Social Science & Medicine 117 (2014) 116–124

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Social recovery and the move beyond deficit models of depression: A feminist analysis of mid-life women's self-care practices

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ARTICLE INFO

Article history:
Received 20 March 2013
Received in revised form
15 July 2014
Accepted 17 July 2014
Available online 18 July 2014

Keywords:
Gender
Depression
Social recovery
Relation to self
Mid-life women
Capacities
Self-care

ABSTRACT

In Australia, like other advanced liberal democracies, the adoption of a recovery orientation was hailed as a major leap forward in mental health policy and service provision. We argue that this shift in thinking about the meaning of recovery requires further analysis of the gendered dimension of self-identity and relationships with the social world. In this article we focus on how mid-life women constructed meaning about recovery through their everyday practices of self-care within the gendered context of depression. Findings from our qualitative research with 31 mid-life women identified how the recovery process was complicated by relapses into depression, with many women critically questioning the limitations of biomedical treatment options for a more relational understanding of recovery. Participant stories revealed important tacit knowledge about recovery that emphasised the process of realising and recognising capacities and self-knowledge. We identify two central themes through which women's tacit knowledge of this changing relation to self in recovery is made explicit: the disciplined self of normalised recovery, redefining recovery and depression. The findings point to the need to reconsider how both recovery discourses and gendered expectations can complicate women's experiences of moving through depression. We argue for a different conceptualisation of recovery as a social practice through which women realise opportunities to embody different 'beings and doings'. A gendered understanding of what women themselves identify is important to their well-being, can contribute to more effective recovery oriented policies based on capability rather than deficit.

1. Introduction

In the early 1990's Governments and consumer groups across Australia, New Zealand, the United Kingdom, Canada and the United States began to articulate a discourse of recovery that valued treatment choices, personal support and opportunities for social participation. The 'new' recovery orientation is claimed to represent a broader biopsychosocial (biological, psychological and social origins of illness) model of mental illness and personhood that values the 'expertise of experience' within policy (Commonwealth of Australia (2013)). Despite these important shifts, we argue that recovery from 'mental illness' remains a highly contested notion that is discursively produced within a complex assemblage of private and public mental health services, early intervention and prevention programs, pharmaceutical products and diverse forms of consumer/survivor identities (Pilgrim, 2008; Smith-Merry et al., 2011; Tilley and Cowan, 2011; Tew et al., 2012). There remain key tensions between different epistemological assumptions about mental health/illness - from social determinants, personal recovery and self-responsibility, to expert discourses that treat (via medication and therapy) behavioural, cognitive and bio-chemical 'deficits'. In this article we explore some of the more specific tensions around recovery from depression through an analysis of women's everyday experiences. Recovery involved navigating through an array of pharmacological solutions to address chemical imbalances, different therapeutic modalities combat a lack of coping skills, while complementary medicines offer a holistic approach and support groups provide social connection. In addition, there is a multitude of self-help practices (e.g., exercise, meditation, bibliotherapy) that individuals are urged to exercise self-responsibility through in the desire to restore their 'normal' functioning. With the aim of furthering the conceptual debate about recovery, we offer a feminist critique of assumptions that inform conventional 'deficit' based individualised, clinical approaches that still persist despite questions raised by the growing body of work with a social

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http://dx.doi.org/10.1016/j.socscimed.2014.07.041
0277-9536/

recovery orientation (Davidson et al., 2005; Hopper, 2007; Pilgrim et al., 2009; Slade, 2010; Lewis, 2012). While we acknowledge the multiple forms of expertise that characterise different clinical approaches (within and across psychiatry, psychology and allied health) we argue that the 'biopsych' emphasis in the biopsychosocial model of depression and recovery continues to be problematic in terms of how we understand the social experience of selfhood, gender inequities and the relational nature of change (Hopper, 2007).

We draw on the international body of feminist research that clearly identifies the disabling effects of gender norms and social institutions that perpetuate inequalities, and contribute to women's depressive symptoms and complicate their recovery (Blum and Stracuzzi, 2004; Cosgrove, 2000; Crowe and Luty, 2005; Fullagar, 2008, 2009; Fullagar & O'Brien, 2012, 2013; Keyes and Goodman, 2006; Lafrance, 2009; Lafrance and Stoppard, 2006; Mauthner, 2002; O'Brien, & Fullagar, 2008; O'Brien, 2012; Stoppard, 1997, 1999; 2000; Vidler, 2005; Ussher, 2011). We foreground this feminist approach to identify the sociocultural context of recovery in relation to the effects on women's subjectivities and choices that arise from expertise connected to particular biomedical categories (Cosgrove, 2000; Stoppard, 1997, 1999). Our aim is therefore to explore how the meaning of recovery was constructed over time by women at mid-life who experienced the disabling effects of depression on their lives and sense of self. In particular, we focus on women's everyday practices and the language they used to articulate the meaning of recovery as a social process of changing the relation to self (and hence to the 'depressed self'). We conceptualise social recovery as a *relational experience* in contrast to clinical approaches that assume a highly individualised self and are measured terms of outcomes, such as a reduction in symptoms and a return to social and vocational roles (Davidson et al., 2005, X2013). Implicit within a clinical approach is the remediation of dysfunction (Davidson et al., 2006, p. 159) and the expectation of compliance on behalf of the patient and belief in the greater value of expert opinion (Davidson et al., 2006). In contrast, recovery and depression are understood in terms of a gendered context that profoundly shapes women's experience of emotional distress in advanced liberal societies (Fullagar and O'Brien, 2012; Lafrance, 2009; Lewis, 2007). Hence, our conceptualisation of depression is more closely aligned with a social or discursive understanding of mental health and disability where social relationships and normalised assumptions about identity are the focus of analysis (Thomas, 2004; Hopper, 2007; Sunderland et al., 2009).

