed to analyze the entire brain instead of focussing only on the neural regions believed to be relevant to predicting antidepressant benefits. As the researchers explain, AI identified specific brain regions like the lateral prefrontal cortices which are responsible for determining whether participants would benefit from selective serotonin reuptake inhibitors [11, 12].

However, how does neuroessentialism explanation encapsulate the interpersonal networks involved with depression?

We might as well take the stance, that there is no a priori approach to truth, cognition, neuroessentialism and the conceptual understanding of depression is within our shared world [13]. Each case will require us to be pragmatic, generating and refining hypotheses predicated on our participation in a shared context. The insufficiency of neuroessentialism approach to capture the comprehensive account is that it seeks the brain solely for solutions, that is, putting the cart before the horse, which makes the harness of the personal account with the neuroessentialist account complex. The conceptual understanding of bodily diseases seems to be easier to grasp; this is due to the shared value, whereas, in depression, diverse values are in play with neuroessentialism data where a contemporary ampliative understanding is required to open up understanding beyond the peripheral explanation.

The failure of neuroessentialism to account for a comprehensive understanding of depression reinforces the urge for an account of depression beyond neuroessentialism. It will be imperative to state that depression as a disorder is complex to define and beyond monolithic elucidation with determinants of the category encompassing multi-levelled features. To understand this assertion mentioned above, it is important to emphasize our lived body as a pre-reflective mode of being in our shared world and alteration to this shared world is allegorical for specific depression. I must emphasize that this account is not exclusive to describe all types of depression. If we place the horse before the cart, we discern the conceptual structure of depression with “I experiential” input, that is, the person participating in a shared activity and the sign of detachment and alteration of experiential feelings associated with depression. Excluding this “I experiential” quotients, the thoughts of the patients suffering from depression would be less meaningful to the practitioner although we see the functionalist account in this paper attempts to circumvent the network structures that block neuroessentialism in psychopathology research by providing causal explanations. A wide range of thinkers has attempted to reframe the question within the context of naturalism and functionalism.

Functional and Meaningful Connections

With the research still ongoing between functional and meaningful account, Thornton suggests viewing the discourse from a different angle. For Thornton, the value theorists are right that valuational description of depression seems to be obscured from our quantitative dimension; for this reason, the conceptual understanding of depression cannot be settled within the neuroessentialism domain. Because the diagnosis of depression is such as putting our values out in our shared context, capturing it in neuroessentialism terms solely raises additional questions. For example, the questions of the intersubjective experience and the role that introspection play in our thought process. What I surmise is Thornton is quite right to stress that the ongoing research has not captured the valuational aspect of depression that one would deem appropriate, that is, meeting the standards of compact understanding. If x' is not known that does not mean x' cannot be known, the plausibility that y' will emerge to give an account of x' does exist. The interface to find the confluence will require fine-tuning existing knowledge. Thornton is clear that seeking solutions to this conceptual issue in the domain of neuroessentialism in regards to depression leaves a gap in our aim to seek viable solutions. To articulate this, he says :

If the diagnostic judgment of mental illness is an evaluation—an expression of our values—rather than simply a description of the facts, then mental illness can-not be an objective matter; it cannot be a feature of the fabric of the world, independent of our own perspective on the world. Thus, the aim of a descriptive account of illness, generally via the notion of function, can be seen as establishing its naturalistic status through reduction to the austere language of physics [14].

Perhaps, a case might arise that patient suffering from depression decline treatment believing that his or her existential feeling is transient and needs no treatment, but a family might be concerned about the medical situation. In this case, the practitioner needs to be judicious when incorporating the evidence of neuroessentialism with the values of the patient and the sane patient should be allowed to accept or decline treatment. Although I suggested that the neuroessentialism data do not provide a comprehensive explanation of what

depression is, value theorists should not look askance at its data. Even though Thornton is critical of the reductionist-naturalism of mental disorders. His findings can be extended to neuroessentialism dimensions of depression that is willing to accept the valuational dimensions as he suggests that reductionist naturalism account fails to provide a descriptive notion of depression compactly. However, he would be open to the non-reductionist naturalism account propounded by Dan Stein because he acknowledges the valuational dimensions as part of the cognitive-affective system. Thornton goes on to remark that :

“In the light of this alternative, non-reduction-ist, form of naturalism, consider again the assumption that seemed to fit recent philosophical work on mental illness. If judgments of mental illness are evaluations, expressions of values, rather than simply descriptions of facts, then mental illness cannot be an objective matter, a feature of the fabric of the world” [14].

