

# **The Recovery Imperative: A critical examination of mid-life women's recovery from depression**

## **Abstract:**

Australia like other countries in neoliberal democracies is grappling with the gendered health 'problem' of depression. More concerning is the issue of recovery and relapse, with depression being the third largest cause of disability-adjusted life years (DALY). In addition, advanced liberal discourses of health position recovery as an exercise of individual responsibility to return to a functioning and productive norm and prevent recurrence. This moral enterprise of health articulates a 'recovery imperative' which overlooks the gendered context which may have created the conditions for women's depression and may in turn impede their recovery. Drawing on insights from governmentality and feminist post-structuralism, the article critically examines the effects of normalized recovery discourses on women's subjectivities. Data for the study were collected between 2005 and 2007 through in-depth interviews with 31 mid-life Australian women. Interviews were recorded and transcribed. A thematic approach was adopted to code the transcripts using NVivo. Three key themes; 'in' recovery, 'eight out of ten' recovered and recovering the authentic self, illustrate how the 'recovery imperative' may be implicated in perpetuating the cycle of recovery and relapse.

**Keywords:** Australia, biopolitics, depression, governmentality, neoliberalism, recovery imperative, mid-life women.

## **Introduction**

Depression has been identified as a gendered mental health problem with consistent epidemiological surveys indicating that women are twice as likely as men to become depressed (World Health Organisation, 2000). Within Australian mental health policy, depression is understood as a biochemical change in the brain often precipitated by a range of psychosocial factors. Despite an increase in prescription rates of anti-depressants (Commonwealth of Australia, 2007), and the uptake of psychiatric and psychological services (Crosbie and Rosenberg, 2007), anxiety and depression has moved from the third largest cause of disease burden in disability-adjusted life years (DALY) (Mathers, Vos & Stevenson, 1999) to first, accounting for 10% of the overall female burden of disease (Commonwealth of Australia, 2010;

Crosbie & Rosenberg, 2007). This suggests that for many women who have been diagnosed with depression, recovery is problematic and ongoing. An issue highlighted by Vos *et al* (2004, p. 1098) who point out that 'major depression is a chronic episodic disorder ... [and] that during a lifetime at least 90% of affected individuals experience a recurrence'.

In response, new directions in mental health policy both in Australia and elsewhere in advanced liberal democracies emphasise the importance of developing a 'recovery oriented' service provision and the need to move beyond narrow biomedical models of illness and personhood. However, I argue the same 'recovery orientation' also reflects modern advanced liberal imperatives of individual responsibility for self-management in overcoming illness. Teghtsoonian (2009, p. 29), in her examination of Canadian mental health policy directions and initiatives, argues 'in their particulars, they are congruent with the neoliberal orientations of the governments that have adopted them'. These same rationalities of government underpin Australian mental health policy. The National Mental Health Policy 2008 explicitly states that consumers of mental health services will 'actively be involved in their own care and recovery ... [and] ... have a responsibility to work together with these services towards their recovery' (Commonwealth of Australia, 2009, pp. 11-12). In addition the policy is focused on 'tracking progress' to achieve 'positive' and 'desired' outcomes, such as a return to productivity (Commonwealth of Australia, 2009, p. 24). At work in these rationalities is the reduction of the increasing cost associated with the treatment of depression and as such individual women suffering from depression are urged to exercise 'responsibility for making choices that do not

burden the health care system with inappropriate requests for costly and unnecessary service' (Teghtsoonian, 2009, p. 31). I contend that within the context of advanced liberal societies, recovery has assumed a moral imperative, and women who have experienced depression are positioned as responsible for their recovery through self- management practices to recover to a functioning and productive norm. As Rose (2007, p. 111) argues discourses of health and health care, and I argue recovery now position the patient as 'free yet responsible, enterprising but prudent, conducting life in a calculative manner with an eye to the future'. This notion of individualized responsibility for recovery fails to understand how the subject is socially situated with respect to gender, class, ethnicity and age (Pilgrim, 2008). I also argue that little consideration is given to the gendered inequities and contradictions of modern womanhood which may have created the conditions for depression and may in turn impede recovery. Along with other feminists across a range of disciplines (Fullagar, 2008a; Lafrance, 2009; Lafrance & Stoppard, 2006; O'Grady, 2004; Stoppard, 2000; Ussher, 2003, 2011, O'Brien & Fullagar, 2008), I have highlighted how women identified discourses of femininity, such as self-sacrifice, pleasing others, motherhood guilt, responsibility for others wellbeing and/or perfectionism, and being superwoman, contributed to their depression (O'Brien & Fullagar, 2008). These same discourses in turn undermined women's wellbeing and complicated their ability to self-care in recovery (Lafrance, 2009; Lafrance & Stoppard, 2006; O'Brien & Fullagar, 2008). Extending on this work I critically examine how normalised biomedical recovery discourses intersect with advanced liberal discourses to affect how women constitute themselves as recovered and recovering feminine subjects.