If we commence thinking about recovery from a social perspective then we may initiate a discursive shift from individualising emotional distress as a personal or biochemical failing. In this way, a more nuanced understanding of the relation between self and the social can be articulated. Recovery can be made thinkable in ways that recognise individual women's rights, capacities, strengths and self-knowledge, while also acknowledging the broader gendered conditions that exacerbate inequality and depression (Nussbaum, 1999; Lewis, 2012). In the first half of the article we consider the effects of 'normalised' notions of recovery in current debates and describe the methodological approach to our empirical research. In the second half, we present the key findings and make connections with the emerging literature on a capabilities approach in the disability and mental health fields. We conclude by drawing out the implications of reconceptualising women's recovery from depression for mental health policy and service provision.

2. Normalised recovery – treating deficits

While clinical treatment practices are intended to help women's recovery from depression and regain their lives, we argue that biopsych approaches unintentionally contribute to normalised understandings of the depressed self. A normalised clinical approach to recovery constructs illness as impairment of the mind (whether biochemical or cognitive) and through treatment, outcomes such as symptomatic and functional improvements return the self to 'normality', and recovery is equated with cure (Roberts and Wolfson, 2004). In a similar way to disability scholars (Beauchamp-Pryor, 2011) who have argued that discourses of cure assume a normalised body, mental illness is constructed as a pathologised state that exists 'within' the individual, as part of the self that is disordered or dysfunctional. We also recognise that across the mental health field clinicians grapple with the complexity of individual lives when identifying treatment modes, negotiating 'patient expectations' and interpreting changing ideas within fields of practice. Hence, we emphasise the relational process of recovery that is shaped by the power–knowledge relations of the clinical encounter, the broader socio-cultural context of women's identities and material inequalities that contribute to ill health. By identifying the social construction of recovery we offer a reflective moment for clinicians who are faced with the increasingly complex task of providing individual support in the face of depression as a broader population problem. The emergence of critical approaches in psychology and social work point towards the convergence of our argument with new practise knowledges that questions deficit models of selfhood by examining strengths, alternative narratives and capabilities (Cosgrove, 2000; Laitinen et al., 2006; Lomas, 2013; Ridge, 2009).

The dominance of a deficit based recovery approach often results in women relating to themselves through an identity that defines them as a 'depressed' subject who requires certain kinds of pharmacological, or psychotherapeutic intervention, to 'fix' the inner problem. For example, women in the 35–44 age group have been the largest users of an Australian Government health initiative *Better Access to Psychiatrists, Psychologists and General Practitioners* (Crosbie and Rosenberg, 2007). Other self-help initiatives include access to telephone and web-based counselling services (Commonwealth of Australia (2006), 2013). While they may increase options for support, these approaches individualise depression and overlook gendered inequities, such as socio-economic disparities, that significantly contribute to women's experience of depression (Fullagar, 2008; Lafrance, 2009; O'Brien, 2012). Normalised 'expert discourses', which powerfully shape both professional and lay knowledge, emphasise a form of self-knowledge that is about learning what medication works, as well as cognitive and behavioural change (Fullagar and O'Brien, 2012). Yet other forms of self-knowledge that are more 'tacit' and acquired through repeated episodes of depression are often undervalued and ignored. We conceptualise women's tacit understandings of recovery through Foucault's (1991) notion of subjugated knowledges that makes visible the undervalued insights and experiences of the marginalised that unsettle normalised truths.

Lafrance's (2009) research, in particular has identified how women struggle to legitimate their emotional distress and relinquish gender expectations that emphasise the needs of others over the self. Women's resistance against gender norms was an important aspect in recovering health and well-being, and we contend that there is a need to understand the everyday processes through which women negotiate gendered expectations to change their relation to self and develop a range of self-care practices. This is of particular concern as women's traditional ethic of care, within western cultures, is deeply entrenched in cultural values that focus on the needs of others and underpin the notion of the self-sacrificing 'good woman' (Stoppard, 2000). Women's self-relation is often characterised as 'harsh and punitive' (O'Grady, 2005, p. 26), suggesting that care of the self may be a challenge to develop.