Arguably, the value-ladenness of depression which is backed by evidence-based shows that depression interventions, including pharmacotherapy and psychotherapy, can ameliorate the conditions of patients. One problematic view that faces neuroessentialism dimension of depression is the belief that its evidence can adequately resolve the conceptual understanding of depression. A critical conceptual issue is the network structures blocking such elucidation. A range of researchers has highlighted these complexities.

Conceptual Challenges Facing Neuroessentialism Dimension of Depression

Considering than an exhaustive elucidation of neuroessentialism fails to account for depression, it will be astute to start rethinking neuroessentialism and lay bare the conceptual challenges facing neuroessentialism as an approach to address depression. I will start with the stronger claim of neuroessentialists that mental disorders are brain disorders. I raise this concern concerning neuroessentialists account of depression; I argue that neuroessentialists ought to do more than describe depression in causal terms if they are going to

change the mind of value theorists [15]. To circumvent this challenge, I call for an understanding instead of an explanation and to tackle this challenge, we might need to start seeking solutions within what I coin contemporary ampliative understanding of mental conditions, understanding guided by empirical facts and norms, but I do not claim norms wholly determine the comprehensive understanding of depression. Similarly, Denny Borsboom et al. 2018 argue why network structures block reductionism in psychopathology research. They note that such view is inconclusive since it is unclear whether most correlates are realizations, causes or effects of psychiatric symptomatology :

“ Despite the most powerful reductionist mindset present in psychiatry, one of the main recent theoretical developments in psychiatry and clinical psychology has been to move away from monocausal explanations of mental disorders” [16].

Kendler et al. supplement the above claim by suggesting that the ontology of mental disorders such as depression should not be predicated on essentialism of any kind, including neuroessentialism instead he mentions that illuminating psychopathology will require it to be conceptualized within mechanistic property clusters, that is, constellation of properties intertwined because they are connected by a various set of mechanisms akin to how Boyd, developed the properties cluster in species in the realm of theoretical biology [17,18].

With these considerations, it would be prudent to call for a methodological shift when addressing the neuroessentialism dimension of depression. At this point, the shift has not taken place, hence the call in this paper. For example, Insel & Cuthbert have explicitly described mental disorders as brain disorders. Insel and Cuthbert state:

“As new diagnostics will likely be redefining mental disorders as brain circuit disorders, new therapeutics will likely focus on tuning these circuits.” [19].

In suggesting this, Insel and Cuthbert assert that illness such as depression stems from chemical imbalances in the brain, what we discern here is the attempt to move the psychopathology of depression to the realm of clinical neuroscience, that is, neuroessentialism account. I mean this instantial shift

is opaque, the discernment observed examining the structural networks of depression from a practitioner, and experimental angles paints a view beyond neuroessentialism.

Insel and Cuthbert findings can be rejected on the premise that we do not have a monolithic explanation that is sufficiently capable of reliably diagnosing depression by genetic or neuroscientific means. Because of this, we are brought back squarely to start looking for solutions to address the neuroessentialists description of depression beyond neuroessentialism. In suggesting that we begin seeking answers beyond neuroessentialism account, I do not want to claim that neuroessentialism data are not useful, and its methodology is wrong. However, I claim that there are conceptual complexities that need to be addressed explicitly and tacitly. This is essential taking into consideration the numbers of people affected by depression and the staggering numbers of 800,000 people that die by suicide globally as a result of mental disorders, as presented by the world health organization (WHO). Insel and Cuthbert share my assertion that there is room for discourse, debate, criticism, revision or rejection of basic methodology in the light of the high morbidity and mortality figures.

