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Social Forces, Personal Pain: Mental Health `Norms' and the Politics of Depression

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Abstract

Depression is now recognized as a major and growing public health problem. But this paper argues that the increased publicity accorded the phenomenon of depression actually masks the social and political challenges depression poses. The norms of `mental health' are not neutral. Rather, they remain predicated on an individualist conception which is exclusionary of large numbers of people and groups. The paper argues that while not separable from the dynamics of class, age and ethnicity, the lens of gender is crucial to the urgent task of revisioning subjectivity along more inclusive - and more relational - lines.

Depression is now regarded as a major public health problem which is wide-ranging in its effects. In contrast to as recently as five years ago, depression is now widely acknowledged. Establishment of national depression institutes (such as Beyondblue in Victoria) is testament to this. The publicity which now surrounds the topic of depression suggests that the long silence regarding it has ended. But this paper argues that the seeming attentiveness to depression represents a new and insidious form of marginalization. In the popularization, but also continuing professionalisation, of depression, the norms of mental health (the implicit template of what healthy psychic functioning is considered to be) remain largely unquestioned.

The rhetoric of liberal inclusiveness notwithstanding, what is assumed to be the norm is rather a *particular conception of subjectivity.* This conception is gendered, classed and ethnicised, in ways which massively disenfranchise a range of individuals and groups. It also reinstates the authority of familiar discourses and specializations at a time when alternative conceptions of what comprises `mental health' have arguably never been more urgent.

A range of institutions and disciplines have discussed the extent to which ostensibly inclusive conceptions of the `person' subtly privilege a *white, middle-class male* `norm'. Correspondingly, a highly individualistic conception of subjectivity is also privileged. The notion of a *detached, autonomous* and significantly *male* actor has been shown to underlie otherwise contrasting perspectives – indeed to be at the heart of the western liberal tradition.[1] The `individual' of that tradition has not only been assumed to be male (and incipiently a white market-place actor). Such an `individual' is envisaged as *separate*, *autonomous*, and as classical liberal theory makes abundantly clear, largely *detached from social context*. This narrowly individualist conception has been widely critiqued from a number of areas (for example, particularly by feminists, but also from within the liberal tradition itself). I will argue that the implications of this legacy for still prevalent ideas about *subjectivity* remain major.

I contend that the axis of *gender* is crucial to a much-needed revisioning of subjectivity. Gender is not detachable from the dynamics of ethnicity, class and age. Yet sensitivity to gender is particularly valuable in challenging the `individualist' norms of mental health which are still so prevalent, and which are themselves so implicated in the phenomenon of `depression'. Gender necessarily operates in interaction with other variables, such that it cannot be privileged in any unqualified sense. But it provides a prism through which more relational – and viable – conceptions of subjectivity can begin to be recognized.

Social strain, depressive symptoms

> a culture like our own that takes seriously individuality, control and hedonism may pay the price of increased depression. Indeed, we do more than just take personal control seriously; we sanction it and glorify it. But suppose depression results from finding oneself helpless and then feeling hopeless. We would predict an epidemic of depression to be raging, and it is.
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> Christopher Peterson, Steven Maier & Martin Seligman, *Learned Helplessness: A Theory for the Age of Personal Control* (New York: OUP, 1993), p.211.

[1] See, for example, Mary Lyndon Shanley & Carole Pateman, ed. *Feminist Interpretations and Political Theory* (Cambridge: Polity, 1991).

The prevalence of `depression' itself suggests the need for more relational conceptions of subjectivity. Yet in one of the several anomalies that surrounds the discourse of depression, for the most part these are not forthcoming from the professions mandated to treat it. As prelude to consideration of the ways in which sensitivity to gender can challenge the still largely intact `norms' of mental health, it is necessary to note the crucial role of social factors in and on depression. It is also necessary to confront the depth of the challenge recognition of the role of social factors poses to existing understandings of subjectivity.

It is over a decade since Seligman and his co-authors published their landmark study.[2] Since then, the `epidemic' of depression is considered by many to have reached *pan*demic proportions.[3] While increased *recognition* of the extent of depression must be acknowledged (as well as increased incidence) there is near-unanimity that depression comprises a serious public health problem which needs to be addressed as a national, and even international, priority. As Hamilton points out, `in developing countries, psychiatric disorders are fast replacing traditional infectious diseases as the leading causes of ill-health'.[4] Of such `disorders', depression is at the forefront.

Conceptualizing depression as a `psychiatric disorder' raises immediate questions of definition. At what point do normal feelings of sadness become a `disorder'? Normalizing the prevalence of depression as a condition to be `treated' means that experiences such as loss in response to bereavement risk being pathologised. It also increases the authority of scientific and medical expertise as the legitimate `treatment' sources (even as a range of `alternative' approaches are proliferating). Since the definition of `depression' has important treatment implications, it needs to be considered in detail. But it is also clear that depression can indeed comprise an illness and disability, and that it exists in this form at high levels. And as Seligman's text substantiates –

[2] Even allowing for the fact that a contemporary diagnosis of depression cannot simply be equated with a similar diagnosis fifty years ago, Seligman et al used a calibrated classificatory scheme to show that `a more recent year of birth confers more and earlier risk for a major depressive disorder' (Seligman et al, *Learned Helplessness*, p.210). They argued that `if you were born around 1910, you had only a 1.3% chance of having a major depressive episode, even though you have had at least a seventy-year opportunity to get it' (p.209). Yet `if you were born after 1960, you already had a 5.3% chance, even though you have only had a twenty-year opportunity…a roughly tenfold increase in risk for depression across two generations' (p.209; for discussion of postulated *reasons* for this, see subsequent discussion).