To explore the effects of the 'recovery imperative' on women's subjectivities, I draw on research conducted with 31 mid-life women in Australia. Employing a governmentality approach informed by feminist post-structuralism I examine how the discourses that underpin the 'recovery imperative' shape the type of subject women attempt to become in recovery. I begin with the conceptual tools through which I examine the recovery imperative. I follow with a discussion of the discourses and assumptions that inform this imperative. I then outline the research project through which I examine mid-life women's experiences with negotiating the 'recovery imperative.' Finally I consider the implications of these discourses on women's subjectivities in recovery.

### **Governing depression and recovery**

Foucault's work on governmentality has been utilised by sociologists to critically examine health care, and as Petersen (2003) points out, it is an 'analytics of power' through which to examine the rationalities and strategies that may be used to govern an area of public health concern. Through the notion of governmentality, Foucault (1982) was concerned with the 'conduct of conduct', the 'contact between technologies of domination of others and those of the self' (Foucault, 1988a, p. 19). Governmentality allows an analysis of the self-government, and the government of others and the apparatuses and knowledges through which the state aims to shape and guide the actions and behaviours of individuals (Dean, 1999; Foucault, 1991; Rose, 1999). In this way governmentality operates to develop 'those elements constitutive of individual's lives in such a way that their development also fosters the

strength of the state' (Foucault, 1988b, p. 82). Read alongside of feminist poststructuralist theories which examine how the embodied feminine subject is produced, and thus governed within the context patriarchal culture, governmentality becomes a powerful tool to examine gendered power relations (Fullagar, 2008b, 2009, 2010; MacLeod & Durrheim, 2002). Drawing together insights from these two approaches problematizes how depression and more particularly recovery is made thinkable as a gendered population problem. Rather than positioning women as passively taking up dominant rationalities, a governmentality approach examines the ways in which women are urged to self-manage their lives and as part of responsible neo-liberal citizenship (Fullagar, 2009).

### **The recovery imperative and the duty to be well**

My notion of the 'recovery imperative' is informed by advanced liberal technologies of government (Rose & Miller, 1992). Rose and Miller (1992) argue that neo-liberalism is a political rationality in which the individual is positioned as an autonomous, rational and active entrepreneurial agent. Neo-liberal rationalities intersect with advanced liberal technologies of government which direct its citizens 'through their freedom ... [to] ... make their decisions, pursue their preferences and seek to maximise the quality of their lives' in line with the goals of those who govern' (Rose & Miller, 1992, p. 201). Within this context, the agent is the universal male and little consideration is given to how gendered norms, inequalities and social institutions may have contributed to women's depressive symptoms, and to how these may impede an individual's opportunity to exercise 'active entrepreneurship'

(Rose & Miller, p. 198) in recovery. These rationalities position an individual woman with depression as a rational, calculative actor who exercises responsibility and control to recover their health and ensure that their illness does not become a statistic reflected in the burden of disease. A healthy, hence recovered neo-liberal subject is one that is 'rational, realistic, autonomous, energetic, productive, and efficient' (Philip, 2009, p. 165). Through this 'moral enterprise' of health which articulates the manner in which we live our lives individually and collectively the 'recovery imperative' informs the appropriate 'practices of intervention' that are 'legitimate and efficacious' (Rose, 2007, p. 54). I contend that these interventions articulate the form of normalized self-management practices, such as anti-depressants and psy-expertise, (psychosciences and disciplines that have informed the current regime of the self, and the ways we relate both to ourselves and others, see Rose, 1996) that women are urged to mobilize as part of their duties as responsible neo-liberal citizens. As Rose (2007, p. 23) points out health, or the recovery of health, becomes 'an imperative, for the self and for others, to maximize the vital forces and potentialities of the living body'. These biopolitical imperatives are an exercise of power which seek to control, manage and shape the lives and individuals and populations in order to maximize human vitality (Rose, 2007). Those who refuse to become informed and active attract negative judgements (Rose, 2007).