Some researchers have opined that seeking solutions outside of neuroessentialism is basing such claims on pure speculation. As Madhukar Trivedi puts it:

“We need to end the guessing game and find objective measures for prescribing interventions that will work .” [20].

I agree partially with Trivedi that we have to find solutions that work, but it is plausible to argue that neuroessentialism has failed to account comprehensively for the structural dimensions of depression where the person is more than the depression. Specific bodily diseases can be dealt with neuroessentially, giving consideration to specific curable malady that can be monitored, seen and removed, but in the case of depression, such evidence is still elusive to neuroessentialism.

The features of depression are just distinctively different from the features of cancer. For example, Ledford compares depression to cancer and according to him, the understanding of what cancer is, is easier to understand as tumours can

be seen and removed, but in depression, such certainty is beyond neuroessentialism data [21]. We even have researchers that claim that we have determined that mental disorders are brain disorders. For example, Hoogman et al. 2017 propound that there is substantial evidence showing that the brain of mental disorders is altered [22]. Such assertions seem to be an absolute claim; even falsificationists might object since a robust empirical finding cannot be settled, that is, it should be able to be determined to be wrong. Causally, what is salient is that the neuroessentialist's attempt to address the complexity surrounding depression in its terms fails because depression in general term does not resemble medical disease by layman definition, that is, its features differ from bodily diseases. A cursory explanation is not going to resolve this pending problem; I will argue that there are multimodule factors that need consideration if we are genuinely going to resolve the conceptual complexities raised by neuroessentialism and these findings might offer a leeway out of the current challenges posed by neuroessentialism. The neuroessentialists active in the area of psychopathology such as depression must ascertain that focussing all our attention on the operationalized findings of neuroessentialism is not sufficient to provide a watertight argument for the conception of depression as a mental disorder.

Others have made analogous claims based on a range of research studies highlighting the difficulties of conceptualizing depression as a categorical disorder. Carragher et al., show that the attempt to consider mental disorders such as depression as categorical has failed because the evidence shows that psychopathology is based on a continuum with normal-range functioning and Kotov et al. also suggest that not a single finding has been proven to be a discrete categorical system [23,24].

The failure to attain an entity which shows the depression explicitly, one might argue is that experiential depression categories do not provide uniformed phenomena when forced into categorical functionality. As Borsboom et al. point out that mental disorders stem from causal interaction among symptoms because of this fact, neuroessentialism is likely not to produce a definitive account. Fulford et al. suggest that certain mental disorders are similar to bodily disorders, and

some disorders are distant from bodily disorders [25]. By looking solely at the underlying cause, neuroessentialism misses the aspect that is important to the diagnosis, which is, the experiential links of depression. Neuroessentialism data confirms that a basic level of the concept of self entails sensory integrative functions, in chorus affect plays a role in developing the necessary level of the concept of the self. If experiential link plays a role in the concept of mental disorders, then it is vital to acknowledge the interpretation of experience that is mediated through a body conduit that is embedded in the world interfacing with heterogeneity system in confluence with various registered human signatures [15].

Indeed, then both neuroessentialism data and experiential reasoning are essential in the conceptualization of depression as a disorder. Nevertheless, recent trends have shown that there is a constant push to present a narrative that mental disorders such as depression can be satisfactorily explained within the domain of neuroessentialism movement. Reliability, as I have stated, is a critical issue in addressing the concept of depression in neuroessentialist terms. In my 2018 paper, I showed that activity in a specific region of the brain is not a discrete causal connection of specific disorders and to circumvent these we must seek solutions beyond neuroessentialism without assuming that such move will detract the evidence of the neuroessentialists [15]. A systematic domain ought to be developed that will allow the confluence of findings of the value theorists and neuroessentialists to be used to assist patients suffering from depression. As Demyttenaere et al. 2004 describe the global impact since mental conditions remain underdiagnosed and undertreated in both developed and developing countries and recent statistics regarding the comorbidity linked with depression call for action concomitantly raising vexing questions about the nature of depression as a disorder [26]. A viable attempt will require that we start looking at the depression within a contemporary ampliative understanding instead of seeking causal answers from neuroessentialist data. As research shows, most patients that commit suicide had contact with their doctors. The inference from this data requires that we start seeking integrative solutions for depression, bearing in mind its intricate nature.

