# At the Limits of Materiality / At the Limits of Discourse: Feminist Struggles to Make Sense of Depression in Women

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**Abstract:**
Depression presents feminist theorists with a significant problem: it makes sense to many of us to point out the ways that depression, as a concept, is constituted discursively. In particular, depression seems indelibly tied to powerful biomedical discourses, and also, for women, to the equally powerful discourses that dictate what a "good woman" should be. Yet to highlight these discursive dimensions of the phenomenon seems to preclude both an acknowledgement of depression as a source of pain and an acceptance of any form of treatment for this condition other than dramatic social change. This article explores the limitations of strictly material and strictly discursive explanations for women's depression, and suggests that a feminist model existing in-between these two dualities is essential to a more comprehensive understanding of women's depression experiences. The narratives of women who experience depression provide a rich source of knowledge by which to deconstruct materialist and discursive approaches to women's depression. A narrative approach also allows us to escape the confines of scientific/positivist research, which has proven inadequate to fully encapsulate the phenomenon of depression in women. The article concludes with an evaluation of the material-discursive models for understanding women's depression recently posed by feminist psychologists Janet M. Stoppard and Jane Ussher.

> Is it tenable to discuss mental pathology as a socio-historical and linguistic construction and as a 'true' debilitating condition? (Fee, "Broken Dialogue" 2)

1 Depression is not a problem that is likely to disappear soon, as the numbers of people receiving such a diagnosis are on the rise almost everywhere. Its chilling effects are experienced by over 100 million people worldwide (Culbertson), and the Canadian Mental Health Association (2001) projects that by 2020, depressive illnesses will be the leading cause of disease burden in Canada and other developed countries. Women apparently experience this thing called depression at approximately twice the rate of men (Bebbington; Culbertson; Kramer; Nolen-Hoeksema; WHO), with recent research showing that the female to male sex ratio for depression is commonly 2 or 3 to 1 (Stoppard, *Understanding Depression*). Put another way, approximately 25% of North American women will experience depression at some point in their lifetimes (Schreiber). A variety of explanations for this statistic have been posed, including arguments based on women's unique biology, or suggestions that our greater likelihood to seek help when depressed causes us to be counted more frequently in statistics on depression (Culbertson; WHO). However, women's greater help-seeking behavior has proven inadequate to explain our over-representation among the depressed (Formanek and Gurian; McGrath, Keita, Strickland and Russo; Nolen-Hoeksema). Thus far, researchers

working from a scientific/positivist framework have been unable to adequately explain why so many more women than men experience depression. Not surprisingly, given the disproportionate numbers of women afflicted, depression has gained the attention of feminist scholars from across a wide range of disciplines. Working from different backgrounds, and often with divergent theories about material and/or discursive dimensions to depression, it is not surprising that feminist scholars have struggled to make sense of this phenomenon.

2 Depression presents feminist theorists with a significant problem: it makes sense to many of us to point out the ways that depression, as a concept, is constituted discursively. In particular, depression seems indelibly tied to powerful biomedical discourses, and also, for women, to the equally powerful discourses that dictate what a "good woman" should be. Yet to highlight these discursive dimensions of the phenomenon seems to preclude both an acknowledgement of depression as a source of pain and an acceptance of any form of treatment for this condition other than dramatic social change. Yet Prozac, only one among many antidepressants on the market, has been prescribed to more than 40 million people worldwide (Eli Lilly and Co.) and women make up about eighty percent of Prozac's users (Zita). Surely some of those 32 million women must identify as feminists, and many of them probably live with a deep inner conflict between their feminist ideology and their individual actions, a conflict that invokes silence and shame. Maria Caminero-Santangelo (1998) writes, for example, about hearing a woman at a Women's Studies conference speak about how her continued use of antidepressants was heavily criticized by many feminists whom the woman had previously considered allies, feminists who subscribed to a discursive understanding of depression which eschewed biomedical explanations or treatments. While the woman in question agreed with the critiques of her colleagues in theory, she also struggled with the fact that "when she was depressed, she could not work, write, or — often — even get out of bed" (10). *In practice*, then, her contributions to feminism would be virtually impossible *without* antidepressants. Gardiner (1995) discusses a similar experience of attending a feminist meeting that "assumed a consensus about social constructionism" (501) among participants, only to discover during meals and breaks that many of the women present were taking Prozac or other antidepressants. She notes that, ironically, "the potential contradiction between such private solutions and the publicly avowed ideology of social constructionism was never voiced" (501). Hence I would argue that the struggle between materialist and discursive explanations for depression is a particularly strained issue for feminism, and perhaps our only hope for a resolution is to locate our understanding of the

phenomenon "in-between" the two conflicting poles of this binary (as some leading feminist psychologists have started to do).

3 This article explores the limitations of strictly material and strictly discursive explanations for women's depression and suggests that a model existing in-between these two dualities is essential to a more comprehensive understanding of depression in women. The narratives of women who live with depression provide a rich source of evidence by which to raise questions about the limitations of materialist and discursive theories on women's depression. A narrative approach also allows us to escape the confines of the scientific/positivist research that has proven inadequate to fully encapsulate the phenomenon of depression in women, while at the same time ensuring that the lived experience of depression is not lost in the rhetoric of theories that posit it as merely a matter of discourse. The article concludes with an evaluation of the material-discursive models for understanding women's depression recently posed by feminist psychologists Janet M. Stoppard and Jane Ussher.