Within the biopolitics of recovery women are urged to engage in a 'project' of recovery (Rose 1996, p. 157) and I argue with the help of experts and expert techniques recover their autonomy and resume productivity. As a contemporary

citizen living in an advanced liberal society, I also contend that this involves the individual woman engaging in 'risk management' to constantly evaluate her emotional and cognitive status to ensure that she recovers. I also suggest that the recovery imperative is informed by a discourse of optimization (Rose, 2007) so that the woman suffering depression not only manages herself to prevent recurrence but also fulfils her obligation to maximize her life potential. In this 'duties discourse' (Petersen & Lupton, 1996, p.13) the individual perceives that they are serving both their own interests and those of society, but at the same time they are also conforming to the 'goals of the state and other agencies' (Petersen & Lupton, 1996, p. 12). As Ramon Healy and Renouf (2007, p. 112) point out 'recovery can be perceived as a new phase in shifting responsibility even more to the individual service user, away from society, service systems, structural factors or government'. The individual is therefore positioned as responsible for working on their body to pursue the health virtues espoused within the recovery imperative such as 'self-control, self-discipline, self-denial and will power – in short those qualifications considered important to be a "normal", "healthy" human being' (Petersen & Lupton, 1996, p. 25). The 'duty' to stay well then incorporates the understanding of health as 'a domain of individual appropriation through rational choice' (Greco, 1993, p. 357). The recovery imperative operates to produce citizens who are psychologically stable and biochemically adjusted 'inasmuch as they are governable, predictable, calculable, classifiable, self-conscious, responsible, self-regulating and self-determined. Constructed and acted upon as such, individuals are rendered entirely responsible for their failures as well as their successes, their despair as well as their happiness' (Rimke, 2000, p. 63).

Underpinning biopolitical imperatives, and hence the recovery orientation in mental health policy is the biomedical illness-treatment-recovery model which emphasises compliance of mind and body with normalized treatment modalities (Whitwell, 2005). These treatment modalities position depression as a neurochemical deficiency. As neurochemically deficient subjects, women are urged as active citizens to engage the help of doctors and psy-experts to correct the internal problem of depression in order to retake charge of their lives again (Rose, 2007). I argue that these treatment modalities are also directed at helping achieve a normal functional sense of self, where one progresses on a linear trajectory from not recovered to recovered, ill to well, abnormal to normal. The restitution or recovery of the patient's former health status is also premised on 'normal' and standardized prognoses, based on an assessment of the abatement of symptoms and the restoration of functioning (Whitwell, 2005). I contend that recovery is therefore positioned as an endpoint that one reaches through exercising appropriate self-management strategies and normalized treatments. This normalized notion of recovery maps a trajectory, which regardless of whether a woman is able to progress along it to become a 'fully recovered' subject, precludes the opportunity for 'thinking oneself differently' (Heyes, 2007, p. 119). The self one recovers is also self-sufficient and fixed, as reflected in the psy-discourse of the 'true self, the inner core of being as the site of genuine deep recovery' (Keane, 2000, p. 329). This often entails recovering a woman's 'self' that was prior to depression. Bringing together my notion of the recovery imperative and a governmentality approach informed by feminist post-structuralism, this paper seeks to understand how women's well-being



is shaped by rationalities that govern the type of subject they are urged to become in recovery. It also explores how these rationalities may be implicated in perpetuating the cycle of recovery and relapse. Next I examine the research project through which I explored the effects of the recovery imperative on women's recovering selfhood.

### **Researching the recovery imperative**

The research project through which I examined the effects of the recovery imperative was conducted with women at mid-life who self-identified as recovering from depression. The research examined the complex biomedical and biopolitical dynamics that shaped how women recovered from depression, and how these discourses affected the types of subjects women attempted to become in recovery. The project consisted of 31 women aged 35-49 who were recruited voluntarily through notices in local newspapers, community centres and women's health centres as well as radio interviews, requesting women who self-identified as recovered or recovering. Ethical approval was granted by Griffith University and women were informed prior to interview, via an information sheet, the interview questions they would be asked. Preceding the interview participants were also informed of the research process and how their interviews would be used. The women participated in semi-structured interviews, which were audio-taped and then transcribed. The interviews ranged in duration from one and a half to two hours and were conducted between August 2005 and April 2007. The midlife cohort was selected as these women are often managing multiple and changing work and caring responsibilities. Culturally mid-life is also viewed as a time when 'past, present and

future intersect', providing a point at which women engage in self-reflection or life evaluation (Wray, 2007, p. 31). Participants were recruited from metropolitan and rural south east Queensland, and metropolitan and rural New South Wales. In depth interviews were conducted in the women's homes or preferred location. Open ended questions were used to explore women's accounts of their experiences of depression and how they negotiated recovery discourses. In addition, demographic details, such as age of onset and number of times depressed were obtained through a brief questionnaire.