[3] As Hamilton notes (in a current work which likewise links `individual' maladies with wider social forces) while major depression `is already the leading cause of disability worldwide, when measured in terms of disability-adjusted life-years it is expected to leap from being the fourth most burdensome disease in the world in 1990 to second place in 2020' (Clive Hamilton, *Growth Fetish,* Sydney: Allen & Unwin, 2003, p.41).

[4] Hamilton, *Growth Fetish*, p.41.

together with a raft of diverse research – depression is *socially influenced* such that it cannot be viewed in individualist terms alone.[5]

Yet it is striking that depression continues to be conceptualized in `individualist' terms, even as research attests to the importance of social factors.[6] The reading of depression as a primarily `individual' disorder remains remarkably resilient at both popular and professional levels. This is while the role of social factors – and the legitimacy of social models of health – is also routinely conceded. We thus have the anomalous situation of an epidemic of `individual' disorders, which, revealingly, are widely treated by pharmaceuticals and carefully selected forms of therapy (chiefly cognitive behavioural therapy – CBT – which aims to intercept and challenge individual negative thought patterns).[7]

Such ambivalence – recognition, on the one hand, of the social constituents of depression, yet simultaneous privileging of primarily individualist readings – is characteristic of the discourse of depression. What accounts for such ambivalence? At one level, this may seem to be obvious. Treatment of depression (which is still largely by professions which themselves continue to operate according to individualist, and often biomedical frameworks) cannot realistically address the social determinants of depression, even where these are held to be significant. It is also argued by many that individualist and biomedical models are as receptive to the role of social influences as it is possible for them to be (hence the popularity of `biopsychosocial' conceptions, which concede the complexity of social and biological interplay). Mounting cultural critiques of biological determinism, and of the `disease model'[8] have required increased attentiveness to cultural and social influences, including within biomedical circles.

But the gesturing towards, rather than serious engagement with, social influences remains. It is still surprisingly easy to *appear* to take social influences on mental health seriously, while acknowledging them in a way which does not challenge `individualist' conceptions. For example, successive

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[5] `The evidence is clear that depression is not exclusively - or even mostly – about genes, biochemistry, or disease' (Michael Yapko, *Hand-Me-Down Blues: How to Stop Depression from Spreading in Families,* New York: St Martins Press, 1999, p.9.

[6] Indeed, Yapko cites evidence that `*environmental factors are more influential in the onset and course of major depression than are genetic factors'* (Yapko*, Hand-Me-Down Blues*, p.35; original emphasis).

[7] The pioneer of which has been Aaron Beck. See Beck et al, *Cognitive Therapy of Depression* (New York: Guilford Press, 1979).

[8] See, for example, Arthur Kleinman & Bryon Good, ed. *Culture and Depression: Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder* (Berkeley: University of California Press, 1985) and Anthony Marsella & Geoffrey White, ed. *Cultural Conceptions of Mental Health and Therapy* (Dordrecht D. Reidel, 1984).

editions of the *Diagnostic and Statistical Manual of Mental Disorders*[9] (DSM-IV; the standard text according to which the `mental health professions' of psychiatry, medicine and clinical psychology base diagnosis) make increasing reference to social and cultural influences. But these are invariably presented as additional points to consider, rather than systematically engaged for the different light they shed on the whole classificatory exercise.[10]

The specifics of temperament, personal experience and family history remain influential in the genesis and manifestation of depression (as other conditions and states). But these *always occur within social contexts* which can themselves mediate `biochemical' influences. This applies even to serious forms of depression – such as bipolar (`manic') disorder – in which medication is routinely part of an effective treatment plan. While not `causal' in any linear sense, social factors influence the onset and experience of psychological (as physical) well-being. Failure to recognize the challenges this poses to individualist conceptions- as distinct from merely noting the existence of social influences – is reductionist and illegitimate.

But ambivalence regarding the role of social influences on depression cuts deeper than a focus on professional compartmentalisations can convey. For as well as challenging narrowly individualist readings, social factors at the same time *encourage* them. As Seligman (and others) argue, in a culture which extols individualism and personal `control' (ironically at a time when for a whole range of reasons, it is least likely to be experienced) failure to meet expectations frequently results in *self*-blame – a key and recurring feature of depression. To the extent that modern culture endorses and sanctions self-blame, it actively encourages `a depressive explanatory style'.[11]

The heightening of expectations which accompanied modernity – and which as Hamilton graphically portrays, are relentlessly fuelled by the workings of consumer capitalism[12] – account in key ways for the increased incidence of `depressive disorders'. When expectations are not realized – as by definition in a capitalist consumer society they cannot be – disappointment, and often ensuing depression, result. Subscription to the enlightenment belief in `progress' (which, for all the assaults on it, dies hard) fosters belief that problems can be solved, as well as impatience with recognition that the complexity of some dilemmas makes their `solution' elusive. As Seligman argued ten years ago, with increased opportunities goes increased likelihood

[9] *Diagnostic and Statistical Manual of Mental Disorders*, *DSM-IV-TR*, fourth edition, text revision (Washington, D.C: American Psychiatic Association, 2000).
[10] See Richard Castillo, *Culture and Mental Illness* (Pacific Grove, California: Brooks/Cole, 1997),, p.16.
[11] Seligman et al, *Learned Helplessness*, p.211.
[12] Hamilton, *Growth Fetish.*

of failure.[13] Yet an individualist culture persistently constructs failure in `personal' terms.

