Thinking through gendered embodiment in women’s recovery from depression

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Overview

• Understanding the biopolitical context of individual distress – gender norms and inequities shape depression and recovery processes

• Medicalisation conundrum: GPs overloaded, rise of exercise exercise as medicine

• Active embodiment involves different relations of self-management/care: Instrumental logics and transformative practices

• Rethinking recovery through gendered embodiment - supporting individual and collective mental health
Gender as a variable, little analysis of gender relations & identities

‘Unipolar depression, predicted to be the second leading cause of global disability burden by 2020, is twice as common in women…(and) more persistent in women than men’ (WHO, 2014)

http://www.who.int/mental_health/prevention/genderwomen/en/

Gendered ‘mental health and behavioural conditions’ (ABS, 2012)
Depression and recovery as social phenomenon

Depression has become a medicalised social problem and treatment/recovery tends to be pharmacological/expert driven.

Yet, depression is inextricably linked to gendered contexts - material inequality, norms about feminine identity, emotions personhood, childhood abuse & ‘expert’ diagnoses of distress/illness that are socio-cultural, political & economic.

What does this mean for thinking about depression and recovery as gendered practices? Complexity of everyday lives, interventions, policy, mental health promotion?
Biopolitics of depression & recovery (Rose, 2007; Rose & Abi-Rached, 2013)

- **Neuroscience** has risen to dominate knowledge about mental illness (chemical imbalance in the brain)
  - Despite lack of evidence & critique. No biomarkers exist but antidepressant prescribing grows (Moncrieff, 2009).
  - Mental illness ‘identity’ works to legitimize emotional distress, but also worsens social stigma/exclusion (Buchan et al, 2013)

- **Neurocapitalism** – truths circulate through illness markets and popular culture (Pykett, 2013, Pickersgill 2012).

- **The ‘pharmaceutical imaginary’** (Jenkins, 2010) has a gendered history: hysterical, neurotic woman, unhappy housewife
Ruby Wax ‘poster girl for mental health, 2013’, positivenews

**Gendered celebrity advocacy**

Ruby Wax “It’s a brain disease. Depression has nothing to do with being sad. It’s not because you had a bad hair day or even that your husband left town,” she says. “I’m trying to break that myth as fast as I can. I can only say it a hundred thousand times.”

Truth making is a contested, affective practice shaping, and shaped by, the materiality of our thinking-feeling-becoming self (Wetherall, 2013, Fox, 2013)
Women positioned as hysterical, emotional, hormonal & now neurochemically unbalanced

Women come to think about themselves as ‘deficient’ and experts prescribe ‘dutiful’ recovery practices to ‘fix’ distress – inequities and different knowledges become invisible

(Fullagar & O’Brien, 2014)
Rise of ‘Exercise as Medicine’

‘Physical activity programmes for people with persistent sub threshold depressive symptoms or mild to moderate depression should be delivered in groups with support from a competent practitioner and consist typically of three sessions per week of moderate duration (45 minutes to 1 hour over 10 to 14 weeks (average 12 weeks)).

NICE (2009, p.21) Depression clinical guidelines

- NHS website: Exercise is positioned as a self-help ‘activity’ & it is being ‘prescribed’
- Usually framed in terms of the biomedical body - ‘the release of serotonins and endorphins during physical activity can help fight mental health problems’.
How ‘exercise as medicine’ shapes our thinking

+ Opens up non-pharmacological approaches that recognise how recovery is a ‘biopsychosocial’ entanglement of person and socio-cultural context. Exercise as empowering activity.

- Limits how we understand active embodiment as a social practice and address inequalities (intersection of class, gender, sexuality, race, age etc)
  
  - Harmful & instrumental logics can prevail – assumptions about the biomedical body benefiting from exercise, self-determination over emphasised and healthism positions exercise as moral duty
  
  - Embodied, emotional, social meaning & inequalities have been largely ignored

• Whose knowledge is valued as authoritative? Who is silenced by expert knowledge? What can we learn from women’s everyday experiences of recovery?
Researching women’s experiences as lay knowledge

