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## **Abstract**

In this article we situate empirical research into women's problematic experiences of anti-depressant medication within broader debates about pharmaceuticalisation and the rise of the neurochemical self. We explore how women interpreted and problematized anti-depressant medication as it impeded their recovery in a number of ways. Drawing upon Foucauldian and feminist work we conceptualise anti-depressants as biotechnologies of the self that shaped how women thought about and acted upon their embodied (and hence gendered) subjectivities. Through the interplay of biochemical, emotional and socio-cultural effects medication worked to shape women's self-in-recovery in ways that both reinscribed and undermined a neurochemical construction of depression. Our analysis outlines two key discursive constructions that focused on women's problematization of the neurochemical self in response to the side effects of anti-depressant use. We identified how the failure of medication to alleviate depression contributed to women's reinterpretation of recovery as a process of 'working' on the emotional self. We argue that women's stories act as a form of subjugated knowledge about the material and discursive forces shaping depression and recovery. These findings offer a gendered critique of scientific and market orientated rationalities underpinning neurochemical recovery that obscure the embodied relations of affect and the social conditions that enable the self to change.

**Keywords:** Depression, women, anti-depressants, discourse, emotion

## **Problematizing the neurochemical subject of anti-depressant treatment: The limits of biomedical responses to women's emotional distress**

Within critical social science approaches to mental health and illness there is a growing body of work that aims to make visible the biopolitical forces shaping knowledge, policy and practice around diagnoses, treatment and recovery (Abraham, 2010; Blackman, 2007; Busfield, 2006; Davidson, 2005; Horwitz, 2011; Pitts-Taylor, 2010; Rogers and Pilgrim, 2010; Rose, 2007a; Smardon, 2008; Teghtsoonian, 2009; Williams et al., 2009). Our aim in this article is to further a gendered understanding of the biopolitics of depression by drawing upon interpretative research with women who problematized the truth claims of psychopharmacology as they recovered. In this way we build upon feminist work that examines the gendered discourses and biomedical assemblages that shape women's subjectivities as reflexive consumers and biocitizens (Blum and Stracuzzi, 2004; Ettore and Riska, 1993; Fullagar, 2008b; Godderis, 2010; Lafrance, 2009; Metzl and Angel, 2004; O'Brien and Fullagar, 2009; Stoppard and McMullen, 2003; Ussher, 2011; Wiener, 2005).

This article extends the first author's previously published work on women's construction of the 'benefits' of anti-depressant medication (Fullagar, 2009) to consider contrasting stories that identify 'problematic' issues. We acknowledge similarities with other research into the efficacy and consumption of medication that has explored issues of stigma, fears of dependency, placebo effects as well as ambivalence about the biochemical-sociocultural meaning of depression itself (Barr and Rose, 2008; Williams et al., 2008; Wilson, 2004). Our specific focus considers how women engage with anti-depressant medication as a bio-technology of recovery that is prescribed by doctors to act upon the self as a neurochemical

subject. By consuming anti-depressants the depressed self is also acting upon and reinterpreting her *relationship* to self (as a complex socio-cultural interplay of identity, mind, body and emotion) in the process of recovery. In the context of the proliferation of expert and popular biochemical explanations of depression, we explore how women understand and enact this changing relationship to self-in-recovery as they experienced difficulties with anti-depressant use and identified the limitations of a neurochemical relation to self.

Bringing together theoretical perspectives from Michel Foucault's (1990; 1991) work on the government of self, more recent work on the rise of somatic subjectivity (Rose, 2007b) and feminist analyses of emotion/affect (Ahmed, 2004; Bendelow, 2009), we explore the discursive context of women's interpretation of their own anti-depressant consumption. Our findings identify how women's identities as neurochemical selves are both reinscribed and undermined as they question, critique or refuse the normalisation of anti-depressant use. First, we explore how women problematised the neurochemical self-in-recovery when medication failed to alleviate (and often exacerbated) emotional suffering through a range of side effects. The changing construction of selfhood generated ambivalence about, and for some resistance to, pharmacological solutions and biomedical expertise. We discuss how anti-depressants were found to be limited and limiting by women who had invested their emotional selves in neurochemical treatment regimes (seeking advice, adjusting doses to find the right balance, trying different antidepressants to find the right one, researching effects, negotiating with doctors).

Second, we identified how women articulated recovery as a process of 'working' on the emotional self through non-medical practices (from therapy to yoga) that were transformative.