Social, cultural – and thereby also political – factors are thus highly implicated in the incidence and experience of `depression', but *themselves individualize the phenomenon*. This insidious individualization (and to this extent *privatization*) of depression is more than the product of nebulous `social' forces. It is attributable to the continuing social myopia of the liberal tradition itself, which for all the many critiques of and within it, remains relentlessly individualist.

Within the constraints of a single paper, it is not possible to rehearse even the basic tenets of liberalism, and the many critiques which are now levelled at them. But the principles of *rationalism, individualism*, *universalism* and *progressivism* remain discernible in contemporary inflections of liberalism (in addition to the less acknowledged allegiances to capitalism, and somewhat paradoxically, to nationalism).[14] It is difficult to see depression other than in individualist terms when liberal values so thoroughly pervade the culture, and when such values consistently deflect attention from wider social influences. The liberal tradition – in this respect analogous to the *DSM-IV* which it so influences – similarly sees social factors as `tacked onto', rather than constitutive of, subject formation.

It is not only that biomedical models within the `mental health' professions retain currency and influence. They are themselves symptomatic of a liberal culture which continues to deny the deep-seatedness of social factors and groups. As Iris Young argued some time ago[15] – and in a critique which is even more apposite now than when she wrote it – liberalism and oppression are regarded by many people as mutually exclusive. Within western `democracies', socialization to liberal norms implies oppression to lie elsewhere. As she discussed, it is only as recently as the 1960s- with the social movement protests against sexism, racism and homophobia- that the reality of group identity within western societies was brought to public consciousness. With reference to `five faces of oppression', Young elaborated how many people within liberal societies escape `individual' status (and ensuing `rights') because of the group to which they belong.[16] To her

[13] Seligman et al, *Learned Helplessness*, p.211.
[14] For illustrations of the diversity of contemporary critiques of liberalism, see Seyla Benhabib, *Situating the Self* (Cambridge: Polity, 1992), Anne Phillips, *Democracy and Difference* (Cambridge: Polity, 1993) and John Gray, *Liberalism* (Buckingham: Open University Press, 1995).
[15] Iris Marion Young, *Justice and the Politics of Difference* (Princeton: Princeton University Press, 1990).
[16] This, she argues, frequently occurs at a cultural, everyday level, thus undermining the accessibility of formal rights. Since culture and politics are routinely dichotomized in liberal thought, this allows many

categories of exclusion and marginalization, among others, could be added that of the contemporary asylum-seeker, for whom even the status of `refugee' has become a luxury.

Liberalism is structured around a series of oppositions, which are not only distinctions but dichotomies.[17] Contrary to its self-presentation, and as Patricia Williams points out in her powerful exploration of racism, there is actually little in the liberal tradition which can guarantee or even foster connectedness.[18]

But liberalism is not only *complicit* with forms of oppression. There are major senses in which it *actively reproduces* them.[19] For the many people who are unable or unwilling to conform to the now covert but still intact `norm' of the individual citizen (white, masculine, `productive' in the market-place sense and able-bodied) liberal `rights' which may exist in a formal sense are forfeited at the cutting edge of culture and the politics of the everyday.[20] And *opp*ression, as feminists have consistently argued, frequently incubates *de*pression. Material poverty, social marginalization and racism (to take but three examples) do not necessarily lead to depression in those who experience them (a deterministic view which would also deny the reality of *resilience*; a concept which recurs in the psychological literature). But they can be powerfully reinforcing of feelings of helplessness. To this extent, they comprise clear risk factors for depression.

In a context in which consumer capitalism is so rampant, those most obviously disenfranchised in liberal societies are those who lack material resources.[21] Yet it is striking that even those who have a surfeit of these are not immune – and indeed may be especially prone – to experiences of depression.[22] This is not to illegitimately equate the situations of diverse contexts, people and groups (Young's telling distinction between *domination* -

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to dismiss exclusion and rights violation as `not political'. SeeYoung, `Five Faces of Oppression', ch. 2 in Young, *Justice and the Politics of Difference*.

[17] For discussion of the complexity of liberal thought, refer to the references in note 14.

[18] Patricia Williams, *The Alchemy of Race and Rights* (Cambridge, Mass: Harvard University Press, 1991).

[19] The relationship between liberalism and exclusion, particularly in the contexts of nationalism, racism and colonialism, has received considerable attention in recent years. See, for example, Phillip Cole, *Philosophies of Exclusion: Liberal Political Theory and Immigration* (Cambridge: Edinburgh University Press, 2000) and Ghassan Hage, *White Nation* (Sydney: Pluto Press, 1998).