## A Narrative Challenge to the Scientific/Positivist Paradigm

> Findings of research conducted within mainstream paradigms have provided few helpful directions for women in understanding and explaining their depressive experiences. (Stoppard, "New Perspectives" 81)

4 The methodology of this research starts from a different place than the mainstream (scientific/positivist) approach used to conduct the bulk of recent research on women and depression. In this paper I combine some of the principals of feminist qualitative methodologies with the literary method of narrative analysis, resulting in a feminist narrative analysis that is used to explore the meaning(s) of depression in women's recent writing on depression and in the transcripts of four oral histories conducted with women who live with depression.[1] Gluck and Patai (1991) indicate that narrative analysis is an appropriate method for interpreting oral history transcripts: "Contemporary literary theory," they explain, "made us aware that the typical product of an interview is a text, not a reproduction of reality, and that models of textual analysis were therefore needed" (3). The texts created from the oral histories conducted for this research are therefore read not necessarily as fact but as testimony about the meaning(s) of depression in these women's lives and about the ways in which these

[1] These oral histories were conducted as part of the research for my Master's Thesis, which I successfully defended at Simon Fraser University in Burnaby, British Columbia, Canada, in 2002. For a more in-depth discussion of the methodology I employ in this article, please refer to that thesis, titled *A Melancholic Musing: Women's Narratives on Depression*. Information on accessing this document can be obtained at http://www.collectionscanada.ca/thesescanada/index-e.html

four women, alongside several recent women writing about depression, suggest that their understandings of depression are reflected (or not) by materialist and discursive theories on depression. It may seem contradictory to use "experience" as evidence in a paper that also has as one of its aims the furthering of discursive theories on depression. However, when lived experience becomes entirely unrepresentable in discussions of discourse, we no longer have a language to speak about the pain and impairment felt by people living with this thing we call depression. Also, when women speak about their "experiences" of depression they themselves often call attention to the ways in which they recognize this experience to be shaped by prevailing discourses. Hence experience, when viewed through this lens, need not be entirely antithetical to a discursive analysis.

5 Ussher documents the trend in the vast majority of research on women's mental illnesses to employ the "*realist/positivist* epistemology that has dominated science since the seventeenth century" ("Women's Madness" 209). Most researchers, whether operating from a biomedical or a psychosocial perspective, believe that knowledge is only possible through observation, and can therefore only be proven to be knowledge through the use of methodologies that promote standardization, replicability, and objectivity on the part of the researcher. Of course, feminist critiques of such methodologies, and in particular of the concept of objectivity, have been extensive (Code; Harding). This research looks to women's subjective experiences of depression not in the interests of uncovering the "truth" or locating a precise explanation for women's depression, but rather for the questions that these representations of experience raise about the limits of both material and discursive theories on depression.

6 Summerfield points out that the practice of oral history originally placed "an emphasis on truth rather than meaning, that is to say on discovering the hidden past through oral history and proving that this revelatory data was valid, rather than on exploring the complexities of its shifting meanings" (92). She goes on to suggest that the current practice of oral history is more concerned with the latter, which is also the approach guiding my exploration of women's first person narratives on depression in this research. Stoppard notes that a "persistent theme of [recent debates in clinical psychology] has been the need to broaden the conception of research 'methods' to encompass those that address meaning and subjective experience" ("New Perspectives" 81). Similarly, Lewis asserts that there has been "little consideration of what individuals themselves experience as depression or of the meaning of those experiences to them" (369). Inclusion of women's narratives on depression is presently lacking in mainstream research on depression, despite the fact that these and other authors

have advocated for the consideration of such narratives as a valid and important means of generating knowledge about depression; it is in part this lack of consideration of women's narratives, I believe, that upholds the binary between materialist and discursive understandings of depression.

7 Although the focus of the oral histories I discuss in this article is on each woman's thoughts about her depression and the concept itself, it seemed unlikely that I could adequately capture women's understandings of their depression or how they perceive their experience as reflected in either materialist or discursive explanations without exploring their life histories extensively. Jack argues that "the story a woman tells herself and retells others about the sources of her depression creates its coherence within the context of her life. Her narrative reveals her whole world [. . .]" ("Ways of Listening" 91). Clearly, then, the use of oral history seems to be the most appropriate method for exploring women's understanding of the sources and meanings of their depression experiences. Questions arising from the 'texts' of these four oral history narratives by women — whose pseudonyms are Percy, Danielle, April, and Maya — can be found throughout this article alongside questions raised by various fiction and autobiography on women's depression published over the last decade, in the interests of fully exploring the limitations of both materialist and discursive theories on depression in women.

## At The Limits of Materiality: Understanding the Discourses That Constitute "Depression"

> Individuals do not experience symptoms in a sociocultural vacuum. (Ussher, "Women's Madness" 212)

8 While critiques of biomedical theories of depression proliferate within the social sciences, depression in the popular imagination remains bogged down by the prevailing discourse of biology-as-destiny. As Jam, the depressed protagonist of Prozac Highway (1997), points out: "You'd have to be really out of touch not to know what the treatment for my condition was supposed to be" (Blackbridge 30), referring, of course, to antidepressant therapy. Over the past few decades, depression has increasingly come to be recognized as more of a medical affliction than a spiritual, social, or even psychological one. This understanding of depression corresponds to the mainstreaming of a belief in the biological origins of many conditions formerly thought to have origins that were at least partially social (Karp; Kramer). There is nothing wrong *per se* with the idea that biology might play a part in women's experiences of depression (and the efficacy of treatment). But when biomedical

theories function as a discourse — and an extremely powerful discourse at that, one which presently marginalizes all other possible explanations for or understandings of depression — the concept becomes highly problematic, primarily for the ways it precludes possibilities of understanding depression differently.

