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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.

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, Freeman, & Sturdy, 2011; Tilley & 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 are a multitude of self-help practices (eg., 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 recovery orientation (Davidson, Lawless & Leary, 2005; Hopper, 2007; Pilgrim, Rogers & Bentall, 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 & Stracuzzi, 2004; Cosgrove, 2000; Crowe & Luty 2005; Fullagar, 2008, 2009; Fullagar & O'Brien, 2012, 2013; Keyes & Goodman, 2006; Lafrance, 2009; Lafrance & 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, Lawless & Leary, 2005, 2013). Implicit within a clinical approach is the remediation of dysfunction (Davidson, Golan, Lawless, Sells & Tondora, 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 & 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, Catalano & Kendall, 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.

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 & 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, Ettore and Sutton, 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 & 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 & 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. The chronicity of depression raises the question of how women themselves come to 'know' what to do in the practice of recovery and acquisition of self-knowledge in relation to normalised biomedical and psy (psychological and psychiatric) recovery discourses? The everyday processes that women engage in as they negotiate their way through recovery are little understood.

Social recovery: A relational approach to self-care

Feminist and Foucauldian perspectives can provide insight into how particular constructions of recovery become normalised as 'truths' through which individuals think and act towards themselves as 'depressed' subjects. This problematisation of the depressed self also connects with the growing body of literature that we characterise as a 'social recovery' orientation. From a range of disciplinary perspectives (positive psychology, sociology, social work, disability studies) scholars have critiqued deficit models of selfhood in favour of socially situated and historicised accounts of the experiences of 'citizens, service users and patients' (Davidson, Lawless & Leary, 2005; Hopper, 2007; Slade, 2010; Lewis, 2012). With its focus on social justice, the capabilities approach within international development has been applied to mental health contexts to identify the structural dimension of inequality and agency freedoms that are important to an individual's recovery and well-being (Hopper, 2007; Lewis, 2012). Through her focus on community based adult learning programmes, Lewis (2012) critically identified the value of a capabilities approach in terms of the social, economic and political impact on individual lives in the context of cost cutting neo-liberal agendas. Such approaches provide an important way of positioning recovery within the social context to provide another reference point for policy and service provision beyond the biopsych discourse of illness and treatment. However, 'capabilities' have also been reconceived in policy implementation discourses to reinscribe neo-liberal ideals of individualised responsibility for recovery outcomes. For example, 'Recovery-oriented mental health practice refers to the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations' (Commonwealth of Australia, 2013, p.25). What does it mean

for women to 'take responsibility' for mental health within the context of gender inequalities? In light of the growing body of multidisciplinary work on recovery, we explore the complex relationships between power, agency and freedom in women's everyday experiences.

We turn to Foucault's (1994) later work on the ethics of self as a useful way to think about how women negotiate the power-knowledge relations that shape their depressed selves and their constructions of recovery in gender specific ways. While Foucault has been criticised by feminists for privileging the masculine self, many also argue that Foucault's work provides a 'way of considering what women might become if they intervene in the processes that shape their lives, and as a result the potential that may arise for the construction of new types of identity' (McNay, 1992, p. 116). Foucault (1991) emphasised how exercises of the self 'on the self' can be disciplinary practices; they may serve as practices of normalisation, or conversely they may enable one to engage in care of the self as an ethical practice of freedom. In this way, recovery can be positioned as a normalised practice that reinscribes women's illness identity or it can be deployed in ways that open up different experiences of agency through social relationships and opportunities to enact different kinds of womanhood (Fullagar, 2009)

Foucault's (1994) ethics is premised upon a relational understanding of selfhood that is situated in the social. His work offers the possibility of examining the creative and transformative capacity of ethical practices that are developed over time and open up different ways of knowing (thinking, reflecting, acting and relating to) the self (Foucault, 1991; 1994). Thus ethical relations to self are enabled by the productive exercise of power that expands the capacities of individuals, groups and communities, rather than assuming a

deficit understanding of the self that requires fixing or cure based on a biochemical illness model. In a similar way, Hopper (2007) focuses on the broader transformative potential of 'creating an imaginative space' within and beyond mental health services where capabilities for women, their freedom or opportunities, can be realised through the practices and contexts that support individual capacities as 'valued beings and doings'.