[20] Young is again lucid on this point; see discussion in ch.2 of Young, *Justice and the Politics of Diifference.*

[21] Which is not to minimize `other' forms of oppression (significantly, Young sees *marginalization* as the most dangerous) which may operate independently or coterminously with material deprivation.

[22] As Hamilton notes, while certainly not restricted to the `rich countries', the incidence of depression is found to be highest in the so-called developed world (Hamilton, *Growth Fetish*, p.41). As he also argues, it is not possible to detach the increased incidence of depression in western societies from the rapacious capitalist consumerism which so typifies them.

varying degrees of which we all experience – and *oppression*[23] - systematic and structured constraints on the achievement of potential – remains apposite). Rather it is to underline that even social advantage and economic privilege do not necessarily serve as insulation from the depression which is so prevalent within western societies.[24]

*Not only is it the case that liberal values are consistent with the marginalization of many. Even those who are `living the ideals' are also at risk.* In liberal `democratic' societies (in which, as Hamilton aptly summarizes, economic growth has assumed the status of `fetish') and as the high incidence of diagnosed depression amply bears out, there exists a rising and more pervasive tide of distress and unhappiness.

The continuing challenge of gender

If the social constituents of depression are frequently elided in `individualist' readings, the influence of *gender* is scarcely even acknowledged. This is notwithstanding the now routine finding of epidemiological studies that the incidence of diagnosed depression in women is twice as high as that for men.[25] As distinct from a purported *sex* disparity in the *incidence* of depression, the role of gender (here defined as social and cultural attitudes to what biological difference signifies) is scarcely noted at all.[26] Yet the prism of gender still holds enormous potential not only for more nuanced understanding of depression, but for reconceptualisation of the mental health `norms' which, I want to argue, themselves partly account for the increased incidence of depression.

Why are gender dynamics crucial to the phenomenon of depression? A major reason is because what we feel we *should* do and be – the standards to which we feel we must measure up – are deeply implicated in experiences of depression. As Yapko admits, `the cultural mandates for a woman to connect

[23] Young, *Justice and the Politics of Difference*, p.41.
[24] Hamilton takes the point further – not only does material wealth not necessarily insulate against depression; rather it may actually be causative of it - `It is not simply that other trends in society, occurring in parallel with rising incomes, have offset the benefits of wealth; the process of economic growth itself has produced a seriously sick society. The richest people in the world are saying they are miserable, that it's not worth it and, most disturbingly of all, that the process of getting rich *causes* the problems. Continued pursuit of material acquisition gives rise to inner conflicts that become manifest in society in various ways' (Hamilton, *Growth Fetish,* p.15).
[25] That the rate of diagnosed depression in women is `double' that for men is a consistent feature of epidemiological studies. As will be discussed, it is a problematic finding in many respects (for example, male suicide rates in this country are considerably higher than those for women (see subsequent discussion).
[26] See, for example, Kathleen Grant, `Gender-based Analysis: Beyond the Red Queen Syndrome', and Shelley Abdool et al. `Towards Gender-Sensitive Health Indicators', in *Centres of Excellence for Women's Health Research Bulletin,* 2 (3), pp.15-18, and 7-9 respectively.

and a man to achieve are *very* deeply ingrained'[27] (original emphasis). The (mis)perception that gender relates `only to women' leads to neglect of its many influences.

Gender affects everybody, and operates at many levels. What is symbolically feminized is accorded different meaning and status than what is masculinized.[28] Certain characteristics and qualities – for example `aggression' and `competitiveness' – are gendered masculine, even when they manifest in women. Others, such as `caring' and `empathy', are gendered feminine even when they occur in men. To the extent that assumptions and attitudes are more entrenched and resilient than overt behavioural and policy changes, approaches to depression cannot remain gender-blind.

In this context, it is also highly revealing that the values and characteristics associated with liberal political economy – particularly in its current and especially virulent `growth fetish' stage – are themselves masculinist. By contrast, and correspondingly, so-called `non-productive' sectors and activities, especially those relating to social service, welfare and unpaid domestic labour, are still feminized. In capitalist economic systems this gendered division of labour has long operated, and is at one level well understood. But increased numbers of women in the paid labour force (as the increasing numbers of men now taking an active role in raising children) has obscured its continued operation at a *symbolic* level.[29]

The long institutionalized liberal binary between `public' and `private' – and the continuing legacy of this binary in encouraging compartmentalization between intellect and emotion; thinking and feeling – sheds light on the resilience of the gendered beliefs which Yapko rightly notes to be so prevalent in depression. Women may *know* that the emotional management of relationships should not fall to them alone, yet still *feel* otherwise. Men may *know* the legitimacy of choosing to spend more time with their children, while *feeling* vulnerable to traditional conceptions of masculinity. Yet gender-blind conceptions of, and approaches to, depression remain equally resilient. As Jack highlights, `researchers developing scales to measure cognitive correlates of depression have been more interested in universal distortions of thought processes and content than in gender-specific beliefs'.[30]

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[27] Yapko, Hand-Me-Down Blues, p.131.
[28] See, for example, Anne Cranny-Francis et al, *Gender Studies: Terms and Debates* (London: Palgrave, 2003, pp.1-2), and Val Plumwood, *Feminism and the Mastery of Nature* (London: Routledge, 1993), pp.41-68.
[29] Which is not to deny the continued existence of material disparity.
[30] Dana Crowley Jack, *Silencing the Self: Women and Depression* (New York: HarperCollins, 1993), p.228.