NVivo software was used as a tool to organize the large volume of interview material. A coding framework was developed to help identify themes and categories in the transcripts. A broad set of themes for this article were initially identified through a self-reflexive auto-ethnography (Ellis & Bochner, 2000). I critically examined the social and discursive practices that have shaped my experiences with depression and recovery, considering what imperatives came into play that directed me towards constituting myself as a 'fully recovered' and productive neo-liberal woman. I then examined the various discursive patterns (Mason, 2002) that women drew on to articulate their experiences with recovery. Through comparing and contrasting these experiences with my own, and engaging with the literature and theory (Ussher & Mooney-Summers, 2000) I refined the themes to examine the key issues in women's recovery. Drawing on insights from feminist post-structuralism, which critically examine power-knowledge relations, this interpretive method of analysis allowed for consideration of 'how' women constituted themselves as recovering subjects within the context of advanced liberal societies (Fullagar, 2009;

Mason, 2002; Mauthner & Doucet, 2003; Weedon, 1987). This interpretive analytic, also moves away from 'truth' claims and recognises that the 'realities' that women narrate during an interview represent are one specific form of knowledge (Mason, 2002), in relation the biopolitical context that shapes how women govern themselves in recovery.

Participants had a complex range of experiences with depression and recovery, thirty of the thirty-one women had sought the help of a GP when the symptoms of depression became so difficult that they felt unable to cope with them without professional help. In addition twenty-seven women had also seen a psychologist and eighteen had seen a psychiatrist. The majority of the women; twenty-one, had three or more episodes of depression; seven had two to three episodes. While the research sought to interview women who self-identified as recovered or recovering, my analysis revealed that all thirty-one women were unable to state that they felt they had recovered to the extent that their depression had gone forever. This suggests that achieving the advanced liberal ideal of recovering a functional and productive self, signified by the cessation of depressive symptoms and the return to previous functioning was problematic. While women may have pursued a normalized ideal of recovered subjectivity, I certainly do not imply that the women did not resist these ideals in various ways. However, it is not within the scope of this article to explore these acts of resistance. Rather it is the effects of normalized trajectories and I present my findings and analysis through three themes; 'in' recovery, 'eight out of ten' recovered and recovering the 'authentic' self. These

themes are closely enmeshed, and examine both recovery as an end state, and the ways in which women govern themselves to in order to achieve this state.

## **Research Finding and Discussion**

### *'In' recovery*

Women's accounts of their experiences with recovery were underpinned by the struggle they engaged in to progress towards feeling that they were 'in' recovery. When questioned about where they were in terms of their recovery most women articulated a linear progression of self along a maximisation and development trajectory with an endpoint being the restoration of normal functioning and the return to productivity. By emphasising an endpoint of being 'in' recovery, women also projected for themselves a static notion of normalized recovery. In order to reach this idealized endpoint that was also equated with cure and signified by the cessation of symptoms, women mobilized biomedical or psy-expertise. Yet few mid-life women appeared to have been able to achieve this ideal to the extent they felt they were over their depression and recovered. Instead they expressed their recovery in terms that indicated they still had more work to do to move beyond their current recovery status. As a result they described themselves as being 'at the stage', 'getting there' and being 'on track'. These discursive resources capture the notion that recovery is a place that one may be 'in' when they had finally recovered from depression. At the same time, 'getting there' or 'at the stage' also creates the impression that the point they were trying to progress towards, was some time in the future and not at the present moment. It is both a time and a space of recovery, but one that these mid-life women can only hope to achieve.

The temporal and spatial elements of recovery represent the movement of self towards a point that signified where one may be in terms of their recovery. This movement of identity across time and space was sometimes 'back into' depression as much as it was forward into or towards recovery. Descriptors such as 'more backwards than forwards', 'up and down' and 'cyclic' illustrate how women felt they were not progressing forwards along the appropriate trajectory, and that relapses into depression were an ever present fear. In this sense recovery was transitory but at the same time was also seen as a static stage or place where one was in terms of being recovered. If 'getting there' or 'at that stage' signified their progression towards recovery, what then signified that they are 'in' recovery? How do they stay or maintain being 'in' recovery? Phoebe (age 43, urban) who had suffered childhood abuse and experienced more than three episodes of depression thought that she was a 'woman in recovery' when she first rang to be interviewed. She was not interviewed until some twelve months later when she felt she was not in the same place with her recovery. During this time Phoebe had returned to work and had not been able to cope with the additional demands of managing work and her domestic responsibilities. She did not feel as if she could ask for help either from her husband or her workplace, but felt that she had to manage her responsibilities in a 'balancing act' on her own. As Marcinkus et al. (2007, p. 87) point out, for women at mid-life achieving a work-family balance is a 'key issue as they deal with the potentially conflicting demands of their careers, children and child care, elder care, and other personal life issues'. The feelings of distress Phoebe subsequently experienced were interpreted as the return of the symptoms of depression and she 'slipped back a

little bit' in her recovery. Phoebe attributed this slippage in her recovery to her own failure to manage her life and exercise the appropriate self-management strategies to enable her to 'get back out there'. The discourse of responsibility that inheres in Phoebe's narrative shifts the focus of recovery onto the individual. In this sense Phoebe had also 'failed' to position herself as an active and enterprising neo-liberal citizen who exercised responsibility to ensure she reduced the risk of relapse.