The Continuity between Neuroessentialism of Depression and the Experiential Data of the Patients

If neuroessentialism account is inconclusive, it is fundamentally valid to seek an alternative that can be complementary to neuroessentialism data. Ken Bryson calls for change when discussing the concept of disease in general; two imperatives must be borne in mind. Firstly we must shift the conversation beyond the study of disease to dialogue with sick patients [27]. Secondly, it is necessary to recognize the diverse values evident in the diagnosis of depression [28]. To start this conversation is to recognize that x' believes that the outcome of y' is out of reach even though the outcome y' can be reshaped to be reached, this can be explained within the domain of altered "I experiential" system. I refer to "I experiential" system as our presence in the world enacting actions that are guided by norms. An example of a quote from healthyplace.com shows a shift in this experiential system.

"Whenever I have a good few months, and I think I've gotten over the worst on my depression, it silently returns. This isn't a battle I asked to fight. I'm tired of knowing it's always coming back" [29].

From the quote above, a sign of hopelessness and altered "I experiential" system of the patients serve as an index of the depression which is personal for the patients, the patient acknowledges a transient recovery, but hopelessness remains part of the experience. Examining this case above meticulously one notices the altered experiential belief that the depression is going to come back even though there is no evidence from a practitioner's standpoint that such is the case. The patient has appealed to his/her own's evidence but when this evidence is integrated within the intersubjective experience, what is noticeable is the alteration of "I experiential" accounts of the patient. To understand this, we must think beyond neuroessentialism data. Another line of thought that is in tune with this claim is that the depressive patients arrive at this conclusion due to her participation in a shared setting; thus, some types of depression is a sign of detachment from shared reality. Refining the general paradigm in our conceptual understanding of depression can bring about a cohesive understanding

when tackling the acute question of what is to be depressed. Evidence suggests that improving the patient's "I experiential" system ameliorate the patient's altered "I experiential" system. The general paradigmatic stance, that is, the move to privilege neuroessentialism data ought to be incorporated into the experiential feeling of those struggling with depression that will involve the understanding of intersubjective domain as a part of the details that will inform the diagnosis and care.

Also, we notice in certain kind of depression the presence of depressive reality versus typical world experience. I intentionally used specific and certain kind of depression in this paper given the variance that is involved when patients describe their experiences; I propound that the diverse values present in their experiences make a uniformed explanation difficult. As a practitioner, I come across these varied experiences often due to the relationship of the patients with his/her environment. For example, this quote from weheartit.com,

"Every thought is a battle every breath is a war, and I don't think I'm winning anymore" [30].

One might argue here that the pre-established sense of living in a shared world is fractured in this case. In a whole world of a depressed patient, a pre-established sense of living in a shared world is malleable, that is, can be reshaped, modified through interactions. However, in this quote above especially "I don't think I'm winning anymore" is a sign of an altered "I experiential" system. In this case, there is a sense of detachment and alteration from the normal world of the patients. The patients suffering from depression can discern this because of their initial understanding of their ordinary world which is achieved through their interaction with their society and technology. It is right to say there are complexities involved between a pre-established sense of living in the world and interpersonal engagement interfacing with multifactorial modules of conducts. It is also plausible that the patient can redesign and reinvent the wholes that they interact with and this understanding can sharpen neuroessentialism data without assuming from the outset that its evidence supersedes intersubjective understanding which can help in differentiating depressive experiences. Patients experiences tend to differ from the features listed in ICD and DSM.