It is also striking that failure to examine the experiential and gendered dimensions of depression – the lived reality of depression- is as true of psychologically oriented research on depression as of more `scientific' studies. As Jack points out, while there exists `a large body of work about the interpersonal nature of depression', surprisingly little of this work addresses the role of gender norms in powerfully shaping interpersonal relationships, and of how women and men are differently affected by them.[31] Why this is the case relates to the major challenges attentiveness to gender poses – namely *the continuing capacity of gender to raise provocative questions about the construction of subjectivity, and its social constituents.*

To consider gender in and on depression is not to apply a `partial' perspective to a phenomenon which is clearly pervasive. Acknowledgement of the `prevalence' of depression can obscure contrasting expressions and experiences of depression about which we need to know more (and on which gender exercises an important and still unrecognized influence). In fact the lens of gender raises questions about both popular and professional conceptions of depression, and the mental health `norms' on which they are based. There are also major senses in which the phenomenon of depression is itself gendered, in ways which open up a range of possibilities for reconceptualisation.

Depression as gendered

The discourse of depression – the ways in which depression is conceptualized, discussed and addressed – has been acknowledged to be highly gendered, and not only by feminist critics. In his widely read study of `the anatomy of depression', embryologist and broadcaster Lewis Wolpert admits that `the Western vocabulary for depression, with its emphasis on hopelessness, anxiety, loss of self-esteem and guilt, has its history in essentially white, male institutions'.[32] It is unrealistic to assume such a `history' does not continue to inform contemporary approaches to depression, particularly if this androcentric background is not acknowledged.

In the discourse of depression, ostensibly gender-neutral terms in fact have highly gendered implications. `Dependence', `passivity' and `attachment' – key and recurring concepts in the language and symptomatology of depression – connote `feminine' characteristics, and are much more widely applied to women.[33] Associated qualities such as `apathy', `hopelessness' and `self-blame' – qualities which are also routinely feminized – correlate

[31] Jack, *Silencing the Self,* pp.220-221.
[32] Lewis Wolpert, *Malignant Sadness: The Anatomy of Depression* (London: Faber, 1999), p.31.
[33] See Jack, *Silencing the Self*, and Jan Horsfall, `Depression: Women in an Individualistic Society', paper presented at the `Women as Well, Gender and Health Conference' (University of Sydney) 1997.

significantly with the symptoms of clinical depression. When viewed in this light, the reported higher incidence of depression in women becomes less surprising (and theories which privilege biochemical readings detached from social context less persuasive).

Without attentiveness to the gendered implications of ostensibly `neutral' terms, it goes unrecognized that *gender has a constitutive role in shaping what depression is considered to be.* `Depression' is itself implicitly feminized, which sheds light on the consistent epidemiological finding that women are diagnosed with it at twice the rate of men.[34] But even the gendered nature of key terms and concepts in the discourse of depression - and their differential implications for the ways in which they are applied, or *not* applied, to women and men- does not capture how deeply gender permeates the way in which depression is constructed.

The implied `objectivity' and `universalism' of standard conceptions of depression has been shown by cultural anthropologists to conceal an ethnocentric (western) bias.[35] Far from being universally applicable, standard criteria for assessment and diagnosis of depression reflect the western contexts in which they were developed. The subjectivity presumed by standard psychiatric, medical and clinical psychological approaches reflects *a particular view* of the person which is not transposable to all contexts and cultures. But that presumed subjectivity is not only acculturated but *also gendered* in ways which limit its applicability even *within* western societies. The more far-reaching challenge gender poses to otherwise diverse `gender blind' approaches is to the nature of subjectivity *per se*.

Questioning the `norms' of mental health: from (masculinized) individualism to (feminized) relationality

> People come to me most often because they are unhappy with how cut off they feel, not because they are not separated or individuated enough. The traditional view of therapy as building up the ego simply does not do justice to what people's needs actually are.

[34] That men are also subject to depression in large numbers – and that gender plays a key role in how depression is expressed - is attested to by the much higher male rates for completed (as distinct from attempted) suicide in this country. Significantly, men choose methods (such as hanging and use of firearms) which are less likely to fail.
[35] Kleinman & Good, ed. *Culture and Depression*.

Mark Epstein, *Going to Pieces Without Falling Apart: A Buddhist Perspective on Wholeness* (London: HarperCollins, 1998), p.31.