9 The early anti-psychiatric writings of Thomas Szasz (1967) were some of the first to question the validity of the very concept of mental illness, arguing instead that mental illnesses are merely metaphorical expressions of human suffering. While the sixties and seventies saw a proliferation of theories that critiqued the power of psychiatrists to define mental illnesses (and thereby the boundaries of "normality") along with the rise in biomedical explanations for them, the eighties and early nineties ironically saw the further entrenchment of biomedical explanations for and treatment of these conditions. This entrenchment likely owes its existence at least in part to the cultural backlash against social movements of all kinds that occurred during this time period, but another explanation for the biomedical take-over is surely found in the increasing research on and development of medications such as antidepressants, and the extent to which such medications came to be seen as the primary form of treatment for mental illness.

10 The resurgence in critiques of biomedical theories of mental illness of the last decade has focused more closely on the power associated with biomedical discourses than on the power associated with individual psychiatrists or the psychiatric profession (although of course noting that psychiatry is heavily implicated in the shaping of biomedical discourses). Some feminist researchers have in particular been interested in how biomedical discourses construct the role of the female body in relation to mental health, and the ways in which these discourses often unquestioningly adopt misogynist values and beliefs (Caplan; Ussher, *Misogyny*). However, unlike earlier critics of biomedical models, amongst whom the "most popular attitude towards the mental illnesses was to deny their very existence" (Sedgwick 4), more recent researchers are not so much opposed to seeing a connection between biology and mental illness as they are concerned with the premise that biology is the primary or only possible cause. As Stoppard argues, "evidence that biochemical processes may be associated with experiences defined as depressive symptoms is not the same as concluding that depression is caused by biochemistry" (*Understanding Depression* 13).

11 Women themselves express a great deal of skepticism about the relationship between their material bodies and their depression, and their narratives tend to suggest that their depression is largely shaped both by symbolic notions of idealized femininity and by their experiences of oppression. When asked about her first experience with depression, for

example, Danielle — one of the women I interviewed for my MA thesis — begins by talking about the impact of a three-year period over which she was sexually abused as a child, clearly indicating her belief in a connection between this traumatic event and her depression. However, she is not immune to the power of biomedical discourses, and while her initial instinct is to suggest that the abuse is a source of her depression, she also ponders the role that her innate biology might play when she states: "I . . . don't know if that [the sexual abuse] is what started it, or if I already had it and that incident really brought it out." Later, she explores this uncertainty further:

> Maybe later on in life, if I didn't have that incident happen to me, then maybe later in life it [depression] would've come out. Or maybe it wouldn't, or if it did it wouldn't stay, it wouldn't be so strong.

Dormen echoes Danielle almost identically when pondering the impact of her experience of incest on her depression:

> Did depression find me because of my stepfather's touch? Did depression rush to fill the shocked space left when he withdrew his touch? Or was depression a consequence of my essential chemical constitution? Or did events themselves create the chemistry? I don't know. (239)

Both of these women hesitate to locate their abuse as the primary or only cause of their depression, but nonetheless they are resisting the idea that their depression is merely biochemical. They each have a clear sense that their experiences of violence are unquestionably implicated in the onset of their depression, pointing to the limitations of strictly biomedical theories.

12 Many other women also suggest in their narratives that their depression was primarily caused by experiences of discrimination and oppression rather than by their biology. While discrimination and oppression often impact women's lives in material ways, they also owe their ongoing existence to powerful discourses that underpin male dominance and social expectations for what a "good woman" should be. When asked to talk about her first experiences with depression, Percy refers to her growing awareness of an inconsistency between how she saw herself and how discourses of normality and appropriate femininity dictated she should be. She explains:

> I seem to remember when I was in high school, times when I felt kind of alone and definitely out of place because by then I was fairly sure that I was gay, and in the context of small-town southern Alberta there was really no outlet to talk about that and it bothered me a lot because I thought that I might be crazy because of that.

A material explanation for Percy's depression might include her experience of discrimination or oppression as a lesbian, but would be inadequate to address the impact that the discursively

constituted and sustained belief that to be lesbian is to fail at being a "good woman" might have on her feelings of depression.

13 Some women indicate in their narratives that they are well aware of the powerful nature of biomedical discourses on depression and the impact that these discourses have on how they understand and interpret their own experiences. For example, Jam in Blackbridge's *Prozac Highway* exposes the power of the biomedical discourse on *depression* when she states that she uses the term depression as "a description of how I feel, subliminally shaped by drug ads and my new shrink" (153). In this statement Jam admits that she is susceptible to the picture of depression painted by "drug ads" and her "new shrink," and that these forces have the power to shape the meaning she ascribes to the word *depression*. Yet her *awareness* of the power of these forces to "subliminally" shape her understanding also indicates that she is resisting or undermining them, because discourse depends on an acceptance of itself as a taken-for-granted reality in order to fully uphold its power.