In contrast to a neurochemical discourse women articulated a different construction that emphasised the every day experience of the emotional self-in-recovery (on woman's relation to self see, O'Grady, 2005). For example, women identified how they thought about and acted upon themselves differently to monitor 'warning signs' and mood changes, develop strategies to manage different emotions and assert the self at work or home. While we identified these two distinct discourses a number of women did draw upon both discourses as they shifted between biomedical and everyday understandings of the complex process of recovery. We go on to argue that these stories can make visible a form of subjugated knowledge that questions the truth claims of psychopharmacology and acknowledges the emotional 'work' of recovery. We conclude by examining the limitations of biomedical-scientific rationalities that position drug therapies as a thinkable solution to the neurochemically deficient self that is depressed.

## **The Biopolitics of Women's Emotional Life**

We situate our empirical research within recent debates that have identified how the expansion of biopower through pharmaceutical markets, recovery oriented mental health policies and media discourses have contributed to the pharmacueticalisation of everyday (Healy, 2004; Karp, 2006; Kramer, 1993; Rose, 2007b; Sardon, 2008; Williams et al., 2008; Williams et al., 2009). Rose (2007a) argues that molecular science has produced new ways of understanding and treating problems of 'the mind' in somatic terms (as a form of neurochemical deficit). Within this context 'abnormal' emotion and cognition have become targets for correction, improvement and even enhancement through pharmaceutical interventions. Yet, with growing evidence that there is little clinical difference in response to

anti-depressant drugs and placebos (Kirsch et al., 2008), critical and ethical questions continue to be raised about the practices that govern and regulate 'emotional health' through 'quick fix wonder drugs' (Bendelow, 2010: 467; Rose, 2007b). The huge investment in drug trials, public health subsidies and personal consumption has occurred despite the growing body of research that critically questions the failure of antidepressants to effectively treat depression (Barr and Rose, 2008).

Feminist work has also revealed how emotional distress has been governed through a gendered assemblage of diagnostic tools, therapeutic practices and biochemical knowledges that identify higher rates of diagnosis and prescription of anti-depressant medication for women (Godderis, 2010; Ussher, 2011). Women as a population are positioned as prone to depression due to a host of 'factors' that revolve around problematic biological bodies and fluctuating hormones (American Psychiatric Association, 2000). Hence, the pharmaceutical promise to alleviate women's suffering and the growth of the anti-depressant market raises a particularly gendered problematic. While the medicalization of women's misery through a range of drug treatments and diagnostic categorisation is well researched (see for example, Gabe and Lipshitz-Phillips, 1982), we approach the expansion of pharmacological treatment for depression from a different conceptualisation of power. Rather than view women as subject to power as a singularly oppressive force we take up Foucault's notion of power as productive of different effects (Foucault, 1980). In this sense women who consume medication are not positioned as dupes of medical ideology nor are women who refuse medication somehow liberated from biopolitical institutions and meanings (Armstrong and Murphy, 2011; Lupton, 1997). Rather, we conceptualise women as active biomedical consumers who are urged to regulate their own emotions, illness identities and hence their

‘conduct’ as responsible and productive citizens in relation to biomedical authority and biotechnologies such as medication.

Anti-depressants can be understood in Foucault’s terms as a ‘bio’technology of self that operates on the depressed subject’s relationship to her mind-body-emotions to attain a desired state of recovery. Recovery is itself a problematic term that is used in a number of ways to signify a return to ‘normality’ or the discovery of a ‘real or true’ self beneath depression (Keane, 2000). Hence, we understand recovery in a performative sense to involve a host of practices or technologies of self that shape individual conduct in relation to the discursive and gendered conditions of women’s lives. Technologies of self are described by Foucault as permitting ‘individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection or immortality’ (1988). While medicalisation may help explain how women experiencing emotional distress come to be diagnosed with an illness identity known as depression, it is less helpful for thinking through the subject’s ‘doing’ of recovery as they actively negotiate a range of discourses about illness, identity and normality (see also, Busfield, 2006; Lupton, 1997). The concept of pharmaceuticalisation places greater emphasis on the complex range of institutional and cultural biopolitical forces that normalize anti-depressants in relation to the individual’s desire for normality, success and happiness. Artist Justine Cooper provides a critical illustration of pharmaceuticalisation in her parody of drug advertising on her website for a fictitious drug ‘HAVIDOL: when more is not enough. HAVIDOL is the first and only treatment for dysphoric social attention consumption deficit anxiety disorder DSACDAD (Cooper, 2009). Yet, as a number of feminists have identified, gendered discourses shape how women’s mental health or illness is regulated in particular

ways that emphasises their emotionality and position as ‘risky subjects’ with respect to the embodiment of care responsibilities (Godderis, 2010; Lupton, 1998; Ussher, 2011). These insights raise questions about how the neurochemical subject who is at the centre of anti-depressant promotion and consumption is gendered and what these gendered effects might be in relation to women’s emotional lives.