We argue that when read alongside of feminist theories which examine *how* feminine subjectivity is shaped, work on the social model of recovery and Foucault's ethics contribute to a more relational understanding of recovery practices as potentially normalising or resistant to dominant ideals of womanhood. Foucault and feminists converge in relation to the instability of power relations, and suggest that they may be contradictory and unstable, hence open to change and resistance. Foucault (1994) suggests that this occurs through problematising the limits of identity and the everyday processes of subjectivation. However, the degree to which mid-life women experiencing 'depression' are able to actively develop the skills to change and resist normalising discourses of femininity and recovery is problematic. For many women, the development of an attitude of self-critique or critical self-awareness that is not directed 'at the self' may be difficult to cultivate. Women's self-relationship is often characterised by self-surveillance, over-responsibility, self-blame, and self-sacrifice (Jack, 1991; O'Grady, 2005; Ussher, 2003; Fullagar, 2008). There is therefore a need to understand how women negotiate normalised clinical expectations and practices that ignore *different relations to self* in recovery. The focus of this article moves beyond these more proscribed notions of recovery, to consider the social processes and tensions that arise for women as they attempt to change their relation to their embodied self

through developing practices of care for the self as they create different knowledge about recovery.

Researching mid-life women's experiences

The project involved a sample of 31 Australian women aged 35-49 who were recruited voluntarily through fliers in local newspapers, radio and community centres. Culturally mid-life is viewed as point when 'past, present and future intersect' (Wray, 2007 p. 31) and women were also often managing changing work and care responsibilities. We also chose to focus on women as their voices are often neglected within the health sector and recovery is generally theorised as a gender neutral process. Participants were recruited from metropolitan and rural Queensland, and metropolitan and rural New South Wales. Participants were largely from an Anglo-celtic background, with two from middle European origins. Other gendered contexts with women from different cultural backgrounds would reveal different notions of depression and recovery (see Beauboeuf-Lafontant's insightful work on Black American women, 2007).

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. The questions were directed at gleaning an understanding of 'how' women began changing their relation to self in the process of recovery. The women participated in semi-structured interviews, which were audio-taped and then transcribed. The interviews were conducted by each researcher between August 2005 and April 2007 in participant's homes or preferred locations and ranged in duration from one and a half to two hours. In addition, demographic details, such as age of onset and number of times depressed were obtained through a brief questionnaire. As the first Australian study seeking to explore the discursive parameters of

depression and recovery, the research requested participants who self-identified as recovered from depression, rather than assume diagnostic certainty as an expert truth. Our participants had extensive experience with clinical approaches to depression and recovery, with only one woman not diagnosed by a General Practitioner. Twenty-nine women had been prescribed medication and twenty-one women still used medication to sustain their recovery. None of the women felt that they had recovered to a point where they thought they would never experience depression again. Twenty-one women indicated that they had experienced three or more episodes of depression and the remaining seven had experienced two to three episodes. The chronicity of depression also highlights the complexity of women's recovery experiences and the need to critically examine the limitations of normalised approaches while also exploring alternatives.

NVivo software was used to code women's comments about their changing relation to self and recovery practices. The key themes for this article were initially identified through memo-writing (Charmaz, 1990) which linked together how women negotiated both recovery discourses and advanced liberal discourses of normative individuality. Memo-writing also enabled links to be made between the initial codes and the second level of thematic analysis. The second level of analysis examined the 'interpretive repertoires' (Wetherell & Potter, 1988) which Mason (2002, p. 32) suggests are the 'various discursive patterns' that individuals draw upon to express themselves. These discursive patterns provided us with 'visible signs, or clues' (Mason, 2002, p. 32) through which to refine and deepen our analysis to examine in more detail how women spoke about the effect of normalised discourses of recovery on their relation to self and the tensions that arose as they attempted to change this relation through developing their capabilities.

While we have examined all participants' narratives to consider the effects of normalised recovery discourses, we have chosen to only draw upon five women's accounts to illustrate the complexity of these negotiations. These participants gave 'rich and experiential' accounts of their everyday practices in recovery (Morse, 2000, p. 4). An overview of the broader sample is summarised in the introductory comments prior to each narrative but our aim in this article was to reveal the deeper complexities. We were therefore concerned in a Foucauldian sense to examine how 'truth' discourses operate and the effect of forms of knowledge on women's recovering selfhood (Ramazanoglu, & Holland, 2002). Perhaps more importantly we also wanted to examine how women resisted 'truth' claims in making sense of their beings and doings in recovery. We present our findings through two themes; the disciplined self of normalised recovery and redefining recovery as a practice of self-care.