Even women who felt they had progressed further towards full recovery were unable to articulate their recovery in terms that indicated that they felt that they were 'in' recovery and would remain there. Instead the women drew on discursive resources that indicated the fragility of their recovery and that they had more work to do to maintain their recovery. These descriptors include 'good at the moment', 'good space at the moment', 'at a point', 'good place at the moment' and 'recovered at the moment'. These descriptors illustrate how difficult it was for them to maintain being 'in' recovery, but was nevertheless a 'space' or a 'time' that they aspired to inhabit or achieve. The 'space' or 'time' women spoke of, seemed to be static, but also conveyed the notion that it may well be temporary and that they would never feel 'cured'. Leanne (age 45, urban) who had experienced two to three episodes of depression, illustrated how temporary she feels her recovered subjectivity feels for her. She also illustrated how she exercised responsibility undertaking the necessary recovery work be able to exert rational autonomy and control over her life.

I've worked hard through what I've identified as depression, worked really hard and just assumed that I would get out of it at some point. And there were times over the years when it felt like that - so, better for awhile and worse for awhile. But now it feels as if it's gone for awhile, first time since I was in my 20's when I feel as if it's gone. Doesn't mean I don't think it'll come back, but I do feel as if it's gone for now.

While Leanne worked on her recovery, she also endured a difficult marital situation. She felt that she lost part of herself through her decision to 'see this through [her marriage], accept whatever happened'. During this time she also battled post-natal depression after the birth of her daughter, and when her daughter was about 5 or 6 her husband left her for a younger woman. She also felt pressure to adopt an 'action ... pull your socks up mentality' that she felt pushed her beyond, as she describes it, her own 'ready time' for recovery. Yet despite the work that Leanne had invested in herself so that she can feel that she had achieved some form of recovered subjectivity, her recovery was tenuous and she only felt that her depression has 'gone for now'. Leanne's relapses back into depression, when she was unable to cope with her difficult life circumstances (losing her sense of self in her marriage and her husband's infidelity) highlights the problematic of the assumption of individual responsibility for recovery. These difficult and gendered life circumstances were overridden by discourses of enterprise and responsibility which allow little consideration of social conditions of women's lives.

What Leanne's example also illustrates, is that in attempting to follow normalized pathways women are potentially setting themselves up for further failure. Not only are they unable to maintain a forward trajectory that will get them out depression and 'in' recovery, their relapses back into depression leave them perpetually engaged in a struggle to move towards the normative recovered subject. Marianne (age 38, urban) discusses at length the battle she engaged in to push herself towards an ideal of recovered subjectivity.

I'm probably over half way at that moment. I realize....No, I am probably charging a little bit better than I was say even 2 months ago. I think I'm at what they call the up hill....at the top of the hill, and I'll just see where I go from there. Yeah, it's like the up-hill battle, but it's like 'Oh, I'm at the top. I'm tentatively looking around and saying....' I don't want to go down the other side, but then again I don't want to go up another one either, so I don't know. But that's like...I know it's a....it's almost like a battle....

While Marianne was doing all the work of recovery, exercising responsibility in the recovery 'battle' to ensure that she returned to normal, she still only felt half way towards being 'in' recovery. It would seem that she would like to remain where she is for a while as the 'battle' of recovery is quite demanding and slippage an ever present fear. However, discourses of 'responsibilization' (Rose, 1996, p. 157) also press her to continue to work on and invest in herself and her recovery so that she can continue her progression and exercise the appropriate normalised self-management and risk reduction strategies that will prevent her from sliding back into depression.

The discourse of 'responsibilization' (ibid) which directs individuals to assume an enterprising relation to self, positions women so that they felt responsible for undertaking the necessary work to 'fix' their depression. In addition, they felt an expectation that they would be 'in' recovery when they returned to previous normal functioning, and when they failed achieve this idealized norm, they interpreted this as a failure to recover, and a failure to exert rational autonomy over themselves and their lives. Justine (age 40, rural) had experienced depression two to three times.