Although debilitated by the experience of depression women are positioned within the assemblage of mental health care services (medical practice, policy and products in the globalised market) as active biomedical consumers within advanced liberalism. In the Australian context of our research direct advertising of anti-depressant medication is not permitted but women can seek further information about medication through established websites that provide advice (for example, [www.beyondblue.org.au](http://www.beyondblue.org.au)) or through their own reading and discussion of Internet sites, popular magazines and social networks. Depressed subjects are expected to become help-seekers who should act upon the imperative to care for themselves (as they are expected to care for others and return to work). In this way, depressed women exercise agency by aligning their desires for recovery with expert and popular discourses about treatment and recovery pathways, or by refusing, resisting and seeking alternatives.

We conceptualise this process through which women govern their conduct as selves-in-recovery not merely in discursive terms but as profoundly embodied and emotional-affective. The self of depression is ‘swamped’ by affects (such as sadness, loss, misery, shame, fear and anger) that can render them unable to get out of bed or make everyday decisions. Hence, we conceive of emotional life as something women experience ‘through’ the mediating



effects of socio-cultural relations. In this sense the complexity of lived embodiment is understood to include but also exceed the valued qualities of rationality, control and self-present knowledge (see also, Dormer and Davies, 2001; Fullagar, 2008a). As Sara Ahmed (2004: 4) states, ‘Emotions shape the very surfaces of bodies, which take shape through the repetition of actions over time, as well as through orientations towards and away from others’. In this sense the emotional self who desires medication to alleviate depression is not simply responding to emotions as an aspect of ‘inner subjectivity’ but is rather negotiating the relational and biopolitical context of identity (who am I as a woman in relation to my ‘depression’ and who am I to become through anti-depressant use?). Next we outline the background to the research and the methodology employed.

## **Women’s Recovery from Depression Project**

Our research project developed in response to the identification of depression as a major public health issue for women and the need for a more sociological understanding of recovery. Depression has contributed greatly to the non-fatal burden of disease for women in Australia, and over the last decade anti-depressant prescriptions have dramatically increased (Commonwealth of Australia, 2007; 2009). To examine the gendered meanings of depression and recovery we conducted a large qualitative study in two eastern states of Australia with 80 women. Participants were aged from 20 to 75 years and they self-identified as recovering or recovered from an experience of depression at some point in their lives. Within this diverse sample there were 72 women (90%) who had been prescribed and used medication at some point in their recovery. The same proportion (90%) had also sought help from their General Practitioner. Some doctors also offered counselling, or referred them to a psychiatrist or the

government subsidised program for psychological support. Despite taking anti-depressant medication, a large proportion (81%) of participants experienced a recurrence of depression in their lives and few considered themselves to be 'fully recovered'. In this paper we focus only on the responses of approximately half of the large cohort (43 women) who identified a range of problems with anti-depressants, were critical of medication as a solution to depression or did not believe in drug therapies for various reasons. Elsewhere we have published work analysing the responses of thirty-one participants who identified largely positive effects of medication (Fullagar, 2009). Six women made no comment about medication in their interviews; half of these women had used medication and half had not.

Ethical approval for the study was granted by Griffith University. Participants were recruited for the project from notices in community newspapers, fliers in health centres, e-mail lists and radio interviews. Given the exploratory nature of the inquiry a diagnosis of depression was not required of participants. Although the majority of women did receive a diagnosis (the range included mild, moderate, major, bipolar and postnatal depression). A number of women also described other experiences that affected their wellbeing, such as anxiety, panic attacks and sometimes psychosis. Semi-structured in- depth interviews were conducted by both of the authors within women's homes or preferred locations and fully transcribed. Interviews probed women's experiences of depression and what helped or impeded recovery, the metaphors they used to understand the changes in their lives and what they felt shaped women's experiences in particular. In this article we focus on the responses women gave about medication use and its effects on their self-in-recovery. Participants were predominantly Anglo-Celtic and heterosexual, with middle and working class backgrounds, and included women who were and were not mothers.

NVivo qualitative software was used to code and analyse comments specifically relating to anti-depressant medication. Initially we completed a thematic analysis to identify the issues women raised about their experiences with medication and problematic effects. A second level of analysis was conducted in relation to the discourses that participants drew upon to articulate their understanding of anti-depressant medication in their recovery. We understand the research interview to be a relationship at that point in time through which a particular narrative of self was created, rather than a representation of ‘inner truth’. The narratives provided a means of exploring how participants interpreted their own experiences of medication in terms of the embodied side effects and their expectations of being treated/cured.