Normalised recovery: The disciplined (or dutiful) self

LaFrance (2009) points out that women largely attribute their emotional distress to depression and take up biomedical explanation after receiving medical diagnosis and treatment. That so many women within our research had initially consumed medication indicates that they also implicitly accepted biomedical explanations for their emotional distress. We noted how women produced meaning about the everyday context of recovery as 'doing and being' in *relation to* the normalised parameters of depression. Throughout their repeated episodes women continued to draw on biomedical diagnoses. While a diagnosis of depression validated many women's emotional pain, acceptance of such a diagnosis also positioned them as 'ill'. The construction of the ill and deficient self invoked a responsibility that required women to 'dutifully' treat themselves as part of the recovery process that would return them to productive roles at home and work. Often these recovery

practices involve a disciplined relation to self as women followed expert prescriptions for exercise, medication and stress management. While General Practitioners did explore the broader dimensions of women's lives, advocating for social support, self-care advice was often focused on changing biochemistry. In addition, consumer expectations in regard to normalised recovery are often understood in terms of a 'clinical or curative outcome that involves symptom resolution' (Lal, 2010, p. 87). The complexity of recovery is highlighted by women's experiences where for many, recovery was not a straight forward process of being cured (two thirds experienced more than three episodes of depression), of reducing symptoms through medication or being able to function 'normally' again. Many women spoke of problematic and ineffective treatments, wrong medication that intensified their distress, or that was simply ineffective (see also Fullagar & O'Brien, 2013).

Similarly, women who had experienced an abatement of symptoms through taking medication, had often not made any other significant changes, and within the gendered context of their lives experienced the return of their depression. Other women had a measure of success in treating their illness with medication, but were fearful of their reliance on medication to sustain recovery and what might happen if they were to cease taking it (see also Fullagar, 2009). Yet women often persevered with expert advice (some also resisted by stopping medication use) and continued in this discipline of self in the hope of moving towards recovery. The sense of ambivalence about the effectiveness of medication and reliance on it to maintain recovery illustrates the difficulty that many women face in disentangling what actually helped them recover, and hence what they had to do to prevent relapse. In the following example we employ Lisa's story to illustrate how the discipline of medication consumption, creates a dutiful subject, but limits the

development of reflective insights into the self, or the gendered context of women's lives. Perhaps more importantly medication consumption fosters a deficit based relation to self in terms of the focus on symptoms. In this regard the medical gaze focuses on women's 'lack' rather than exploring how to generate capabilities and relational capacities to support recovery through different experiences of subjectivity.

Lisa (40 years), a sole parent working in a skilled occupation, privileges medication as being responsible for her recovery, yet she still only feels as if she is '90% and not 100% better'. She was initially prescribed the wrong medication, and without adequate support she had to relinquish her son to the child protection authorities. She was finally prescribed the 'right' medication, which she says helped her to start getting 'better' and enabled her to get her son out of foster care. Lisa interpreted the change as biochemical as she stated, 'it was only because of the medication' that she was able to recover and regain custody of her son. The desire to recover quickly in order to resume caring provided a powerful context for her disciplined medication use. Lisa had tried several times to 'wean' herself off medication, but found that she was 'getting stressed and anxious again', which in turn threatened her recovered selfhood and engendered fear of recurrence. For Lisa, ceasing her medication evoked intense emotions (fear, shame, guilt) that generated a conflicted sense of subjectivity as a patient, mother, employee and competent self. In essence Lisa was focused on her lack of capacity to control her 'difficult' emotions. Her disciplined relation to self focused on learning 'to control' the stress that created her unwanted emotions. Yet, Lisa downplayed the capacities that enabled her to cope with the gendered and material inequities she faced on a day-to-day basis as a mother trying to manage work and her sole parenting responsibilities. Medication promised to restore 'normal' functioning and rational

control over the biochemical aspect of depression (Fullagar, 2009). However, the reliance on anti-depressants for control over the self serves as a reminder that Lisa lacked socially valued capacities that a woman at mid-life is expected to demonstrate (Hopper, 2007). Within the repertoire of recovery that articulates a dutiful self, Lisa's deficiency is reinscribed every time she consumed her medication and her options for developing other than normalised capabilities are closed off.