14 Similarly, in her memoir *Prozac Diary* (1998), Lauren Slater indicates her awareness of the power of biomedical discourse when she states: "it could have been [. . .] something she [sic] was born with, a simple physiological fact pressed into her genes. She knows that's the fashionable explanation these days, and it's way too simple, of that she's sure [. . .]" (141). Her awareness of the pervasiveness of biomedical explanations — that they are presently the "fashionable" explanation for her depression — shows that she is obviously not accepting this discourse uncritically. Yet she goes on to talk about how, in looking at her family history of mental illness, it does seem possible that biology plays some role. Because she makes it clear that she is both aware of and resistant to the power of the discourse to define her experience, she is able to discuss biology as one possible factor of her depression without positioning it as the main or only cause, which suggests that there are limitations to the ability of either strictly material or strictly discursive explanations to capture the meaning of depression for Slater.

15 A wholehearted acceptance of biomedical explanations for depression might actually contribute to making women's depression worse rather than better, indicating again that a strict emphasis on the material is inadequate to encapsulate the complexity of women's understanding of their depression and their interpretations of its meaning. Meri Nana-Ama Danquah's memoir *Willow Weep for Me* (1998) points to the dangers of such a wholehearted acceptance; after learning that her sister has also been diagnosed with clinical depression, Danquah believes she can no longer avoid facing the fact that "[her] own depression was most likely biochemical. That conclusion," she continues, "did me in" (214). Danquah is distressed

by this new awareness because in her mind, if her depression is an innate part of her biology rather than a result of her experiences of racism, sexism, and poverty, as she believed until this moment, it is therefore inescapable. This realization sends her into a downward spiral of deepening depression and alcohol binges. It does not occur to her at this time that biochemistry might be merely *one* (not *the*) cause of her depression, likely because of the overwhelming power of biomedical discourses to assert themselves as the primary or only explanation for this condition. Danquah later admits that at the time of her sister's confession she had no way of understanding that it is "not as if nature were not heavily influenced by nurture and vice versa" (214), and that this realization was necessary for her to be able to function again on a day-to-day basis.

16 In her memoir *Prozac Nation* (1995), Elizabeth Wurtzel also implies that her resistance to a complete faith in biomedical discourses was a source of her ability to understand and make meaning from her depression:

> I have gone from a thorough certainty that [my depression's] origins are in bad biology to a more flexible belief that after an accumulation of life events made my head such an ugly thing to be stuck in, my brain's chemicals started to agree. (306)

Here, Wurtzel introduces the notion that biology might be influenced more by environment and experience than the other way around — a theory that holds potential to severely undermine the dominance of strictly biomedical explanations for depression, for if biology is shaped by experience then surely we must take into account the ways in which depression is constituted socially, in the interests of showing and accounting for the ways in which experience itself is largely constructed through prevailing and powerful discourses.

17 A resistance to biomedical discourses is an important aspect of women's depression narratives, and through their descriptions of their hesitation about or outright resistance to accepting these models wholeheartedly, women are in turn re-constituting these discourses, with a difference. The growing amount of published first-person narratives on depression also functions to constitute new or different discourses on depression, while at the same time the experiences of those writing the texts are of course also being *shaped* by the prevailing discourses on depression. For example, Fee ("Pathology") argues that Wurtzel's memoir *Prozac Nation*, likely in part because of its status as a bestseller and now a major motion picture, "is now itself *constitutive*" of the meaning of depression (87, emphasis in original). Because of the skepticism of Wurtzel and other women writers about the sole power of biomedical discourses to encapsulate their depression experiences, the very fact that these narratives have become constitutive of the discourses on depression themselves is also in effect contributing to a *reconstitution* of biomedical discourses. This reconstitution is

significant in that it stands to undermine the ultimate defining power of biomedical discourses without throwing out entirely the notion that biology likely does play some role in depression — in a sense, women's resistance to these discourses without rejecting them entirely will allow us to avoid throwing "the baby out with the bathwater," as Jane Ussher argues ("*Biological Politics* Revisited" 426). When women are aware of the pervasiveness of biomedical explanations for depression and yet resistant to them, insisting on pointing to the ways in which their depression is also a social experience, then they contribute to reconstituting biomedical explanations as only one — rather than the — possible factor contributing to their experience of this thing we've coined depression. In doing so, they effectively undermine the power of biomedical discourse without discounting that which is useful within it, which in turn leads us towards a theory of depression that can exist "in-between" material and discursive approaches.

18 A failure to address the ways in which women's depression is constituted through the very pervasive discourses that both create and reinforce socio-cultural standards for femininity or "good womanhood" is perhaps the most significant limitation to materialist discourses on women's depression. While strictly material explanations for women's depression may include some discussion of the impact of a woman's social status on her susceptibility to depression, they fail to address how these powerful discourses on femininity tremendously shape women's lives and must therefore be intimately tied to depression. There is evidence from many of the narratives used in this research to indicate that there is a definite link between the pervasive power of "good woman" discourses and women's feelings of depression, which points to the limitations of a strictly material theory of women's depression. As Maya — another interviewee — explains:

> there's definitely messages about what good girls are or what good women are and there's no way to ever achieve those things or feel satisfied if you've got some aspect of them, because then you're just doing something wrong in another area.

