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Speaking of Women's Depression and the Politics of Emotion

Catrina Brown[1]

Abstract

Women are at least twice as likely to experience depression as men, and up to 25% of women can expect to be depressed in their lifetimes. Depression is likely to recur in up to 85% of women, yet most women who experience depression cope on their own. Feminist research has explored the discursive, and social context of depression among women and acknowledges women's agency as they simultaneously struggle and cope with depression. "Getting on with life" is often an imperative, but begs the question what are they getting on with, especially if their lives have been significant in causing unhappiness and distress. I explore how depression is shaped by the discourse of self-management, gender performance and the notion "the good woman." Dominant depression discourses individualize, decontextualize, and emphasize personal responsibilization for the causes and treatment of depression. This produces an epistemic injustice for speaking about and coping with depression. Social work practitioners must make space for acknowledging women's resourcefulness and agency in their management of sadness and distress. We must also address not only the dangers of responsibilization, but the limitations of this approach to women's well-being.

Keywords

Women, narratives, managing depression, politics of emotion

Feminist approaches to women's mental health and well-being acknowledge that women are at least twice as likely to experience depression as men, and up to 25% of women can expect to be depressed in their lifetimes (Ussher, 2010). Feminist research has explored the discursive and social context of depression among women, emphasizing women's agency as they simultaneously struggle and cope with depression (Scattolon, 2003). "Getting on with life" is often an imperative but begs the question what are they getting on with, especially if their lives have been significant in causing unhappiness and distress (Scattolon & Stoppard, 1999). In this discursive analysis, I explore how depression is shaped by the neoliberal discourse of self-management alongside discourses which shape gender performance and social notions of "the good woman" intersected for instance by race, sexual

[1] School of Social Work, Dalhousie University, Halifax, Nova Scotia, Canada

Corresponding Author:
Catrina Brown, School of Social Work, Dalhousie University, Halifax, Nova Scotia, Canada B3H 4R2.
Email: catrinagbrown@yahoo.ca

orientation, poverty, and economic inequality.[1] Although women's experiences of depression are not homogeneous, and there is no one story, the neoliberal economic, social, and political context is overarching. Yet how women from diverse social locations make meaning of and voice their experiences of depression within this context is important for us to understand. Within a dominant neoliberal framework, depression discourse individualizes pathologizes, decontextualizes, and emphasize personal *responsibilization* (Lemke, 2001; Shamir, 2008) for the causes and treatment of depression. This dominant framework creates conceptual voids that reproduce inequity and oppression and subsequently produce an *epistemic injustice* for speaking about and coping with depression (Fricker, 2003).

Social work practitioners must make space for acknowledging women's resourcefulness and agency in their management of sadness and distress. At the same time, we must also address not only the dangers of responsibilization but the limitations of this approach to women's well-being. In this article, I problematize the linguistic incongruence and dangers women face in making meaning of and speaking of their experiences with depression within prevailing expectations of self-management alongside the hegemonic influence of biomedical frameworks (Gattuso, Fullagar, & Young, 2005). With an awareness of the history of significant work that feminist (i.e., Baker-Miller, 1976; Bass & Davis, 1988; Brown, 1988; Burstow, 1992; Butler, 1985; Caplan, 1995; Chesler, 1972; Comas-Diaz, 2000; Courtois, 1996; Herman-Lewis, 1992; Howard, 1986; Lerner & Porter, 1990; Penfold & Walker, 1983; Ussher, 1991) and mad scholars (Burstow & Weitz, 1988; Capponi, 1992; Lefrancois, Beresford, & Russo, 2016; Smith & David, 1975; Szasz, 1970) have contributed to social justice and women's mental health, I explore the discursive shaping of conversations on depression among women and suggest that feminist narrative–based practice in social work can offer an approach to creating counternarratives, which acknowledges women's distress, depathologizes women's experiences, and situates them within their social contexts.

This article bridges the gap between "expert"-based understandings which often reflect a biomedical paradigm and women's knowledge through a material-discursive approach which suggests depression is situated within the dual and necessarily intertwined context of women's lives and women's bodies (Lafrance, 2009; Lafrance & Stoppard, 2007; Ussher, 2010). Research suggests that a conventional "disease management approach" fits poorly with women's own understanding and management of depression. The uneasy fit between biomedicine and subjective experiences of depression produces significant gaps in knowledge or epistemic gaps about depression. Indeed, regimes of truth provide the discursive context of depression for women to take up subject positions of "being depressed" (Ussher, 2011).