The method of analysis brings together insights from a feminist approach to the discursive analysis of power–knowledge relations and a critical perspective on the interpretive practices that individuals use to make sense of their lives (Alvesson and Skoldberg, 2000; Mason, 2002; Wetherell and Potter, 1988). Our analytic focus on ‘how’ women constitute their selves-in-recovery aims to move beyond the limitations of a biological-constructivist dualism that assumes medication has either biological or placebo effects. In this way we critically examine questions about the efficacy and appropriateness of anti-depressant medication in the everyday context of women’s lives. We do not claim to represent all women’s experiences, but rather offer a partial glimpse into the biopolitical context that shapes self-government in everyday life. In the second half of the article we examine two discursive constructions about the problematic effects of medication that were evident across women’s diverse experiences of depression and recovery. First, we identify a neurochemical relation to

the self-in-recovery where medication was problematised as means of treating the truth of depression as a chemical imbalance. Second, an alternate discourse about the limitations of medication was identified through the construction of the emotional self-in-recovery as situated within the context of everyday life.

## **Research Findings and Discussion**

### ***Problematising the neurochemical self-in-recovery***

The notion of an anti-depressant ‘side effect’ is something of a misnomer as the forty three women in our sample identified a wide range of mild to severe problems that negatively affected and complicated their experience of recovery. The type, dose and length of medication use could worsen some depressive ‘symptoms’ (the inability to think clearly and lethargy), created unwanted changes (numbed emotions and lack of libido) and difficulties arose from reducing or changing medication (when it ‘stopped working’ or women desired to stop taking it). These embodied effects were often described and explained through a number of discourses as biochemical (changing serotonin levels) in origin, emotional-psychological (stemming from fear about dependency on drugs and perceived weakness of character) and social (linked to a reduced capacity to ‘function’ in relation to gender expectations in work-leisure-family-community domains). Despite their very different experiences of depression which ranged in terms of type (eg., major episodes, post-natal) and duration (chronic over a life time or a one time experience) participants drew upon common discourses that were culturally available to them. While women drew upon a range of discursive constructions and acknowledged the social context of their lives, biochemical discourses were dominant in women’s own ‘explanatory models’ of depression as a neurochemical problem of imbalance,

lack or disruption. Hence, we explore within this theme how women with negative experiences of anti-depressant use drew upon, and also problematised in different ways, the normalised neurochemical self that figures in the discourse of recovery via treatment. The normalisation of biomedical treatment is not surprising in terms of the Australian help-seeking context where medical professionals are positioned as a source of front line support within the health policy framework of 'Medicare' (Commonwealth of Australia, 2009). In addition to seeking medical advice most women actively researched information on the Internet, talked with friends and read popular literature on depressive experiences and medication use. Yet, the extent to which pharmacological solutions to depression are normalised in Australian culture was also questioned by Jorm et al (2000) a number of years ago. They identified preferences across the population for non-medical options and a mistrust of medication to solve mental health issues such as depression. The authors interpreted these responses as a problem of the population's inadequate mental health literacy and called for better education. In contrast, we argue that this cultural context provides a compelling biopolitical background against which to examine more closely women's interpretation of the problems of, and alternatives to, anti-depressant use in recovery.

### **Reinscribing the neurochemical self**

Women who were strongly invested in anti-depressants as the primary enabler of recovery found themselves in a difficult position when side effects worsened their emotional despair. This was more common in older women who had been prescribed medication for many years or those women who had struggled with depression for most of their lives as they tried different treatments and approaches to recovery. For example, Janeka (30 years) who was

single and unemployed in a rural area with limited opportunities, still thought of herself as a 'resourceful person' who could cope with difficult emotional situations. She had initially resisted taking medication, however, after a series of difficult life events culminating in a serious back injury she resorted to anti-depressant medication to help her with physical and emotional pain. At this point Janeka's construction of self shifted from that of a 'resourceful person' to understanding herself as a biological subject with a neurochemical deficit. She stated: 'you're rebalancing chemicals in the brain, and... you know there's something on a really biological level'. However, like many women who had struggled with the ongoing effects of depression Janeka also found herself trying various medications with little success.

When Janeka eventually found an anti-depressant that 'worked', she then had to negotiate the complicating effects of medication on her life. She commented that 'there were all these side effects; like I couldn't stop eating ... then I put on weight, which made me feel even more like shit'. Janeka was still taking medication at the time of the interview and said it was a 'slow recovery' because of the 'side effects'. At the time of interview she described herself as '70% recovered' and continued to focus on increasing her biomedical expertise as a knowledgeable consumer of medication so she could recover further. Beverly (47 years) who was married and living in an outer suburban area had a similar experience although she had consumed anti-depressants for longer and was still taking them at the time of the interview. She had worked with her psychiatrist for a number of years trialling different anti-depressants without sustained success. In the comment below Beverly articulated her fear that medication was failing to help restore her 'functioning' and this undermined her hope for recovery.