Women strongly connect the impossibility of living up to socially constructed standards for "good women" to their feelings of depression. This connection has also been noted in a number of feminist studies (Bart; Jack, *Silencing*; Scattalon and Stoppard; Schreiber; Stoppard, *Understanding Depression*; Lafrance and Stoppard; McMullen and Stoppard). However, Stoppard suggests that the impact of societal standards for "good women" on women's depression remains "unaddressed" by mainstream research, which frequently tests for "'sex-differences'" in depression but "neglects symbolic aspects of gender" ("New Perspectives" 86). Hence an exploration of the places where experiences of depression and

awareness of these discourses overlap in women's narratives is central to uncovering the limits of materiality as related to women's depression.

19 Blackbridge explores standards for "good women" and the cost of failing to live up to them in *Prozac Highway*. She describes the dilemma thus:

> Jam hadn't been raised to go to college. She'd been raised to marry young and be a housewife, which was sort of what she was doing [. . .]. Unfortunately, she was messing up on the wife part. She kept breaking up with her boyfriends and having miserable one-night stands with women. She knew enough to keep her mouth shut about the women [. . .]. (109)

At the point at which she's making this confession, Jam is in therapy and her depression is so bad it is causing her to cut her arms as a means of relieving the pressure of what she is feeling, which is: "*hate myself, hate myself*" (110). Jam's feelings of self-hatred are clearly connected at this point in the text with her inability to do what she has been raised to do — synonymous with what "good women" are expected to do. Later, she also discusses how her inability to live up to standards of "good radical-lesbian rebel art grrrl womanhood" also contribute to her self-doubt: "She hadn't forgotten she was over forty when she put on that outfit [. . .]. You couldn't be a rebel art grrrl at forty. You were supposed to have a teaching job, or a show in a museum, or disappear" (189). Jam has eventually overcome her anxiety around failing to measure up to mainstream standards of good womanhood by getting involved in a feminist counterculture in which she is able to cultivate acceptance from herself and others. But in the above scene she finds herself faced yet again with the inescapable nature of these "good woman" standards, even within countercultural or feminist communities. Hence even those who embrace feminism are not impervious to discourses that constitute appropriate femininity — the expectations are different in feminist circles, but the discourse of course pervades even the boundaries of feminist and other countercultural communities. Indeed, one could argue that there is a powerful discourse shaping what a "good feminist" should be, and that our failure to interrogate this discourse may also contribute to women's feelings of depression and their ability to admit and respond to those feelings.

20 Recently, new research by Michelle N. Lafrance and Janet M. Stoppard (2006) has identified a connection between individual women's abilities to distance themselves from "good woman" standards and recovery from depression. This is a fascinating finding and key to feminist understandings of depression in women. It also supports arguments that the discursive dimensions of depression must be taken seriously even when it comes to "treating" the condition. Lafrance and Stoppard also found, however, that recovering from depression by distancing themselves from "good woman" standards (e.g. "letting go of caring, cooking, and

cleaning, saying no to others' demands, and taking care of oneself" [318]) caused women "to be faced with a discursive double bind where caring for oneself was central to their well-being but threatening to their identities as women" (320). This finding suggests to me that individual efforts to shirk the power of discourses on appropriate femininity may be insufficient for recovery from depression in the long-term: the discourse itself may require radical shifts and changes in order to have an ongoing positive effect on depression in women. Lafrance and Stoppard similarly conclude that we may need further "research and social action aimed at investigating identity options that may be more useful to women" (321).

21 Discursive constructions of appropriate femininity also show variation by cultural or racial background. Danquah talks about the impact of symbolic standards for "good black women" on her experience of depression in her memoir. She recalls that she has always been made aware that the most important characteristic of a "good black woman" is her strength: "Black women are *supposed* to be strong — caretakers, nurturers, healers of other people — any of the twelve dozen variations of Mammy" (19; emphasis in the original). These standards of "good black womanhood" are maintained in a variety of ways, from the proliferation of 'Mammy' imagery to the insistence of many black women themselves on strength as a birthright. Danquah describes the responses of other black women when she discusses her depression: one common reaction is "'What do you have to be depressed about? If our people could make it through slavery, we can make it through anything'" (21). White people also play a part in upholding the image of the strong black woman; at a dinner party, Danquah was once told by a white woman that "when *black* women start going on Prozac, you know the whole world is falling apart" (20). All of these remarks pressure Danquah to conform to this construction of black womanhood, and her feelings of inadequacy feed her depression. It is not the material reality of racism, but rather the discourses that underpin it that contribute in this instance to Danquah's depression, again underscoring the limitations of strictly material models for understanding women's depression.

22 Similarly, April — another interviewee — discusses the different standards that define "good aboriginal womanhood":

> There's some really fucked up messages out there about how to be a woman, you know, for aboriginal women [. . .] they tend to put a lot of onus on women being responsible for the ills of a nation. And that's really fucked up, you know, it's like it doesn't matter that the men have been drinking and beating the crap out of their wives and doing whatever, it's apparently our fault. If we would be just a little happier, a little more loving, if we stayed home and cleaned our houses and did this and did that, then things wouldn't be so awful.