When she experienced her worst distress she was being bullied in the workplace by a male supervisor, coping with a child with an intellectual disability, and her husband regularly worked away from home. Justine assumed that it was her responsibility to



take 'control' to alleviate the resulting distress. She said that 'I had to fix it, because this is my problem'. However, Justine also said that her 'fix it...give yourself a kick in the pants' approach she had adopted to help her restore herself to normality simply did not help. Even when she did manage, through anti-depressants to regain some of her former functioning, she did not feel as if she was completely recovered because she felt she was not 'back to my normal self'. In this sense recovery maps 'out a development trajectory defined in advance, which culminates in an idealized normative subject' (Heyes, 2007, p. 118). This static notion of self is also gender neutral, and gives scant attention to the role that gendered expectations both of the 'traditional ('good mother')' (Bryson et al., 2007, p. 1150) and the ideal of 'supermum, superwife, and supereverything' (Choi et al., 2005, p. 177) may play in complicating mid-life women's recovery. It also gives scant attention to how the assumption of individual responsibility for recovery added an additional burden of responsibility to mid-life women's already burdened life.

#### *Eight out of ten recovered*

Women also drew on a numerical scale to indicate how close they were to returning to what they judged to be normal or average. Lynelle (age 35, urban), for example described her recovery in these terms saying that 'probably in terms of a scale of 1 to 10, I'm probably an 8'. This calculative relation to self also typified the notion of recovery as a standard against which women who have suffered depression judge themselves. Rose (1996) points out that the psychological sciences have made possible procedures for the calculation and rational management of individuality.

These procedures are manifested in tools for measuring depression such as checklists from DSM-IV, ICD-10 and Kessler's Psychological Distress Scale (K10) which position women as calculable entities. These psychological tests also allow women to judge themselves against what is 'deemed normal or average' (Philip, 2009, p. 157). Women who have been diagnosed through such tools in turn come to see themselves through a calculable lens. Rimke (2000, p. 68) also argues that popular discourses 'contribute to the idea that individuals are calculable and uniform entities, capable of being held responsible for their social conduct and experience in the world'. The numerical indicator was similar to women's descriptions of pursuing a linear progression towards being recovered. However, it was far more prescriptive and women pushed themselves relentlessly towards a self maximisation trajectory, often articulated as 'full recovery', which allowed them very little leeway in how they constituted themselves as recovering subjects.

A diagnosis of depression seems to represent a failure to be able to function at full capacity (to fulfil their roles as wives, mothers, workers etc). Yet their attempts to achieve an ideal of 100% or 10/10 functioning indicated that many had set themselves a project of self through which, as enterprising neo-liberal individuals they can achieve that final marker of 100% functioning that will signal their return to normality. In attempting to attain 100% functioning, mid-life women are positioned in a double bind, as they desire both to be more than they are and a return to a previous functional state. Karen (age 40, urban) typified the pressure women placed on themselves to recover to the way they were before their depression, but also to attain 100 % functioning. She says that 'when I notice that that they're back to

where they were [sense of humour, ability to multitask], that's probably when I'd say that ... I'm as close to recovering as I will be'. She also described herself as '85-90% better', and for her recovery meant being able to get through the last 10% that signified she had regained her full functioning. As Rose argues (1996, p. 154) the 'enterprising self is thus both an active self and a calculating self, a self that calculates about itself and that acts upon itself in order to better itself'. That Karen was unable to maximize her potential as an enterprising individual is reflected in her inability to be at 100% functioning which is not only where she thinks she should be but also where she is 'meant' to be as a fully recovered subject. In her 'project of self' (Rose, 1999, p. 157) Karen was engaged in negotiations with herself and her partner to try and overcome the demands of achieving the last percentages of recovery.

So, I think...I keep trying to tell myself and my partner keeps trying...just take steps, just take one step and then you're one step - that way. You don't have to think 'that's where I'm meant to be' and I think that's probably something I would try and aim to do - is just to say 'holistically to-day, try and be better' and don't think about the fact that...you know 'I'm not recovered yet' try not to be judging yourself on that.

In effect Karen, like other mid-life women who gave a numerical indicator of their recovery status, was measuring herself against a perception that 'normal', non-depressed women are always functioning at full capacity all of the time. Those women who did not identify depression as a life-long condition were also measuring themselves against a previous notion of self that seemed to be fully functioning. Yet paradoxically it often was the previous self and its fully functioning capacity of fulfilling gendered expectations and responsibilities that had contributed to depression in the first instance.