The difficult and ongoing negotiations that Lisa engages in with the biomedical discourse of deficiency became very apparent in her construction of a future self. During the first part of the interview Lisa made five references to not believing that she would ever recover from depression. The extent to which Lisa feels trapped by her inability to move beyond her notion of herself as an ill subject is captured poignantly when she says that 'to me going off the medication is getting myself better, but I think it's something that I'll never recover from'. While anti-depressants have enabled Lisa to recover her ability to care for son, she had only found limited ways of caring for herself (some family support, seeking State care for her son so she could sleep and rest). The promise of control and continued recovery through anti-depressants paradoxically highlights how maintaining a socially valued subject position (capable mother) is hinged on uncertainty. Rather than allowing Lisa to expand her capabilities, the reliance upon anti-depressant prescription allows little room for other imaginative options to be explored in terms of social recovery (Hopper, 2007). The depressed mother in this context is positioned as responsible for improving her emotional wellbeing despite the absence of adequate social, material or psychological support.

In exercising dutiful recovery women also drew on the expertise of the psy-disciplines to 'find' recovery within the self. Like finding the right medication, all but three women

searched for the right psy-expert to help recover their pre or non-depressed selves. The self-help techniques that women often practised again focused on their sense of lack (psychological skills or qualities), positioning them as deficient selves in search of an inner truth. Women 'learnt' how to make valued choices to modify their behaviour so that they could perform valued gender identities (mothers, wives, workers). Often the self-discipline they mobilised to overcome 'deficiencies' reinscribed their depressed identity as they judged themselves as constantly requiring disciplined and remedial attention. The foundational notion of a coherent inner self whose problems can be articulated through identifying causes in the past or present (changing thought patterns) via psy-expertise does not necessarily address the gendered context that shapes the relation to self. While some personal capacities may be expanded, introspective forms of self-knowledge can exacerbate punitive and perfectionist relations to self. This is especially the case if the 'inner truth' is unable to be found and issues resolved through continued self-analysis and practices of rumination.

Mary (37 years, urban), for example, illustrated the difficulties that arose when women tried to disengage from psy-mediated notions of recovery to engage in other self-care recovery practices. Mary was in a conventional marriage with two children, worked full time and had struggled with the ongoing effects of childhood abuse on her sense of self-worth. At the time of interview she was reading a book titled *Dealing with Depression*, however each time she referred to the book she says that it triggered a relapse into depression. While Mary had begun to recognise that reading the book evoked such a response, her relation to self was still entrenched in the norms and language of biomedicine and psy-expertise. This form of exercise on the self 'requires positing an inner self that is always present, coherent and

intelligible, and available to be “worked on”; recovery now appears as a matter of habit and self-conduct’ (Keane, 2003, p. 329). Mary’s self-work in recovery was therefore focused on ‘coping’ with managing her feelings so she could feel ‘normal’ in her day-to-day existence. Through this psy-mediated discipline of self, Mary was attempting to regain the autonomy and rationality, the socially valued gender identities (Hopper, 2007) that depression had taken away from her. This emphasis on changing the inner self is highly individualised and highlights how *capabilities deprivation* (Hopper, 2007) is connected to the struggle women undertake to undo punitive gender patterns of perfectionism, and disengage from the ‘good woman’ ideal to practice self-care (Lafrance, 2009). Despite Mary identifying that her husband and sons had been supportive, her expectations of herself as a mid-life woman still encompass an ‘other-oriented’ (O’Grady, 2005, p. 28) relation of care as part of traditional heterosexual family relations. While Mary has sought value in the ‘other orientation’ of feminised care, she was not able to value her own self-care practices as relations that would support her well-being.

Mary indicated that she had to ‘make herself’ do something to create the imaginative space that would enable her to relate to herself differently. Mary’s self discipline was focused on trying to negate her perception of herself as deficient and in need of ‘treatment’ in her desire to achieve a ‘normal’ recovered state. Disengaging from these normalised practices (self-blame, rumination) was particularly difficult for Mary, who indicated she had suffered depression for her ‘whole life’ hence she had difficulty imagining her life differently.