So the responsibility for the desolation of aboriginal communities, the result of years of racist oppression, gets placed through this discourse onto the shoulders of aboriginal women, as though the power to change the circumstances of aboriginal people lies solely in their hands. April also notes that a common critique of aboriginal women is that they are not "traditional" enough:

> Being an aboriginal woman, you can be creative, but it has to be at basket-weaving, you know, it has to be at doing dream catchers, or beading [. . .] you can be creative in that way, but don't think you're going anywhere else! There's not a lot of permission [to do things differently] in the aboriginal community [. . .] I mean, it's there, but few and far between, you know? And [. . .] it has to reflect positively on us as aboriginal people [. . .]. What's really really sad is [. . .] living in the community we're living in [a small native community in northern Canada], well God forbid if you're an educated aboriginal! And how dare you be an educated aboriginal woman! [. . .] Because now you're white, you're not Indian!

April's awareness of these very specific ideas about what constitutes "good aboriginal womanhood" and her inability or unwillingness to measure up to them has been a source of anxiety and depression at various points in her life. These discourses are shaped by aboriginal communities themselves as well as by the outside (white) world. Clearly, a failure to consider the impact of these discourses on April's feelings of depression would not encapsulate her depression in all of its complexity, and points again to the limitations of strictly material models which might suggest that April's depression stems in part from racism but would fail to see how these powerful discourses that exist within her own community are also implicated in constructing her experience.

23 Both biomedical and "good woman" discourses clearly interact in dialectical relationships with depression in women. These discourses are inescapable for women, even those women who have the knowledge and time to deconstruct the impact that they might have on their lives, or those who embrace feminist or countercultural communities that do not subscribe as readily to mainstream ideas about what a "good woman" should be. While the standards of good womanhood vary across time, culture, and community, it is clear that they continue to significantly impact women's feelings of depression. The role of biomedical and "good woman" discourses in shaping the meanings women attribute to their depression indicates that a strictly material explanation for women's depression does not adequately capture the phenomenon, and is therefore inadequate as a theory on which to solely base understanding or treatment of the condition.

**At The Limits of Discourse: Being Responsive to The Real And Present Pain of Depressed Women**

> We cannot dismiss mental health problems as linguistic constructions or mere justifications for regulatory control. We need to offer something more concrete than critique for women who come forward for help. (Ussher, "Women's Madness" 208)

24 Some critics of either biomedical or material theories of mental illness might be inclined to dismiss any theory which considers biology or materiality as factors, even when such factors are indicated by those who suffer from the symptoms of depression or other mental illnesses. Such critics argue that those who experience depression are as susceptible to the power of biomedical discourses or materialist rhetoric as any unstudied or non-critical thinker unpracticed in the art of discourse analysis would be. However, it is important to give credence to women's own thinking about their depression experiences and recognize that their ambivalence about the role of biology or materiality may have to do with more than the competing discourses that they are subject to. While discourse analysis is an important tool for feminists, it can sometimes result in attempts to "dismiss mental health problems as linguistic constructions or mere justifications for social control" (Ussher, "Women's Madness" 208). As Ussher has more recently (2004) reminded us, even early feminist critics of biomedical models did not intend to imply that we should "completely reject" biology's role ("*Biological Politics* Revisited" 426), and she asks: "[a]s we escape into debates about discourse, do we not forget the materiality of women's lives?" (428). Similarly, Fee points out that "the realistic and observable suffering of persons has not been part of the narratives of critics and theorists emphasizing social and linguistic dimensions of mental disorder" ("Broken Dialogue" 13). While both of these authors ultimately believe that discourse plays a tremendous role in how depression and/or mental illness is experienced and understood, they recognize that to insist that mental illnesses are *only* discursive greatly limits our ability to acknowledge and be responsive to the undeniable presence of suffering in the lives of those who experience such phenomena firsthand.

25 Feminist research has long argued that women's over-representation among those labeled mentally ill is due in large part to the tendency of the psychiatric profession to pathologize those women who for a variety of reasons fail (or choose not) to live up to socially constructed standards of good womanhood (Caplan; Chesler; Ehrenreich and English; Gilman; Showalter; Ussher, "Misogyny"). Gardiner points out that "feminists have considered women's depression a result of women's circumstances under patriarchy" (502) since the second wave of feminism. Chesler's seminal work on women and mental illness (originally published in 1972) argues that women's overabundance in mental institutions and psychiatric

treatment throughout history is in fact one of the main means by which women are oppressed. Her research paved the way for the development of the predominant feminist theory on women's depression: that depression in women is an understandable response to living in an unjust, misogynist, patriarchal world; that it therefore has no basis in biology but is purely socially constructed, and is irremediable except through undermining both the material conditions and discourses of appropriate femininity that uphold such inequalities.

26 Yet obviously, a complete refusal to acknowledge any possible biological or other material connection to depression — an insistence on the correctness of discursive explanations — functions in a way that is potentially as totalizing and oppressive as the very biomedical models that feminists and others have worked so hard to destabilize. When we as feminists refuse to recognize or acknowledge the impairment and pain that results from depression, whether or not the concept itself is largely discursive, we offer little to the predominantly female population that suffers from it. Further, we create a dramatic conflict within feminism where those feminists who experience suffering as a result of depression are left without a language to discuss the resulting impact on their lives and on their very participation in feminism. As indicated by the stories recounted by Caminero-Santangelo and Gardiner earlier in this paper, if we deny the material dimensions of depression entirely, we create an environment in which depression is collectively talked about as discursively constituted, while on a personal level we turn to antidepressants and other medical solutions as private, and often shame-filled, attempts to ease the pain and suffering of an experience that has become unspeakable; an environment where women's very real pain remains cloaked in confusion and conflict.