Even when women exercised responsibility and mobilized the appropriate normalized recovery practice, their reliance on medication to keep their symptoms in abeyance signified to them that they were not 100% recovered. They continued to push to towards a self-maximization trajectory where they would be fully recovered and no longer reliant on medication. Roslyn (age 43, urban) described herself as '99% fully recovered', however she says that she would be 100% recovered if she could cease her dependence on medication. She was still focused on attaining that last percentage point that would signify she was recovered. As a responsible neo-liberal citizen, Roslyn was also engaging in risk management strategies to ensure that her depression did not return. She said that she had 'all the tools and strategies in place now to know what I have to do to keep moving forward'. Despite constituting herself as '99% fully recovered', that she had not been able to achieve the final 1% spurred her on to maximize her project of recovery and the successful achievement of 100% fully recovered.

Some women, who had experienced multiple episodes of depression, felt that because they had not achieved an elusive marker of functioning at a full percentage that they would never recover. These women were constantly exercising prudence and responsibility to ensure that they maintained their tenuous recovered subjectivity. Meredith (age 41, rural) was one such woman who had experienced more than 3 episodes of depression. At the time of interview she felt that she was only at 90% of what she considered to be fully recovered.

So, yeah I'd say I'm about 90%, to what I consider to be a 100% of being well. Yeah; mind, body and...just health wise. Yeah I think, I'm not there yet. Not exactly how I'd like myself to be, but I guess that's an on-going endeavour too.

Meredith's 'on-going endeavour', was also one of individual responsibility as she said 'I know I need to put in more effort into it, but...yeah, I will get there....Yeah, because I want to. I want to be a fully functioning person'. Yet the 'fully functioning' person that Meredith strove to attain, involved her resuming the 'domestic responsibilities' which she felt weighed her down and prevented her from recovering. The assumption of individual responsibility for recovery added an additional burden to the demands she already felt from her husband and children. In addition her calculative relation to self continued to drive her towards putting more effort into her recovery so that she could be '100%' well. Meredith's use of a numerical indicator to describe her wellness and her emotional state highlights the difficulties that arise when recovery is conceptualized as something that can be measured. What is the 100% that she and other women are trying to attain? Does it represent a return to a former state; a state prior to diagnosis that left women feeling as if they were flawed and therefore unable to function at full capacity? The significant issue is that the women who use a numerical rating are using it to represent a linear progression of self toward a final 100% functioning.

### *Recovering the authentic self*

In their attempts at constituting the 'fully recovered' subjectivity articulated through discourses of the recovery imperative, women also mobilized the help of psy-

experts. These experts offer women the hope that with the appropriate self-modification and self-work, they will be restored to a rational autonomous norm (Rose 1996). Knowing and mastering the 'truth' of the psychological self was centred on a universal subject who is 'stable, unified, totalized, individualized [and] interiorized' (Rose, 1996, p. 169). Jasmin (age 37, urban) a single mother of two children said that regardless of how much therapy she had gone through, without medication she still was unable to exercise the self-mastery she felt was required to control her emotions (Fullagar, 2009). Her search to know the 'truth' of her self not only impeded her recovery, but also contributed to her depression.

Depression is about...partially about, when it's not chemical imbalance and that sort of thing, it is about the fact that you're struggling to try and find out who you are. And the self is trying to find who it is, and being true to yourself and trying to find truth and all that sort of stuff...No wonder your mind goes crazy because it is, it's trying to decipher truth and who I really am.

Jasmin's lack of success at finding this inner truth, had led her to the conclusion that her depression was all 'biological' and that to maintain her recovery she must continue to take medication. This in turn had undermined her sense of self as she saw her reliance on medication as a personal 'weakness';

Oh, you're so weak and...you know you should be able to handle it. Yeah, what's wrong with you that you need medication and tablets to function in the world' and all that sort of stuff?

Jasmin was unable to access the 'inner reservoir of power' through which to demonstrate she is accountable and responsible for her own recovery (Rimke, 2000, p. 64).

This notion of interiority also extended to women aspiring to adjust their inner depressed selves to adequately reflect the self they felt they should be in recovery. In this sense women's depressed selves represent a problematized identity that does not 'adequately represent to the world the owner's genuine character, potential, or inner truth' (Heyes, 2007 p. 16). Recovery then becomes a regulated exercise of choice as women attempt to modify their thoughts and actions in order to achieve normality (Rose, 1996). Anya (age 36, urban) a single professional woman, was very focused on restoring herself to a normalized notion of recovered subjectivity through an 'expert' other (Rimke, 2000, p. 62). At one point in her recovery Anya was seeing a counsellor three times a month, and as a result, she draws heavily on psy-discourses as she continually refers to her 'negative' attributes which prevent her from achieving the 'positive space' of recovery (Rose, 1996, p. 65). This 'positive space' equated to a return to 'normality' and the ability to exercise rational control over one's emotions. Because Anya did not feel as if she was always able to exercise rationality in relation to her emotional self on an ongoing basis, she felt that she was vulnerable to the return of depression in her life; 'It depends on what day it is - of the week. It depends on what time of day it is - whether I'm having a good week or not. I'm vulnerable'. Anya's vulnerability highlights the difficulties that arise when women come to know and govern their emotional lives in accordance with a psychological norm of truth about recovered subjectivity (Fullagar, 2008a). Hence, Anya engages in self-blame because she is unable to exercise the appropriate rational autonomy over her life. The focus on control and rationality impedes Anya from experiencing and understanding her emotional self beyond this norm.