Women's negotiation of sadness and distress in their lives illuminates dominant socially constructed discourses of depression, self-management, and gender. I begin by outlining my theoretical approach and examining competing approaches to depression, arguing the strengths of the material-discursive approach adopted by feminist researchers. I then explore women's coping with depression, how they make sense of, and language their experiences within the dominant-discursive contexts available. I examine the politics of emotion and the imperative of self-management and responsibilization within neoliberalism. Drawing on Hochschild's (1983) work on the *managed heart* or the social management of emotion and Ahmed's (2004a, 2004b) cultural politics of emotion, I elaborate on how the dominant discourse renders the invisible social and political context of depression as the focus remains on the individual. Subsequently, I argue the frameworks available for women to make meaning of their depression are often injurious for them, while reinforcing the dominant biomedical paradigm and continuing to decontextualize women's depression through centering on individual disease and pathology. Feminist research argues instead for the need to counterview these discourses and create counterstories, which acknowledges women's agency in dealing with depression and which challenges hegemonic deficit–based approaches to depression

and women's coping and to clearly situate the construction of depression as a social and political phenomenon (McKenzie-Mohr & Lafrance, 2014a).

Theoretical Approach

This article is influenced by contemporary postmodern feminist and narrative theory (Bordo, 1990, 1993; Butler, 1997; Butler & Scott, 1992; Foucault, 1980; Foucault, 1984; Haraway, 1988; Scott, 1988, 1992; White, 2007). Taken together, postmodern feminist and narrative approaches emphasize the unpacking of women's gendered stories which are situated within the culturally available meanings and discourses that make them possible. This blending enables an analysis of women's depression that does not lose sight of the construction and performance of gender and specifically gendered expressions of well-being, while seeking to escape limiting cultural meanings and descriptions of depression. Moving past the single story, this approach emphasizes multiplicity, complexity, and diversity, whereby gender is intersected for instance by race, class, and sexual orientation. Identities are not essentialized: They are seen as socially constructed and differently situated within social relations of power (Brown, 2012). While women may internalize dominant stories about depression and its treatment, many of these stories do not work well for them (Hare-Mustin, 1994; Madigan, 2003; White, 2001, 2007). At the same time, women may challenge these dominant discourses in the ways they negotiate depression in their lives (Lafrance, 2009). This approach provides a framework to explore the ways that dominant stories of depression may hinder, even injure women who are depressed by focusing only on individual deficits and the ability to cope with them.

Lafrance and Stoppard (2007) argue that there are two culturally competing ways to understand depression: those that locate depression in the *body* and those that locate depression in women's *lives*. The dominant medical model views depression as a medical illness involving biochemical imbalance in the brain. Women's experiences of depression cannot be explained solely by biomedical frameworks which emphasize their reproductive lives such as menstruation, pregnancy, childbirth, and menopause or by their cognitive styles (Lafrance & Stoppard, 2006; Stoppard, 2000; Ussher, 2010, 2011). Corresponding with a biochemical view of depression, dominant approaches to treatment have increasingly involved the prescription of antidepressants, especially to women (World Health Organization, 2001, 2004). Feminist and mad studies demonstrate the inadequacy of the biomedical model which is for the most part dangerously detached from women's life experiences. Lafrance (2014) argues that the "hegemony of the biomedical model can be understood as less a matter of 'truth' than of power" (p. 141), noting that evidence has yet to provide rigorous support for biomedical explanation of depression.

While medical approaches often emphasize differences in women's and men's bodies, psychological approaches often emphasize differences in men's and women's cognitive styles arguing that while men are problem solvers, women are ruminators when dealing with stress. Ruminating is typically understood as a passive, rather than active response, and one more likely to produce depression (Lyubomirsky, Tucker, Caldwell, & Berg, 1999), although more recently ruminating is seen as an active coping response even if not always helpful (Brotman & DeRubeis, 2004). McMullen (2003) critiques the common focus on depression as individual deficit and on one's capacity to cope as evidence of psychological character. In contrast to these deficit-based views (biomedical and psychological), an alternative approach rooted in feminism locates the problem of depression in women's lives (Lafrance & Stoppard, 2007).