At first I used to believe ‘Oh yes, this is going to work and I’ll be better and I’ll be back on track of life’ you know ‘I’ll be functioning again’ and everything ... now I think, I don’t have a lot of promise in them, like I’m a bit disheartened, I think ‘yeah okay, we’ll try this one, probably mightn’t work’ ... and that’s a bit scary too, because I’m thinking ‘now medication doesn’t work, what is there? What else is there?’ because I put so much hope into the medication.

Beverly described a ‘pattern’ she went through when she was prescribed a new drug by her psychiatrist. She would have a couple of weeks of feeling really ‘high’ and then she would come down with ‘a real crash’ and she would become ‘really depressed’ again. Beverly interpreted her ‘failure’ to respond to medication as a failure to ever be able to recover and manage her selfhood, ‘it was part of me and my make-up and that I just had to accept and get used to’. Encouraged by her doctors Beverly remained invested in a neurochemical relation to self and quest to find the right medication although she had begun to lose faith in the biomedical promise. The interpretation of the truth of the self as neurochemical worked to prevent some women from developing other kinds of self-understanding about their emotional life and social circumstances.

The subject position of expert biomedical consumer in these instances is not necessarily relinquished due to the problematic effects of medication or loss of faith in treatment, but reinscribed through the ongoing hope or desire for a neurochemical fix. This desire to restore the neurochemical self does not reside ‘within’ individuals, rather it is an emotional or affective relation that is produced and circulated through the assemblage of discourses about treatment, consumer-doctor partnerships, promising new markets and policies aimed at

restoring a productive population (Ahmed, 2004; Rose, 2007a). For women who did lose faith and start to question the normalisation of medication within their recovery it was a difficult process to articulate their concerns and have these emotions acknowledged (eg., fear or anger). Michelle (41 years) talked about how the ongoing practice of prescribing medication for her depression further undermined her sense of worth,

I've been on this medication, which is almost 12 months. And they won't listen, and they say 'No, you're going to stay on the medication.' ... Sedating me too much ... I feel like an underclass.

Michelle was not able to hold down a job, was living alone in government housing, had little community involvement and had meals delivered to ensure that she would eat. The lack of available alternatives severely undermined Michelle's sense of agency in recovery and this was compounded by the effects of medication and sense of injustice. This example illustrates how the focus on anti-depressant use and adjusting one's 'neurochemical deficits' intersects with gendered discourses about recovery that invoke self-responsible care and the 'good woman' ideal (Stoppard, 2000; Ussher, 2011). By questioning biomedical expertise or expressing one's loss of faith in the truth claims that underpin medication use, women also problematise how they have been positioned as compliant biocitizens.

### **Side effects and emotional estrangement**



In this theme we explore how women interpreted medication to be problematic in terms of their emotional relation to self as they began questioning the authority invested in neurochemical explanations. The problematic experience of anti-depressants was described not just in terms of embodied side effects but also in relation to a feeling of ‘false security’ where medication failed to live up to its promise. Like a number of participants Robyn (25 years) thought one of the antidepressants she was prescribed helped her mood for a while, however, after continued use it left her feeling numb and estranged from her emotions.

They mess with my emotions. Sometimes I wouldn’t feel anything, so that really hindered my recovery ... on the anti-depressants, at times I would not even know why I was feeling bad. Whereas when I wasn’t on them, I always knew.

Robin who was unemployed and living with her partner in an outer suburban area had experienced depression since her late teens. After having taken medication for about one year she stopped after finding that anti-depressants sent her plummeting back into depression. She also felt that they left her feeling so emotionally disconnected that she engaged in self-harm, drank alcohol to numb herself further, or punched and cut herself to connect with some kind of feeling. Overall medication hindered Robyn’s recovery because she felt distanced from understanding her emotional responses to life situations. Women also spoke about how medication was unable to address or compounded the absence of pleasure or positive emotions in everyday life. In a similar way to Robyn, a number of women articulated the self-in-recovery not in purely neurochemical terms but through the language of emotional confusion, feeling like a ‘failure’ and being ‘out of control’ (suicidal thoughts).