Several times in the interview Mary was asked what kinds of things had helped her expand her capacities and sustain well-being to which she replied ‘not much’ and then said ‘I walk for an hour a day’. When Mary was asked how walking helps her recovery, she replied; ‘I

don't know, I don't focus on anything but the music; I wear head phones; but exercise helps, so they tell me'. In this example, exercise as part of dutiful recovery does not necessarily increase self-knowledge. Mary also hesitatingly expressed a desire to create an imaginative space in which to engage in an activity that provided her with enjoyment. She said 'if I can get near my sewing machine, it would be good. I like to enjoy sewing'. Mary does not express a strong sense of entitlement to enjoyable leisure pursuits, a common issue for women who feel a lack of entitlement to enjoy time to engage in any type of leisure activity (Miller & Brown, 2005, Fullagar, 2008). Mary's story highlights the challenges women face in overcoming gendered constraints that impede their exploration of different relations to self and how leisure practices are an important domain of capabilities. It is not surprising that Mary was engaged in continual self-surveillance and introspection as a means of working on her self in the quest for a "'true self" ... the site of genuine and deep recovery' (Keane, 2000, p. 239). Yet this same discipline of self tended to reinscribe her depressed identity. It was therefore difficult for Mary to embrace or enjoy alternative practices of self care, as developing a relation of care that is not directed at inner self improvement is often difficult for women to cultivate. These individualised practices emphasise a women's ability to take control of their life, giving little consideration to the pervasive effects of gender discourses about caring for others over oneself, that impede women's recovery. Equally, Mary's attempts at self-care were implicated in a dutiful orientation to recovery and not as means through which to engage in other well-being practices that might facilitate different emotions and relationships. While her desire to take up sewing more often hints at other possible doings and beings that could be enacted in recovery, such individual or social opportunities remain unrealised (creative pursuits and social networks). Similarly she did not know why music helped, and had not been encouraged to explore what a musical

relation to self might generate in terms of different emotions, relations with others. Instead, Mary's recovery was shaped by medical expertise about 'managing' her depression which produced a very limited context for self transformation.

Redefining recovery and depression

An important aspect of changing the relation to self that women identified was questioning the limitations of a normalised or dutiful way of managing oneself as a self in recovery and exploring alternatives. While most women did not describe themselves as feel as fully recovered, many were redefining what recovery meant for them. They had begun to develop self-knowledge which involved far more than a rational decision to make behavioural changes to 'get over' depression or taking medication. Recovery was interpreted as a complex process that involved translating emotions, multiple meanings and gender expectations about oneself as a woman at mid-life. One of the ongoing struggles that women articulated was how to change their relation to their depressed self (negative, unmotivated, stuck) to begin to develop knowledge and practices of care for themselves. Recovery was being redefined in relation to women's experiences (often negative) with biomedical approaches and the process of identifying what worked for them. Women stressed the importance of creating an imaginative space where they could escape from the dominance of their depressed identity, sometimes through a practice as simple as getting out into the garden and away from gendered responsibilities, where they might just 'be' or reflect on what their emotions meant in the context of everyday situations. These spaces of being and doing beyond the depressed self involved a shift (sometimes very temporary) in focus from seeing oneself as 'deficient' (chemically imbalanced, unable to cope, failing) to noticing or practising caring for oneself and living emotional relations differently. Pam's

story illustrates this shift as she redefined recovery beyond singular or normalised notions of recovered selfhood, to create space for 'other-than-conventionally prescribed possibilities' (Hopper, 2007, p. 874).

Pam (44 years, urban), a married self-described 'home manager' with a deeply ambivalent relationship with the Church, had two children living at home and said that she considered the 'term recovery and thought oh, I would reject it, in fact for my own path'. She then qualified this by saying that 'everyone has their own way of going potty ... Mine happens to be ... when I'm not coping with things I happen to become depressed'. Pam said that she no longer thought of her depression as a sign of her personal deficiencies and she contrasted this to her younger self who was very self-critical. 'Going potty' had become a descriptor and signifier of her embodied response when she had been too busy to take time to look after herself, or when she felt that demands were being made of her that would increase her distress. In describing her symptoms as 'very text book stuff', she had legitimated to herself and to others that her 'symptoms' were part of a biomedical story of depression. Yet, redescribing herself as 'going potty' allowed her to feel and acknowledge distressing emotions, without reducing this to a notion of individual deficit. Pam drew upon multiple discourses about depression and recovery ('personality' and 'biology' and 'not coping') in the creation of her own interpretive repertoire about emotional distress that focussed on what she could 'do' to recover (garden, disengage from destructive social relationships, consider her different strengths and purpose in life). Pam's use of multiple discourses of depression and recovery suggests that women draw upon normalised discourses to legitimate their distress and feel 'safe' ('I'm not going nuts') and at the same time hold