27 A serious limitation of a discursive perspective that remains entirely unwilling to address material aspects of depression lies in the reality that if we scorn all forms of individual treatment for the condition, we sacrifice a comprehensive knowledge about these treatments or about the ways that they might effect women differently than men. Rachel Perkins, a lesbian feminist and clinical psychologist, discusses this risk in her article "Choosing ECT," which explores her difficult decision to choose electroconvulsive therapy to treat her own depression. Perkins tells us that many women asked her how she, "a radical lesbian feminist and a psychologist [. . .] [could] choose to submit [herself] to such torture" (623), a question that she seemed to find unhelpful at best and highly judgmental at worst. She also echoes the feminist described earlier by Caminero-Santangelo when she explains that depression kept her from "working (or doing anything very much) for about six months" (624); that her pain was debilitating to the point where, when faced with a reoccurrence, she

wondered whether she could deal with it at all. For Perkins, ECT provided a possible solution to this pain and debilitation, and in her article she describes the highly unhelpful responses of friends and colleagues whose discouragement of the practice was often ill-informed. As she explains: "the classic feminist line of regarding ECT as a single, awful entity is inadequate" (625). This "line" prevented Perkins from knowing several things that she should have known before choosing ECT: details about sex-difference in the treatment, which she outlines in the remainder of the article, presumably in the interests of preventing other feminists faced with a similar decision from being forced to choose ECT in the face of feminist-constructionist discourse that would insist that such a solution to depression is unthinkable, inadequate, or just plain "torture," with little thought to the torture that transpires through this entity known as depression.

28 What is required, clearly, is a way through the materialist/discursive binary to an understanding of depression that can balance a responsiveness to individual women's suffering from depression without losing sight of the fact that both the very concept of depression and women's experience of it are also constituted discursively. Gardiner seems to lament the loss of a time when "the necessary cure for depressed women was neither drugs nor psychotherapy but social change" (511), yet she nonetheless suggests that as feminists we need to remain "wary of [. . .] the automatic dismissal of biochemical medications" (515). Thanks to poststructuralist critiques of concepts such as "natural," "essential," and "authentic," an acceptance of the use of Prozac and other medications to treat women's suffering as a result of depression need not necessarily be antithetical to feminist discursive theories on depression. As Zita insists, a "drug-free female body is only one of many physicalities of the body that could be called 'natural'" (76).

29 The trick for feminists wishing to accept Prozac or other medications as one possible response to the material suffering stemming from depression without compromising their discursive views lies in recognizing the ways in which the drug can be useful in combating symptoms of depression while at the same time resisting the ways in which the drug is used to reinscribe biomedical discourses that locate depression solely within the individual sufferer. We each have the potential to become, "if need be, a Prozac-tipped but not Prozac-promised feminist" who exists both "with and against" the drug and all that it signifies (Zita 78). Indeed, Slater goes so far as to suggest that the common side-effect of decreased sexual desire while on Prozac could be read as a decidedly *feminist* characteristic of the drug; she positions Prozac as a new tool of radical feminism by envisioning millions of women "who have become indifferent to the mating game, who care less about their bodies in general, who have

aged prematurely and celebrate their spinsterhood" (162-63), and as a result of this triumph she imagines "Gloria Steinem becoming the spokesperson for Eli Lilly" (163). While she ultimately decides there are too many flaws in this idea to provide her with much comfort, Slater's desire to help feminists become more accepting of Prozac is likely motivated not only by her personal desire to reconcile her use of the drug with her own feminism, but also by her awareness that to remain responsive and relevant to women with depression, feminists must find a way to make peace with Prozac. Zita argues that so long as we remain committed to a "more radically and collectively spirited feminism" (76) that locates the sources of depression outside of the individual, there is no reason to fear that responding to women's material experience of depression automatically undermines our attempts to recognize the ways in which the notion of depression is also constituted discursively.

30 Recent feminist writings on depression and mental illness call for a material-discursive (Stoppard, *Understanding Depression*) or material-discursive-intrapsychic (Ussher, "Women's Madness," "*Biological Politics* Revisited") framework for understanding women's depression. Such frameworks attempt to oppose strictly material understandings of depression by addressing how a woman's depression experience (and indeed *all* experience) is shaped by the discourses that constitute it. Yet at the same time, these approaches also encompass a material understanding of women's depression — they look at the symptoms women experience and the impacts of depression on women's psychological and physical well-being, and give these factors as much weight as the discursive analysis; in short, they offer both a framework for understanding and a response to women's depression that exists in-between the stark dualities of strictly materialist or strictly discursive theories.

## Searching for an "In-Between:" Reframing Women's Depression With Material-Discursive Models

> In-between. There's a phrase that is far too underappreciated. What a great day it was, what a moment of pure triumph, to have discovered that there are in-betweens. (Wurtzel 330)

31 In an attempt to incorporate discursive theories of depression with a desire to be responsive to the materiality of depression, feminist psychologists such as Stoppard and Ussher have developed models for understanding women's depression that attempt to incorporate both the material and discursive aspects of depression in women without privileging one over the other. In their approaches, they argue that biological, psychological, social, and discursive understandings of women's depression can co-exist on equal terms. Ultimately, the goal of applying a material-discursive framework for understanding

depression in women is to reframe women's depression as "the outcome of a process involving reciprocal interactions between a woman's physical embodiment and her discursively constructed experiences" (Stoppard, *Understanding Depression* 108-9).