While we are not suggesting a causal relationship there were seven participants who reflected upon how their ‘failure’ to get well intensified emotional distress to such an extent that they considered suicide. For example, Phoebe (43 years) was trialling a number of medications of which anti-depressants were one. She stated, ‘I was driving home this day and it was raining and there was a truck up ahead of me and it had stopped. And I thought “Mm...you know if I could drive under that truck, everyone would think it was an accident, and then that would be okay”’. It was not only that women feared harming themselves. After only one dose of medication that left her feeling estranged from herself Pam (44 years) feared what she might do to her children. In terms of the effects of depression and medication, women’s ‘failure to recover’ was articulated in relation to their feelings of success/failure as mothers, workers, partners and ‘self-responsible’ citizens who assume responsibility for the care of others. Compounding this was the inability of medication to alleviate distress or fulfil expectations of ‘cure’ which also forms part of the gendered context for such suicidal thinking. As Canetto and Lester (1998) argue suicide can be understood as an interpretive response to painful emotions that is underpinned by cultural scripts about women as weak and emotional. Anti-depressants are proffered as a rational solution to help women overcome feelings of ‘weakness and emotionality’, yet women identified the intensification of their fears of self-harm, lack of trust in self and guilt in leaving others behind. These accounts suggest that women deployed a construction of the self-in-recovery that privileged an emotional relation to self. The failure of medication revealed the limitations of conceiving recovery as a pharmacological pathway out of a neurochemical problem. However, the normalisation of medication and the gendered context of women’s lives often meant that the failure of medication was interpreted as their own failure to successfully recover. In the next section we discuss how some women managed to deploy a construction of the emotional self-in-

recovery that explicitly resisted, refused or rejected the normalisation of neurochemical subjecthood.

### ***Working on the emotional self-in-recovery***

Being reflexive about the effect of the research ‘relationship’ on our findings we identified a patterned response in the interviews about what women felt ‘helped and hindered’ their recovery from depression. Many women initially drew upon a normalised discourse about seeking help from medical and psy-professionals, trying medication or seeking social support in self-help groups. When questioned further about what else they did that ‘helped’ their responses revealed a host of everyday practices and changes in work-family-leisure relationships that significantly influenced their emotional relation to self-in-recovery.

This construction of recovery was often described as a process of ‘working on the self’ to enable change and resistance to normalised ideas about gender identity, relationships and also the value of medication. Some women clearly articulated their resistance to and refusal of pharmacological solutions to emotional problems, while for others both discourses co-existed (often in an uneasy relationship). We suggest that the difference between these two responses is related to the length of time that women had not been using medication and had spent developing a different relation to self. However, the process of resisting was never simple and nor were women ‘self present’ subjects who consciously made consistent decisions about their emotional wellbeing. Rather, the emotional relation to the self-in-recovery was fluid and required ongoing ‘work’ that sustained change in the subject’s self interpretation.

One of our younger participants illustrates this complex process of changing the emotional relation to self. Jaguar (27 years) had tried to manage her depression without medication because she felt that anti-depressants ‘levelled’ her emotions out too much and she found it difficult to feel happy. For Jaguar, ceasing medication meant that she could feel her emotions rather than be shut off from them: ‘So, to go off it you feel kind of fun because you do have more feelings, or those feelings are more intense’. Yet at the time of interview, Jaguar was still taking anti-depressants because she feared the self that contemplated suicide when she was severely emotionally distressed. Jaguar was also going through a very challenging life event as she struggled with her emerging lesbian identity. Interestingly, when asked if she did anything else to help her recovery besides taking anti-depressants, she said that she did not. However, immediately after this statement she commented that she ‘worked hard on herself’ to understand her emotional relation to self rather than attempt to control unwanted emotions through medication. Jaguar stated that recovery ‘was really like a discipline’ and she made a job for herself everyday of things that she needed to keep trying to do. These included, exercising, eating well, laughing, dancing and finding new social connections in the gay and lesbian community. She also spoke of allowing herself to have ‘bad days too’ and was trying to deal with negative emotions rather than become overwhelmed by them. She also said that rather than doing things she felt ‘obligated’ to do she acted upon her desire where ‘the things to go and do are things I do because I want to’. Jaguar described the shift in her desire to articulate a gendered (and sexual) identity that moved beyond the normalised expectations associated with what women should do, think and act in order to be valued. The ‘work’ of recovery was articulated in terms of self-discipline and self-care as it involved a different relation to self where different (‘positive’) emotions enabled and were enabled by connection with others and pleasurable experiences of agency.

A number of women challenged and refused biomedical authority as a result of the failure of medication and the recognition that medical expertise alone would not help them recover. Thirteen women talked about the strategies they engaged in their quest to find non-medical practices of self-care. Sometimes they managed to cease taking anti-depressants in conjunction with their doctor, other times they ignored expert advice, reduced their doses as well as challenged medication as the primary treatment mode. Understanding how women create meaning about their medication use and negotiate biomedical expertise may provide useful insights for those professionals who adopt the unhelpful language of ‘non-compliance’ when women exercise agency to refuse (Egan et al., 2003).