counter notions of social recovery that focus on everyday doings and beings that are non-illness related (Pam identified as a passionate gardener).

While Pam accepted that she has 'learned to live with' her complex emotions, she has created a distinction between herself as a mid-life woman and her 'experiences of depression'. Pam captured this distinction rather eloquently: 'if you can see yourself as separate from the thing that you're experiencing – sometimes it's easier to cope with. Your identity doesn't get caught up in it – so much'. Pam hesitated to draw on a normalised discourse of recovery as she recognised that at some point in the future she will again have similar feelings of emotional distress. It was not something she spoke of in fear; rather she said: 'the really good thing is that whatever it is, will in fact go away, so that's how I feel about the word recovery'. So, rather than being defined by her illness or trapped by discourses of dutiful recovery and a deficit notion of self, she recognised that these feelings would arise as part of her life. When they arise she engages the self-care strategy of retreating to her garden, which has become a creative or imaginative space where Pam can experience joy and pleasure. It is also a space that had allowed her to develop her capacity to better deal with her emotional life and injustices she experienced in the Church. Pam also emphasised the importance of the social support of her husband, mother and sisters, and through these relational practices she is able to deal with disturbing emotions. Rather than feel she 'has' to recover, or feel inadequate because of her at times unsettling emotions, Pam has focused on her capacities in dealing with her emotional life through nurturing herself spiritually and emotionally. She is therefore redefining recovery as a social practice of self-care and as such she drops the label.

The practice of dropping the label also raises a key point for many women in redefining recovery and to glimpse other possibilities for being and doing. Women had begun to narrate other stories about their emotional distress, expanding their capabilities in relation to how they experienced their emotion. Phoebe, for example, who had been subjected to childhood sexual abuse, went to a health retreat where she took risks, doing things that she had never done before, including climbing a telegraph pole and jumping off. She said that while it was terrifying, she also learnt that 'it was good terrifying'. This was quite a contrast to the years she had spent being terrified when she was being abused, both by family members and then her husband that she had 'forgotten there's good terrifying, I'd spent so many years with my heart in my throat, all the time, and I'd forgotten there are good ways to be stressed and afraid'. The health retreat offered Phoebe an opportunity to experience the 'dignity of risk' (Hopper, 2007, p. 877) where she joined with other women to realise her capabilities through embodying and narrating physical and emotional strengths. Phoebe's story emphasises the profoundly embodied relation to self that exists in stark contrast to the prescription of medication to correct deficient neurochemical pathways in order to restore 'normal' functioning. Embodying risk was a counter discourse that Phoebe and several other women drew upon as they engaged in different social practices that implicitly challenged gender norms around caring for others (Fullagar, 2011). Whether it was signing up to a netball team, yoga class or solo holiday, women who resisted the 'good woman' ideal (Stoppard, 1999) to schedule time out from family and domestic responsibilities were able to create imagined and embodied spaces to practice self-care as a gendered form of social recovery. However, gender inequities clearly affected those women who were unable to attain the financial, social and emotional support needed to explore different recovery practices. Within the context of contemporary neo-liberal Australia recovery largely remains

an individualised therapeutic practice where the distribution of State services through biomedical and psy-expertise limits the range of capabilities that women are able to realise beyond normalised gender ideals. Despite the rhetoric within mental health policy about adopting recovery orientation there has been little consideration of how this might translate into non-clinical support for women who are yet to be recognised as ‘experts in their own mental health’ (Laitinen & Ettorre, 2004, p.205).