I mentioned earlier the importance of a sense of belonging, technology and environment, from a practitioner's point of view, depressed patients tend to highlight environmental factors and interpersonal connection as central to their recovery. As the quotes in this paper suggest, we must shift the conversation beyond neuroessentialism acknowledging its evidence, but we must not deny the experiential change described by patients suffering from depression. One might claim that patient's quotes are open to different interpretation however it does not change the understanding that fractured "I experiential" feeling is a feature of specific depression where the patients feel estranged from the shared world. For the neuroessentialists, patient's perspectives are to be considered, and I agree that this should not be accepted at face value knowing that cognitive biases are features of altered "I experiential" system of a depressed patient. Patient's mundane feeling ought to be analysed before establishing depression to prevent overdiagnosis.

While the systematic appearance of depression is a precondition for neuroessentialism research, its conception can be questioned if it fails to paint a full image, its hard push to preclude the personal and the interpersonal elements in diagnosis of depression renders it insufficient. I suggest we move the conversation to the position where we can adopt the objectification of the subjectivity experiences of depression patients and the curse of introspection linked with depression. For example, this is believed to be linked with prisoner's depression where the incarceration makes them forecast negativity for themselves.

Contrary to orthodox views that depression is just brain disorders, fractured experiential feeling tends to be a feature of depression; diagnosis must be established from the position of empathy. There is also a pronounced awareness about the bodily dimension of experiential feeling linked with depression; an example from Blurtitout highlights this connection.

"Absolute exhaustion. Every movement needs to be carefully considered and relayed to your body, and yet even the act of thinking is exhausting. It feels like wading through treacle with no end in sight, just as endless ocean of thick treacle with no visible landmarks and no place to stop and rest" [31].

Here again, we discern a shift in the patient's "I experiential" system raising the patient's outlook to the level that views recovery as an insurmountable reach. As noted above, positing a comprehensive account of depression will require us to start seeking solutions from integrative accounts.

Conclusions

Depression neuroessentialism account needs to be balanced in several ways. Relatively, few studies have started looking at the whole brain instead of focussing as known traditionally on the specific brain correlates. Consequently, we are moving in the right direction, but some uncertainties about the entire structure remain. Data are limited for the brain account of depression since this cannot be translated to all individuals because subthemes with variable quotient in feeling are not adequately objectified in neuroessentialism account. Evidence of neuroessentialism is uncertain, and one cannot guarantee that they are free from redundancies. Categorical diagnoses are still equivocal, and its approach has not answered the vexing questions raised by neuroessentialism. Fortunately, the contemporary ampliative understanding of depression will require us to navigate the conversation into the direction that will include the personal, interpersonal, environment, technology and to find viable remedies for people suffering from depression where nutritional psychology and psychiatry play a role even though it is not the focus of patient's symptom. In this case, dietary modification might influence the recovery of the patients.

Additional research is needed to incorporate the data of the patients into the neuroessentialist data since psychopathology of depression is not that clear-cut. Much existing research has focused on adults and in the West and generalizability of explanations extending to a diverse population is not assured. Nevertheless, local context is still vital to the recovery of patients, and this ought to be improved, making sure that participants in the mental healthcare ecosystem are getting the support that they need. The heroes of this ecosystem should be compensated fairly, and policymakers must invest in their professional development to avoid ennui in the pro-

fession and offer practitioners the tools required to carry their engagement with the patients.

Having sketched a general framework for combining neuroessentialism data with patient's experience, it is clear that this paper is not an anti DSM paper but a paper that seeks to exhibit perspicacious understanding to the serious questions raised by neuroessentialism account of depression keeping in mind that depression patients are gravitating towards community care as part of their recovery plan. Mental health practitioners must be equipped with understanding when there are conflicting imperatives during treatment which sometimes will require harnessing various data.

It is salient in this paper that neuroessentialists data do not adjudicate the concept of depression; currently, its data are impervious to the experiences of depressed patients. We recognize improvements with patients when the fractured sense of belonging to the shared world is re-established. Non-pharmacologic treatment may be practical to treat specific depression, at the same time administering psychotropics to certain mental disorders might be beneficiary to the patients, and this needs to be addressed on a case by case basis. A contemporary ampliative understanding of depression will entail an interplay between the evidence of neuroessentialism and the phenomenological study of the experiences of patients which is fractured in depression.

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