Women’s fear of being reliant on medication led some to decide to manage their recovery without it. Tayla (31 years) was initially prescribed anti-depressants after she had suicidal thoughts. She decided to stop taking anti-depressants after a conversation with another person who had a similar experience. Tayla reflected on her own experience, ‘Nup, I’m not going to be on medication for 5 or 6 years. I just went cold turkey...I can beat this with (the help of) husband, kids, friends...’. Tayla, who had been somewhat socially isolated in her rural community, enlisted the help of her friends who would drop around meals or mind the children so she could take time to soak in a bath. She also took a stand in regard to the unrealistic demands she felt were being placed on her in the workplace. Tayla’s response to the fear of becoming trapped in neurochemical selfhood changed the everyday gendered context that she identified as contributing to her emotional distress in the first place.

Ironically the failure of anti-depressants treatment for many women opened up alternative ways of thinking about and practicing recovery. Allie (69 years), who lived through the era

when barbiturates were prescribed to treat depression, challenged this form of treatment by refusing to take it because it sedated her too much.

I thought no, this is no good, there must be something, something else. But I didn't know what the something else could be and it wasn't until many, quite a few years later that I learnt, yeah how to deal with depression ... And then it was a matter of dealing with it, I mean I learnt how to ... live with it if you like, but it was many more years after that before I came through it.

Over the thirty years since Allie was first diagnosed with depression, she has learned that her emotional distress was a signifier that something was amiss in her emotional life that she needed to address. During this time she has also learnt to 'self nurture, count her blessings, journal and meditate'. Part of the self-nurturing is developing different embodied ways of living,

I mean I think you can't go past exercise, but it's not the only answer, it's very complex, depression is complex and also the overcoming it is complex, so you try lots of things until you find what works for you.

Central to women's struggle to interpret their changing sense of self-in-recovery was this negotiation of biochemical and emotional meanings about their experience. To move beyond the state of depression women, such as Allie above, talked about different technologies of

self that they deployed to help move them out of the stasis of depression. This change was not attributed to a neurochemical substance but rather to the emotional work that manifested in a new relation of care to the self that they experimented with and practiced over time. Such changes meant that women were less focussed on the biotechnologies of recovery (such as, managing medication doses, dealing with side effects and consultations with doctors). In contrast they talked about the importance of understanding their emotions (looking for warning signs about mood change, distinguishing feeling sad from a slide into depression, finding enjoyable experiences). In addition, they took action to change their embodied experience (joining choirs, taking up yoga or gardening, planning travel adventures, listening to music, playing team sport or walking by oneself). And they questioned social or gendered expectations about how they 'ought' to live (becoming assertive in relationships, having time out from motherhood, downshifting work or seeking new careers). Renata (38 years) talked about her changing relation to self,

Because I notice that I haven't done exercise, or something for myself, or a massage, or something like that; that's when I start to go off the rails. And so what I do is, just say knowing my signs, is I kick in the self care. So ... I mentioned the massage ... or I cut my workload down.

Women, like Renata and Allie, found another language through which to relate to their emotional selves that was founded in an experiential form of self-knowledge and care rather than neurochemistry. This relation to self required women to question the gendered ethics of care that accords women value for putting the needs of others (children, male partners and ageing parents) before their own. These findings highlight how women's knowledge about

what works for them in the process of recovery largely remains a form of ‘subjugated knowledge’ within the contemporary biopolitical context (Foucault, 1997). At best non-medical practices are considered to be a form of ‘self-help’ that women should responsibly engage in to ‘augment’ the primary role of anti-depressant treatment. And at worst they are dismissed as ‘anecdotal stories’ against the construction of gold standard ‘evidence’ associated with randomised treatment trials (despite the questions raised by placebo effects). We argue that anti-depressant treatment urges women to act upon their ‘faulty biochemistry’ to correct or improve the neurochemical self. Yet, the neurochemical self is not so easily improved and the effects are personal and social; the focus on changing biochemistry occurs at the expense of acknowledging the emotional and gendered context of depression that shapes women’s self-knowledge. If women’s experiences were taken seriously as an ‘evidence base’ there would need to be a vastly different approach to knowledge in medical and therapeutic practice, education and community programs about mental health literacy. Ironically, the impetus for more critical debate at a personal and more broadly at a social level could very well be the ineffectiveness of pharmaceutical solutions and the limitations of scientific rationalities to understand the cultural complexities of emotional life.