- In-depth interviews with 80 Australian women (20-75 years, rural & urban) to explore meanings of recovery
- Beyond assumptions of ‘natural or spontaneous recovery’: ‘Social recovery’ explores the entanglement of self within the material-discursive conditions shaping human, non-human relations.
- Recovery is never neutral, multiple meanings.
- Range of embodied practices identified (sport, gardening, walking, swimming) and logics of self-care that are shaped by social relations -
  - Affect/ emotions (shame, joy)
  - Material resources (cost, work or unemployment, housing)
  - Cultural context (ethnicity & gender norms shape norms about care for women and their families)
Sport & exercise are also implicated in depression

- Conundrum: Young women have highest rates of dep. across life course, also increasing participation in education & work, drop out from sport

(at 17) ‘I was doing a lot of competitions with ballet…there’s all the pressure that people have at school when you’re trying to get a good OP, but then all the pressure with dancing and… trying to pass your RAD exams… I was trying to juggle both…If I didn’t get all these good marks, and I wasn’t the best dancer at my ballet school, then I actually wasn’t worth anything’. (Anna, 25)

- Gendered practices of compulsive exercising, body shaming cultures – pressure to embody ‘success’
Walking as an embodied practice: Gendered logics of self-management and self-care

- moving out of my thoughts, feeling different
- time for oneself, away from care responsibilities for others
- being in open space/green, sense of calmness
- disciplined walking routines for ‘health’
- walking to feel alive/pleasure
- social walking to connect with others/ the dog
- walking sustained self-care habits over time
- walking to belong in the world, be outside the home
- Walking was free, flexible, low skill, safe
Exercise as self-management - instrumental logic

Mary - biomedical view of her depression, medication
‘I walk for an hour a day’. [how does this help?] ‘I don’t know, I don’t focus on anything but the music; I wear head phones; but exercise helps, so they tell me’.

- ‘not much’ helps, complex history of childhood abuse, conventional family role, little sense of entitlement to leisure time for self
- Walking is part of dutiful recovery, disciplined self but little self-knowledge produced
- Logic of healthism, lack of pleasure in embodied activity or engagement with place
Transforming gendered ethics of care

‘(leisure was) pretty non-existent. It’s only since I’ve… forced myself to make time for myself and do things for me…I’ve started playing netball, so I class that as my time, because that’s for me… with netball, it’s structured so you’ve got to be there (for the team)…when I do exercise I feel good….feel better about yourself. Judy (post-natal dep)

- structured commitment helped lack of motivation,
- influenced expectations of self & work demands,
- improved assertiveness with others,
- used with other strategies (medication, therapy, meditation)
Walking, swimming, transforming relations of self-care

Suzi, ‘(Psychiatrists) put you on medication, the follow up appointments were just to modify the medication not to discuss anything else. I would go there um spend five minutes in his office and pay a $120, so I only went back twice and said to him this is ridiculous I’m not doing it anymore…

I would say that (recovery) was entirely about learning more about myself and what I do and how to do that better, and using lots of different, strategies I suppose, but also making some fundamental lifestyle changes and there’s no going back.

I think I’m you know the sort of person that’s always been very supportive of other people and I still am, but I think I just set some limits on how much I will do for other people at my own expense
Suzi, exercise is very significant for me in managing all of this.

I think in a number of ways, physically, well I believe that if you look at what’s going on as cognitive, emotional and physiological, that if you change any one of those you change all the rest, it has an effect.

getting back into exercise for me was a way of then changing how I felt about things, so feeling physically good.. (I have a) very different rhythm most days now, every second day I swim…every day I take Harry for a walk. I do other bits and pieces of extra walks, my sister is a gym instructor so she’s written up this note book of exercises
Conclusion – reflecting on our assumptions about physical activity and mental health as gendered

- Exercise as medicine is unlikely to be a ‘panacea’ for depression
- We need to analyse the gendered norms that shape meanings of active embodiment to support mental health – constraints & enablers
- One size does not fit all: social connection, pleasure, ‘feeling alive’ lived meanings – question dominant health or sport norms ‘fitness, winning, looking good’
- Identify social inequalities that constrain active living for women (fear/desire, financial access, skills, cultural appropriateness, childcare, body shaming)
- How might think across active living/ sport/ mental health organisations to ‘join-up’ and address the social/gendered conditions of depression & recovery


• Fullagar, S and O’Brien, W (2012) Journeys, battles & feeling alive: Metaphors of women’s recovery from depression, Qualitative Health Research, 22(8), 1063-1072.