The authority of psy-expertise also underpins self-help discourses which imply that depression is the result of internal distorted thinking (Philip, 2009). Self-help techniques such as bibliotherapy are 'prescribed' as an individualized solution to the 'internal' problem of depression. As Rimke (2000) suggests 'the self-helper' is driven by notions of responsibility to draw on various techniques to transform themselves in order to achieve the normalized subject position articulated through the recovery imperative. Lynelle (age 35, urban) a single professional woman was referred to a psychiatrist after her first episode of depression. The psychiatrist gave her a book related to 'mood therapy' and told her to go home and read the first 'x number of chapters' of the book then come back and see him. Through this practice Lynelle says that she came to understand that 'this is what I'm thinking...why I'm feeling what I'm feeling'. Hence each time she experiences distress she draws on the book, and reinscribes her notion of someone whose moods require adjusting so that they can be restored to 'normal' functioning. In a more recent episode of depression Lynelle also saw another psychiatrist who gave her 'exercises to do' to help her change her 'thinking traits and personality traits...because they were not functional'. This attribution of self-blame is common for women who feel pressure to conform to expectations in regard to what they 'should' be doing, fearing that they may be seen to be not coping (O'Grady, 2005). Coping is also a psy-discourse which emphasizes one's ability to regulate and control distressing emotions and is influenced by personality and social resources (Folkman & Moskowitz, 2000). Women are expected to be able 'rise above' their supposed emotionality to cope with and regulate their emotions (Lutz, 1990). When not coping is perceived as not being normal, it becomes pejorative as it signifies a sense of failure.



Underpinning bibliotherapy and other self-help practices are 'distinctly liberal virtues such as autonomy, rationality and productivity' (Philip, 2009, p. 161). Lynelle continues this recovery practice so that she can cope, manage her emotions and maintain her recovered subject position, as she does not think that 'you can ever afford to stop...in terms of keeping yourself in check'. The focus on correcting the 'internal' problem of women's depression overlooks 'the possibility that their difficulties originate in the features of their social and political environments rather than their individual personalities' (Teghtsoonian, 2009, p.34). This suggests that both gendered expectations and normalized notions of recovery complicate women's efforts to exercise rational autonomy over their emotions and lives.

### **Concluding Comments**

While the adoption of a recovery orientation was hailed as a major leap forward in terms of policy and service provision, the recovery imperative, in which the individual is responsible for optimising their recovery opportunities, added an additional burden to mid-life women's already overwhelming expectations of themselves. Underpinning both mental health policy and the recovery imperative is the biomedical illness-treatment-recovery model in which normalised outcomes can be achieved through the consumption of anti-depressant medication and accessing psy-expertise. These treatment modalities are still largely entrenched in dualisms such as ill/well and normal/abnormal and draw on networks of power and knowledge and institutional mechanisms that often preclude other ways of thinking

and speaking about recovery. These practices inform dominant knowledge in relation to how women should recovery from depression; mental health policy positions women as responsible for their own recovery and as failed citizens should they experience relapse. Current mental health policy largely ignores the social constitution of gender as a pivotal factor for creating depression and impeding recovery. This suggests that mental health policy's focus on 'optimal individual outcomes' (Commonwealth of Australia, 2009) requires rethinking in light of the pressure women feel to conform to what they perceive as normalised outcomes. It also highlights the need to understand the complexity of mid-life women's recovery as a gendered and embodied experience and not simply as the correction to neurochemical deficiencies or the changing of erroneous thoughts and behaviours

My findings raise critical questions about mental health policies that utilise recovery discourses to signal a new way forward, but are still enmeshed in neo-liberal imperatives of individual responsibility. As other scholars have argued (e.g , Davidson, Lawless & Leary, 2005; Davidson & Roe, 2007; Lafrance, 2009; Pilgrim, 2008; Roberts & Wolfson, 2004) there is a pressing need to engage more critically with notions of recovery. There is also a critical need to utilise what women themselves have identified as both constraining and enabling in their recovery to inform both mental health policy and treatment modalities. Without an understanding of how recovery discourses intersect with advanced liberal discourses, the issue of the chronicity of women's depression will remain unexamined and women will continue to struggle towards achieving a normalised ideal.

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