Implications for practice and policy

In this article we have argued for an understanding of depression and recovery that foregrounds the relational construction of self and the gendered context women’s lives. Our aim has been to make visible women’s own knowledges as they negotiated different ways of ‘being and doing’ recovery – from the highly normalised ‘dutiful’ practices (medication and therapy) to everyday practices that contribute to an understanding of social recovery. We have drawn upon several lines of thought to examine how women negotiate the gendered context of caring for themselves in recovery to make visible the connections between individual mode of functioning (doing and being), capabilities and the discourses that shape feminine subjectivity (feminist and Foucauldian insights). Insights from a capabilities approach also complement other social recovery orientations that emphasise ‘strengths’, ‘mindfulness’, ‘appreciative inquiry’, ‘solution focussed’ and ‘narrative based’ understandings of individual identities in their everyday social contexts (Gehart, 2012; Lomas, 2013; Ridge, 2009; Tew, Ramon, Slade, Bird, Melton & Le Boutillier, 2012).

While recovery has become the aim of biomedical treatment and mental health policies there remain distinct differences in terms of the way discourses are deployed to locate depression ‘within’ the self, rather than open up a more relational notion of social recovery.

Hence, we have identified some of the effects of well-intentioned expert discourses about recovery on women's lives as they often attempted to unsuccessfully perform 'dutiful' recovery. Issues of 'relapse' and ongoing demand for medical/therapeutic support illustrate the cyclic problems that are connected to the failure of expertise to 'solve' the complex interrelationship between depression and women's lives. Yet, there are a range of other approaches that do not employ deficit models of selfhood and instead aim to work with individuals within the social context (to varying degrees).

Practitioners and advocates in women's health movements have historically recognised that personal recovery is political. For example, Laitinen and Ettorre (2004), and Laitinen, Ettorre and Sutton (2006) outline their focus on women's empowerment, where women who had suffered depression were active in their healing and became experts in their own health with guided help from professionals. In this way rather than becoming the object of 'medical intervention' women learned to understand themselves and engage in 'affective transformations on both individual and social levels' (Laitinen, Ettorre & Sutton, 2006, p. 316). We extend this line of thinking and argue that women's diverse experiences of recovery can be incorporated into a more critically reflective policy and practice approach across a range of settings, promotion and provision for individuals, groups and populations. For example, the *Better Access* scheme in Australia could incorporate insights from feminist approaches and even more mainstream 'social prescribing' models in the United Kingdom to offer women broader, community based options for social support, leisure and educational opportunities (Brandling & House, 2009; Bungay & Clift, 2010). However, as many state funded programs require a diagnoses of depression there is a contradiction produced in relation to a 'recovery orientation' that begins with women's self-understanding, experience

and desires. Hence, within the biomedical apparatus women remain positioned as 'ill' and their recovery defined in contradictory ways that work to undermine policy claims about choice or empowerment (Laitinen, Ettorre & Sutton, 2006).

In addition to individually focused work, professionals can draw upon critical social perspectives to create gender sensitive support systems and programs that enable diverse meanings of recovery and prevent relapse. Assisting women to recognise that a diagnosis of depression does not define their identity and self-knowledge is also about finding other ways to experience themselves and their emotions, may help them engage in well-being practices to move beyond the stasis of depression. The danger with any 'prescription for recovery' is that it can easily normalise expectations about change that can also disempower women when they aren't able to easily change the gendered context of their lives or blame themselves for failing again. Instead, we argue that professionals can learn from women's tacit knowledge of what has worked for them to draw out strengths and capacities in everyday life. For example, emphasis can be placed on the meaning and pleasure derived from everyday leisure and self-care activities and the way in which they allow women to negotiate a different gender relation to self and with others. Allowing for a movement of self that is not linear, but multiple and ongoing, allows greater flexibility when normalised desires to recover '100%' are not achieved. Women's individual capacities and collective capabilities, rather than their deficiencies, become a co-created source of knowledge where power is shared to realise the possibilities for transformation on individual, organizational and social levels. The identification of complex power *relations* that contribute to disabling social environments for women with depression is a logical extension of a capabilities approach. Addressing gender expectations about 'good women'

ideals in relation to motherhood, work and family can occur alongside the work needed to combat the stigma of depression and the material inequalities that result from marginalization (Tew et al., 2012).