As the quotation above indicates, gender analysis – and particularly the critique of feminist theorists – is not alone in stressing the need for more relational conceptions of subjectivity. In his synthesis of Buddhist concepts with those of psychotherapy, Epstein suggests some of the many vantage points from which revised readings of subjectivity might be addressed. In focusing on feminist critique I am not wanting to imply any theoretical monopoly for the revisioning which is arguably so urgent. My aim is rather to point to a conceptual prism which remains, for some of the reasons I have sketched, strikingly underutilized. In any case, and as noted previously, gender necessarily operates in interaction with other variables. Thus it can also enhance approaches which are likewise concerned with the limits of narrowly individualist perspectives, but which currently lack, and would themselves benefit from, gender-sensitivity.

How is inner life configured? Ideas about the nature of subjectivity cannot be assumed. Even, and especially, where they are not explicit, it is necessary to examine the conception of the self on which they are based. This is particularly necessary in the context of health, illness and well-being, where notions of what constitutes `mental health' serve as often implicit templates of what healthy psychic functioning is considered to be.

If the conception of the `person' on which standard mental health assessment is based is actually a *male* person, the implications are major. This would mean that the assumed `person' is not generic but *genderic,* in ways which privilege particular forms of masculine understanding and experience. Men (in this respect like women) are diverse. They differ according to ethnicity, class, sexual orientation, and a range of other variables. Clearly gender needs to be seen in conjunction with other factors. But this does not diminish its importance, since it is *a particular kind of masculinity* which has had disproportionate influence, and which remains coercive – albeit in more complicated ways – in the contemporary period.

The professions of psychiatry, medicine and until recently clinical psychology – elite domains of socially sanctioned expertise in the west for treatment of mental (as physical) health – have been particularly shaped by white, middle-class male norms. Professions, as all institutions, are subtly as well as more overtly influenced by the orientations, attitudes and values of those who make them up. To the degree that white middle-class men have predominated in the `elite' professions of medicine and psychiatry (professions, it needs to be underlined, which are themselves accorded

disproportionate influence in defining, assessing and treating `mental health' so-called) this influences the conduct as well as composition of such professions. It necessarily influences the ideas and assumptions which underlie them.

Dominant professional conceptions of what comprises healthy subjectivity and optimal psychic functioning continue to be inflected by ideas which subtly privilege a particular form of subjectivity. It is one which values individualism, autonomy, rationality, and productivity in the sense of public sphere activity. In short, *the raft of values and characteristics which are still symbolically gendered masculine.*

Historically, women as a group (i.e. notwithstanding their considerable diversity) have been and remain less able to access the `norms' of individualism, autonomy and detachment. This is due to a number of factors, a central one of which is the continued equation between femininity and care-giving. Yet as noted previously, the `norms' of autonomy and detachment are also highly and increasingly problematic for large numbers of *men*. There are senses in which the standards of `mental health' so called are themselves conducive to depression, in ways that attentiveness to gender can reveal.

A conception of subjectivity predicated upon individualism, autonomy, detachment, `rationality' and public sphere activity is untenable. As feminist writers have consistently emphasized, the conception of the `person' as unencumbered, autonomous and detached from social life and processes was never a viable one. The very notion of a separate, public-sphere actor presupposes a range of needs being met from the so-called `private' sphere, itself feminized as the realm traditionally allocated to women. As the basic facts of childhood and infant dependence testify to, human life is *relational,* and does not cease to be so. As Jack points out with reference to the parent-infant studies of Daniel Stern,[36] the earliest developmental task of human infants is to successfully *connect* and *attach* to care-givers, not to `individuate' from them. This goal continues into adult life, and as the quotation by Epstein illustrates, failure to achieve it becomes grounds for the seeking of therapy in western societies.

The conception of self which is adhered to, whether implicitly or explicitly, also has major implications for how research `findings' are interpreted. Clinical writing on depression has reported differences between women and men in depressive response to loss. While women become depressed over

[36] Jack, *Silencing the Self,* with reference to Daniel Stern, *The Interpersonal World of the Infant* (New York: Basic Books, 1985).

conflict in close relationships, men are more likely to become depressed over loss of an achievement-related goal or ideal, or over issues pertaining to performance.[37] As Jack notes, one longstanding clinical view has been that such sex differences suggest women's `greater dependence on relationships, their difficulty in achieving individuation and autonomy'. Yet as she also points out, whether or not a woman's depression in response to disruption or loss of close relationships is interpreted as `dependent' rests on the interpreter's understanding of the role relationships play in psychic life –

> …assumptions about the self and the function of attachments in adulthood are crucial to theories of depression. Such assumptions guide interpretation of the depressed person's words as well as the understanding of what constitutes health and healing.[38]

If the researcher or clinician subscribes to the `individualist' conception of self (or, irrespective of her or his views, the methodology, measuring scale or research tool is predicated on the individualist conception) `dependence' is going to be read very differently than it would be according to the relational view. If the conception of the self is predominantly *individualist,* signs of dependence will be seen as problematic. If, however, the conception of the self is *relational,* degrees of dependence, in men as well as women, will be read not only as inevitable but as healthy- `Attachments and reliance on them should not be seen as dependence, but as a healthy, normal human need, and, in fact, a source of valuable strength'.[39]

The need for gender-sensitivity at the level of *method* thus needs to be emphasized as well. Standardized methods for detection and `measurement' of depression[40] themselves resist recognition of the influence of gender and culture. The link between a methodological orientation which privileges positivism, empiricism and Cartesianism[41] and white middle-class masculinity has been elaborated by a number of writers.[42] To the extent that it has become normalized, such an orientation can indeed appear to be gender-neutral as well as `value-free'.