## **Concluding remarks**

Our research set out to document the self interpretations of forty three women who felt highly ambivalent about the effectiveness of anti-depressants or were critical of ‘side effects’ that impeded their recovery. A number of older women had been caught in a cycle of recovery and relapse as they moved through the revolving door of drug trials and experimentation for over 20 or 30 years. With pressures relating to work and family many



mid-life and younger women desired a fast working remedy for their depression and yet they experienced complicating embodied effects and fears about dependency or recurrence. The problematic issues with anti-depressant treatment made alternative understandings of recovery 'thinkable' for some women, for others it reinscribed a neurochemical relation to self and a loss of hope in the possibility of recovery. Our findings identified two discursive constructions that figured predominantly in the responses of women concerning the neurochemical and emotional self-in-recovery. The experience of side effects contributed to the problematization of the neurochemical self (often exacerbating distress) and a feeling of great ambivalence about pharmacological promises. Anti-depressants were critiqued in terms of the 'false security' they offered women who invested their emotional selves in biotechnologies of recovery (seeking advice, adjusting doses to find the right balance, trying different antidepressants to find the right one, researching effects, negotiating with doctors). These problems and limitations contributed to a different interpretation of recovery as a process of working on the emotional self (identifying warning signs of mood change, developing strategies to manage expectations, experiencing different emotions, asserting oneself). Women deployed a wide range of everyday practices (from therapy to yoga) that transformed their emotions through relations of self-discipline and care of the self (see also, Fullagar, 2008a; O'Grady, 2005).

Many women recounted how their interpretation of emotional distress became more critical and relational as they sought out other ways to think about, relate to and act in relation to the self they desired to become. This included rediscovering the value of pleasurable leisure experiences that enabled time-space for oneself or as a means of social connectedness. Women also spoke of changing careers, downshifting from stressful jobs or leaving/starting relationships and questioning the gender expectations that had urged them to be 'good

women' and put needs before their own desires (Stoppard, 2000). What signified this shift in understanding recovery were the different emotions that 'moved' and affected the embodied self in different ways that could not be reduced to biology, cognition or a purely constructionist notion of the body. Ahmed (2004: 164-5 ) makes an insightful point about the significance of pleasurable emotions that has relevance for thinking about women's entitlement to recover from depression in ways that they find helpful,

Pleasure involves not only the capacity to enter into, or inhabit with ease, social space, but also functions as a form of entitlement and belonging. Spaces are claimed through enjoyment, an enjoyment that is returned by being witnessed by others.

In light of the cultural significance of emotion we suggest that the growing body of work is particularly useful for thinking about the complexity of women's recovery experiences as they negotiated multiple discourses about what they should 'do' to move beyond depression (Bendelow, 2009; Blackman, 2007; Lyon, 1998).

We conclude our analysis of the limitations of biomedical discourses by highlighting how the privileging of anti-depressants in recovery can render invisible the emotion work undertaken by women to address depression as a gendered experience. We are not suggesting that the interpretation of the emotional self-in-recovery is not a problem free alternative as women's experiences can be interpreted through many power-knowledge relations that may individualise accounts of change. Women did draw upon a range of psy-discourses to understand their emotional selves (such as, cognitive techniques, identifying a real self or

rediscovering a childhood self) in an individual way (Wright, 2003). Yet, many women also identified their changing gender expectations, material pressures and negotiation of inequities. Although we do not have the space to critically engage with the range of psy-discourses what we want to identify is how women's experience of a different emotional self contributed to their own accounts of the recovery.

Understanding the significance of emotion in women's stories may 'risk' reinscribing historical gender discourses about emotionality and weakness. However, situated within a more critical context we argue that it can open up a space for examining the tensions that exist between neurochemical and emotional relations to self and subjecthood. The irony that we have identified through this research in the era of pharmaceuticalisation is that despite its truth claims anti-depressant medication is largely unable to adequately address to the emotional complexity of contemporary subjectivity for women (and also for men with different gendered challenges) (see also, Emslie et al., 2008). Our research revealed the limitations of biomedical-scientific rationalities that position drug therapies as a thinkable solution to the neurochemically deficient self that 'is' depressed. Hence, these stories make visible women's experiences as a form of subjugated knowledge about the emotional and gendered self. Their insights offer both critique and alternative ways of thinking about recovery that could be incorporated into practice and policy domains by reflexive mental health professionals. Given the extent of pharmaceuticalisation and the market driven imperatives of biomedicine this is no easy task. In this sense, we hope our research contributes to the growing number of critical discourses that question the normalisation of psychopharmacology and search for alternatives in the areas of women's health, the mental health consumer movement and critical psychiatry/medicine (Blackman, 2007; Davidson, 2005; Dowrick, 2004; Stavropoulos, 2003).

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