Explicating the range of tacit self-knowledge produced by the women in this study was a significant moment for us as researchers. The interview process itself was telling in terms of the power of biomedical discourses of treatment as women recounted all the recovery activities they engaged in via 'expert' advice. Further probing revealed many forms of treatment were problematic or ineffective on their own. Only by asking different questions (what else did you do that helped?) were we able to open up conversations where women talked about their everyday successes and meanings to create alternative understandings of recovery. At the policy level these findings support the emerging focus on social recovery pathways and support systems, from community based services, women's wellbeing centres and social programs (Tilley & Cowan, 2011; Branding & House, 2009; Bungay & Clift, 2010). They also highlight the need for different professionals to foreground the 'social' more strongly in biopsychosocial models of mental health that continue to articulate the biomedical as the primary discourse. Importantly greater credence needs to be given to a relational construction of identity and the gendered conditions of women's lives that they identify as contributing to their depression and impeding their recovery.

Concluding remarks

For many mid-life women a diagnosis of depression had a significant impact on their identity, their life opportunities and their relation to self. As they attempted to recover, this relation to self was mediated by biomedical and psy-discourses that often limited their options for caring for the self in recovery. We identified how within an advanced liberal

society, such as Australia, discourses of individual responsibility for recovery were drawn upon by many women to articulate a notion of 'dutiful' recovery, complicating women's recovery efforts. Recovery involved governing oneself through normalised practices such as consuming medication, seeking therapy or following prescribed 'lifestyle' activities (sleep, diet, exercise). However, as mid-life women negotiated gendered ideas about 'successful' womanhood they struggled to practise care for themselves and identified many problems with normalised approaches. Our research has demonstrated how the neo-liberal ethos of individualised responsibility for recovery fails women as it neglects gender inequities and the 'cultural imperatives' that emphasise care for others before oneself (O'Grady, 2005, p. 1). This caring relation was often intensified for mid-life women who may have older children at home and also be caring for ageing parents or relatives. This invisible work further depleted women's emotional resources when these were already in a fragile state. In addition discourses of individual responsibility used by medical practitioners to articulate the 'doing and being' of recovery emphasised how women could engage in self-help pursuits or resume productive roles at home and work. These expert recovery practices often became a just another 'task' that a woman 'had to do' as a responsible prudent neo-liberal subject (Rose, 2007), leaving them very little time and space to be able to imagine different (and more critical) ways of relating to the self beyond the biomedical.

Paradoxically it was often the failure of normalised discourses of recovery to deliver on their promise that led women to exercise agency in ways that shifted their relation to self. As we have illustrated, for this group of mid-life women recovery was also a generative process of caring for the self in ways other than simply those prescribed by experts. Women often did not know 'how' to move beyond normalised discourses when they 'failed' to successfully

recover. For many it was a complex process of translating and interpreting emotions, tacit meanings and expectations to think about the embodied self differently. Through documenting the multiplicity of meanings about depression and recovery as an everyday practice, our research has identified women's capacities and knowledge rather than deficits. Rather than concentrating all their recovery efforts on changing biochemistry or attempting to find the truth of the self, many women recognised the importance of developing self-care practices that enabled them to think about and relate to themselves as women beyond heteronormative ideals (other focused wives, mothers, daughters, survivors, workers). They recognised the importance of developing self-knowledge that was not simply limited to taking medication and changing inner behaviour, but on valued being and doing, as well as capabilities. This self-understanding can also be seen via Foucault as a form of subjugated knowledge that has been largely ignored within the biomedical assemblage of diagnoses, treatment, institutional contexts and pharmaceutical markets. Women's recovery experiences reveal the implicit workings of power that shaped their emotional lives and recovery narratives through the negotiation of gender demands that affected their emotional capacity, material wellbeing and were plainly unjust. Women also experimented with ways of dealing with complex emotions through engaging in leisure related self-care practices that allowed them to feel different (strong, creative, relaxed, joyful). In this way women's stories revealed how important it is to question neoliberal imperatives about self-care and self-responsibility as gender relations cannot simply be ignored in professional contexts that seek to 'change behaviour', increase 'help-seeking' or 'empower' service users/patients. Ignoring the gender relations that shape women's emotional wellbeing can unintentionally limit how professionals, citizens and women experiencing distress

themselves, think about and act in the name of recovery from depression, and may indeed contribute to ongoing distress and injustice.

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