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[37] See Jack, *Silencing the Self,* pp.6-7 and accompanying footnote.
[38] Jack, *Silencing the Self,* p.7 (emphasis added)
[39] Jack, *Silencing the Self,* p.18.
[40] See Ann Bowling, *Measuring Health: A Review of Quality of Life Measurement Scales* (Buckingham: Open University Press, 1994), pp.93-119.
[41] And which so characterizes frameworks used in the study and diagnosis of depression; see Obeyesekere in Kleinman & Good, ed.*Culture and Depression,* p.139.
[42] See, for example, Dorothy Smith, *The Conceptual Practices of Power* (Toronto: University of Toronto Press, 1990) and Sandra Harding, ed. *Feminism and Methodology* (Bloomington: Indiana University Press, 1987).

Once again, these points have been made by a number of critics, and the inevitability of `situatedness' is now widely acknowledged. But the gendered history of the professions sanctioned to `specialize' in depression has compounded adherence to methodological approaches which are reductionist of qualitative data. Significantly, the realm of the qualitative is itself feminized, in contrast to the `hard' masculinized realm of the `objectively' measurable. Individual clinicians may freely concede the elusiveness of `universal' criteria for diagnosis of depression, the limits of `objectivity' and the inevitability of gender and social factors on mental and physical health. But such admissions are routinely undercut to the extent that they do not figure in prevalent assessment, diagnostic tools and treatment practices. Gender needs to be addressed at the level of *method* as well.

Yet the lens of gender may still seem problematic to the degree that increasing numbers of people aspire to – and also acquire – characteristics which were formerly the preserve of white middle-class masculinity alone. To the extent that increasing numbers of women in paid work now access the fruits (and from the perspective of emotional equilibrium, the decidedly mixed benefits) of material prosperity, doesn't this problematise the claim that dominant mental health `norms' remain masculinist? And since increasing numbers of men (including and especially white middle-class men) are aspiring to negotiate more relational styles of living, to what extent is the argument that mental health norms presume an `individualist' *male* actor still tenable? As Hamilton points out, `[I]n the marketing society, power and oppression are no longer predominantly with the domination of one group by another but are bound up with what people do to themselves'.[43]

But striking changes in the ways in which power is exercised (which Foucault has done so much to elaborate) do not, in my reading, seriously challenge the continued dominance of conceptions of subjectivity which presume a white middle-class male `norm'. Nor do they diminish the extent to which these remain coercive (including, as the high incidence of depression in western societies bears out, for many white middle-class men themselves). What has increasingly occurred is *proliferation* of this `norm', in ways which are psychologically debilitating for diverse people and groups.

The capacity of social and economic factors to structure subjectivity *per se* is precisely what `individualist' readings and frameworks deny. What we are now witnessing, I contend, is *widespread* internalization of the white middle-class male norm, and the psychological malaise (itself expressed in varied gendered forms) this generates. The norms of `mental health' remain

[43] Hamilton, *Growth Fetish*, p.107.

gendered (masculinized), classed (middle) and ethnicised (white), and autonomy, detachment and market-place `productivity' remain the assumed template of the accompanying characteristics.

No wonder so many women are depressed, and no wonder depression is not confined to women! The (gendered) template of `mental health' virtually guarantees that failure to live up to mainstream `norms' of psychic robustness will condemn large numbers of us to (varying) experiences of depression. In health literature and policy, even that attuned to social factors, there remains an implicit tension between `individual' and `social'.[44] But the lens of gender allows us to see `individual' subjectivity as *also* and *necessarily* social (ie *relational,* which is conventionally coded as `feminine). Focus on depression throws such reconfiguring into sharp relief:

> Depression is both individual and social; it combines
> The personal and the political. The relational
> Perspective asserts that the self is social. Mind and
> Self come into being through communication with others.
> One cannot heal the self in isolation. Since the individual
> Is in the deepest sense relational…it is the self-in-relation
> That begs for healing.[45]

Connecting the Strands

Location of still prevalent mental health `norms' within a liberal political culture *universalizes, individualizes* and *privatizes* the many social constituents of depression. A seeming corollary is that the specificities of gender, ethnicity and class are insignificant, when they are highly influential on `individual' subject formation. Reservations about the importance of gender fail to account for the continued potency of its symbolic workings, which at the level of emotion and feeling, manifest in depression as perceived failure to live up to gendered `norms'.[46] That subjectivity is not unitary, but rather comprised of various layers and registers, sheds light on the disconnections between `thinking' and `feeling' which are so characteristic of depression, and which are still so socially sanctioned.