32 Ussher has expanded on the material-discursive framework to include intrapsychic factors, as she believes such factors as the psychological effects of women's efforts to conform to "good woman" standards are not given adequate weight in material-discursive frameworks. In her article outlining a material-discursive-intrapsychic model for women's mental illness, she suggests that the material component involves looking at the "factors that exist at a corporeal, societal, or institutional level" ("Women's Madness" 219) such as a woman's physical (bodily) symptoms of depression, the presence or absence of a social support network, and the barriers she may face to gaining economic independence. The discursive component involves consideration of the impact of "social and linguistic domains" (219) on a woman's experience, such as how discourses creating constraints for "good" womanhood impact her feelings of depression, or the way a woman interprets the phenomenon. And finally, the intra-psychic component involves consideration of the factors which operate at the "level of the individual and psychological" (220), such as exploration of the reasons why a woman might blame herself for staying in an abusive relationship, or the impact that psychological methods of coping with abuse, such as splitting or dissociation, might have on a woman's wellbeing. Broken down in this way, it becomes apparent that this model allows for a very thorough interpretation of women's depression.

33 Another advantage of material-discursive approaches lies in the potential for such approaches to remove the pathologizing elements of women's depression by acknowledging, particularly through the incorporation of the discursive analysis, that depression need not necessarily be seen as a strictly material experience in order for women's depressive symptoms to be taken seriously. Material-discursive models also open the door for a variety of different treatments for depression to be taken into consideration, and to be seen as equally reasonable or valid forms of treatment — from a decision not to do anything in particular to combat depression up to feminist activism for social change. Under these models, neither medical, psychological, discourse analytic, nor social resolutions are given status as "more" or "the most" effective in combating depression, and in fact none of these types of resolutions is seen as being adequate in and of itself. A combined approach to resolving depression becomes a necessity when one understands depression through a material-discursive or material-discursive-intrapsychic framework. For example, in the case study provided by Ussher ("Women's Madness"), possible interventions into "Clare's" depression include

discourse analytic resolutions that explore the ways in which discursive constraints dictating "good" womanhood impact Clare's feelings of depression and her tendency to blame herself for staying in an abusive relationship; intrapsychic resolutions, such as therapy to deal with these self-blaming tendencies; and material resolutions such as outside interventions to deal with her husband's violence and safety-planning to try to ensure that Clare has alternative housing should she decide to leave her husband.

34 A material-discursive approach also creates space for a woman's bodily experiences of depression to be incorporated into both our understanding of her depression and the types of treatments sought or offered. As discussed earlier, when we argue that women's depression is merely discursive, women's bodily (and emotional) experiences or expressions of depression can be dismissed or marginalized. By contrast, material-discursive approaches address women's bodies as simultaneously material *and* discursively constituted entities. Such a position on embodiment allows us to acknowledge and seek resolutions for women's physical and emotional symptoms of depression without requiring us to believe that depression is *only* a biological (and not at all a discursively constituted) experience. Stoppard offers an explanation for how the discursive aspects of embodied experience intertwine with material or lived experience when she writes: "under certain circumstances engaging in practices of femininity can exhaust a woman's body, while undermining her morale and sense of well-being" (*Understanding Depression* 92).

35 Unfortunately, material-discursive or material-discursive-intrapsychic models appear to be having little impact on mainstream understandings of and treatment for depression in women, at least in Canada. A recent study by Linda M. McMullen and Janet M. Stoppard concluded that "feminism is having, at best, only a negligible impact on clinical psychology in Canada" (282). The authors note that fact-sheets on depression published by the Canadian Psychological Association include no discussion of the impact of "good woman" discourses on depression in women (even in a fact sheet on post-partum depression), fail to mention "the consequences of gender discrimination or violence" (282) and offer "[n]o routes to alleviating depression other than through individual behaviour change" (282). Feminist psychologists have been at the forefront of developing and championing these more comprehensive models for understanding and treating depression in women. Yet they are up against a missing paradigm shift in how psychology (or biomedicine for that matter) is practiced: until such disciplines embrace discursive theories and move beyond strictly individualized understandings of "illness" and "treatment," the impact of feminist theorizing will likely continue to be alarmingly minimal.

36 Material-discursive approaches attempt to blend or encompass both the material and the discursive aspects of women's lives in a way that allows for a variety of possible individual, discourse analytic, and social approaches to resolving women's depression. Such models also acknowledge the reality that conventional treatments for depression do work for some women, and that "women can recover from depression without the kind of broad-ranging social changes in material conditions which some feminist analyses would suggest are required" (Stoppard, *Understanding Depression* 203). In so doing, advocates of material-discursive approaches also suggest that when women are given information on and access to a greater range of choices for understanding and responding to their depression, they will have a better chance of finding a resolution that works for them. Material-discursive frameworks provide new and exciting ways of understanding and resolving women's depression that exist "in-between" the stark duality of material and discursive explanations. But until such models are incorporated into mainstream or conventional approaches to understanding and responding to depression, and until medical plans and insurance companies no longer endorse or cover the expenses of strictly biomedical approaches to treatment while dismissing others — in short, until these institutions take seriously and incorporate the wealth of feminist research on depression in women, it seems unlikely that most women will be able to experience these potential benefits.

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