While social models of health have long challenged narrowly biomedical readings, the axis of gender goes further in challenging the neutrality of mental health `norms' *per se*. As against the `ideals' of autonomy, independence and detachment (which while not always explicitly articulated,

[44] On this point see Penelope Hawe et al, *Indicators to Help with Capacity Building in Health Promotion* (North Sydney: NSW Health Department, 1999), p.15.
[45] Jack, *Silencing the Self,* p.205.
[46] Yapko, *Hand-Me-Down Blues,* p.131 and previous discussion.

underlie the implicit template of what healthy psychic functioning is considered to be) the lens of gender reveals how deeply such apparently `objective' standards are coloured by depreciation of `feminine' qualities (ie qualities which are femin*ized;* gendered feminine, as distinct from being the preserve of women alone). What emerges, then, is the need for a revised reading of subjectivity, which sees the need and capacity to *connect* as the major indice of psychic health and emotional well-being.

Such qualities as `passivity', `apathy', `dependence', `selflessness' and `self-blame' – qualities which are routinely feminized – correspond to the symptoms of clinical depression. And as Horsfall points out,[47] abstract notions of mental health are themselves profoundly gendered in presupposing the affective needs of `the well individual' to be met by another/others. To the extent that women have traditionally been less able to access `autonomy', individualist conceptions of mental health – which are still dominant in health policy and research[48] – are most obviously discriminatory of women. But they are also coercive for increasing numbers of men who aspire to relational, rather than narrowly `individualist' ways of living and being.

References

Abdool, Shelley et.al. `Towards Gender-Sensitive Health Indicators', *Centres of Excellence for Women's Health Research Bulletin* (2, 3, 2002), pp.7-9.

Beck, Aaron et.al. *Cognitive Therapy of Depression* (New York: Guilford Press, 1979).

Benhabib, Seyla *Situating the Self* (Cambridge: Polity, 1992).

Bowling, Ann *Measuring Health: A Review of Quality of Life Measurement Scales* (Buckingham: Open University Press, 1994).

Castillo, Richard *Culture and Mental Illness* (Pacific Grove, CA: Brooks Cole, 1997).

Cole, Phillip *Philosophies of Exclusion: Liberal Political Theory and Immigration* (Cambridge: Edinburgh University Press, 2000).

Cranny-Francis, Anne et.al. *Gender Studies: Terms and Debates* (New York: Palgrave, 2003).

[47] Horsfall, `Depression: Women in an Individualistic Society', p.2.
[48] Hawe, *Indicators to Help with Capacity-Building in Health Promotion*, p.7.

Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, fourth edition, text revision (Washington, DC: American Psychiatric Association, 2000).

Epstein, Mark *Going to Pieces Without Falling Apart: A Buddhist Perspective on Wholeness* (London: HarperCollins, 1998).

Grant, Kathleen `Gender-based Analysis: Beyond the Red Queen Syndrome', *Centres of Excellence for Women's Health Research Bulletin* (2, 3, 2002), pp.15-18.

Gray, John *Liberalism* (Buckingham: Open University Press, 1995).

Hage, Ghassan *White Nation: Fantasies of White Supremacy in a Multicultural Society* (Sydney: Pluto Press, 1998).

Hamilton, Clive *Growth Fetish* (Sydney: Allen & Unwin, 2003).

Harding, Sandra *Feminism and Methodology: Social Science Issues* (Bloomington, Indiana University Press, 1987).

Hawe, Penelope et.al. *Indicators to Help with Capacity Building in Health Promotion* (North Sydney, NSW Health Department, 1999).

Horsfall, Jan `Depression: Women in an Individualistic Society', paper presented at the `Women as Well, Gender and Health Conference' (University of Sydney, 1997).

Jack, Dana Crowley *Silencing the Self: Women and Depression* (New York: HarperCollins, 1993).

Kleinman, Arthur & Good, Bryon, ed. *Culture and Depression: Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder* (Berkeley: University of California Press, 1985).

Marsella, Anthony & White, Geoffrey, ed. *Cultural Conceptions of Mental Health and Therapy* (Dordrecht D. Reidel, 1984).

Mezzich, Juan & H. Fabrega, ed. *Culture and Psychiatric Diagnosis: A DSM-IV Perspective* (Washington, DC: American Psychiatric Press, 1996).

Phillips, Anne *Democracy and Difference* (Cambridge: Polity, 1993).

Plumwood, Val *Feminism and the Mastery of Nature* (London: Routledge, 1993).

Seligman, Martin et.al. *Learned Helplessness: A Theory for the Age of Personal Control* (New York: OUP, 1993).

Shanley, Mary Lyndon & Pateman, Carole *Feminist Interpretations and Political Theory* (Cambridge: Polity, 1991).

Szatkowski, J. `Causes of Gender Differences in Depression', *http://journalofscience/wlu.edu/winter1999/articles/psych/depressionhtm*, 1-9.

Smith, Dorothy *The Conceptual Practices of Power: A Feminist Sociology of Knowledge* (Toronto: University of Toronto Press, 1990).

Stern, Daniel *The Interpersonal World of the Infant* (New York: Basic Books, 1985).

Williams, Patricia *The Alchemy of Race and Rights* (Cambridge, Mass.: Harvard University Press, 1991).

Wolpert, Lewis *Malignant Sadness: The Anatomy of Depression* (London: Faber, 1999).

Yapko, Michael *Hand-Me-Down Blues: How to Stop Depression from Spreading in Families* (New York: St. Martin's Press, 1999).

Young, Iris Marion *Justice and the Politics of Difference* (Princeton: Princeton University Press, 1990).