In an effort to avoid the body/mind and individual/society binaries which the above approaches typically reflect, Lafrance and Stoppard (2007) and Ussher (2010, 2011) suggest a third approach. This material-discursive approach to understanding depression is rooted in a postmodern perspective. According to Stoppard (2000), depression like all human experience is a complex biopsychosocial phenomenon, that "... involves experiences grounded in the materiality of the body which

continually, and reciprocally, feed back into people's experiences in the social context of their everyday lives" (p. 21). A number of pivotal explorations have emerged which adopt this approach, all with an emphasis on the discursive construction of meaning and women's embodied experiences of depression taken as inseparable from the circumstances of their lives (Banyard & Graham-Bermann, 1993; Hurst, 2003; Lafrance, 2007; Lafrance & Stoppard, 2006; McKenzie-Mohr & Lafrance, 2011; McMullen, 1999; McMullen & Stoppard, 2006, 2003; Schreiber, 2001; Ussher, 2010, 2011). These studies emphasize the role of gendered expectations and social context and the embodiment of women's experiences of depression.

Women typically do not view the body and the social in binary terms and many opt to use antidepressants a way to level out feelings of depression (MacKay & Rutherford, 2012). However, many women do not want to simply be prescribed an antidepressant when they tell their doctor they are feeling depressed (Lafrance, 2014). They may resist what they view as a superficial approach as it fails to make an effort to understand their distress in the context of their lives. Women told Lafrance stories of having their voices silenced and their knowledge and accounts subjugated. Importantly, her research found that women needed to break free of oppressive social expectations in order to find a way to tell their counterstories of depression and to "highlight and name those otherwise taken-for-granted aspects of women's lives that are so often integral to their stories of sadness" (Lafrance, 2014, p. 154). This finding suggests feminist narrative practices in social work may help women establish more helpful counternarratives through unpacking unhelpful and oppressive social expectations together with exploring the history and development of their depression stories.

The Social Contexts of Women's Experiences of Depression

The social context of women's lives, including age, education, employment and economic inequity, the emotional and caring labor, sexual orientation, racialization, and gender-based violence, is relevant in women's rates of depression (Jones, 2008; Lafrance, 2009; Mays & Cochran, 2000). These intersected social contexts are often associated with psychosocial perceptions of having little life control, few social supports, and isolation and have been observed as significant in the development of depression among women (Hughes & McCormack, 2000; Lafrance, 2009; McGrath, Keita, Strickland, & Russo, 1990; Stoppard, 1999; Ussher, 2010). Existing feminist research provides important insight into how women's gendered lives play a role in their depression demonstrating links to the challenges of managing multiple social roles as women juggle paid and unpaid work (Mazure, Keita, & Blehar, 2002), how women cope with depression by "getting on with their lives" (Scattolon, 2003; Scattolon & Stoppard, 1999), and their efforts at constructing a nondepressed self (Lafrance, 2007; Lafrance & Stoppard, 2006; Ussher, 2010).

Poverty has been consistently associated with depression among women, as it creates significant stress, insecurity, and disadvantage (Belle & Doucet, 2003). Following up on their original research, Brown and Moran (1997) found that low-income mothers, especially sole parents, are at very high risk of depression. Recent research lends support to the findings that women living in poverty caring for young children are particularly at risk for depression (Levy & O'Hara, 2010). Lafrance and Stoppard (2007) found that women's stories of daily life are consumed by domestic practices and governed by the needs of others which often depletes their physical and emotional resources. High rates of depression among women between the ages of 35 and 64 may reflect stress related to conflicting social roles (Statistics Canada, 2006). Even when employed full time, women are still largely responsible for the care of their children, families, and elderly parents (Statistics Canada, 2006). Compliance with traditional gender roles (e.g., women's exclusive focus on caregiving and the well-being of others) often results in increased depression among women.

This is echoed in research among African Canadian women, which found that racism, family burdens, and work-related stress were often associated with midlife depression (Etowa et al., 2005). Women reported that they were expected to assume the role of the "strong black woman" taking care of others' needs at their own expense. Similarly, Beauboeuf-Lafontant's research on black women's experiences of depression suggests that the discourse of strong black women encourages taking care of other needs in a selfless manner. Beauboeuf-Lafontant (2007) argues that women's experiences of depression are both gendered and raced. The process of normative feminine "goodness" has been characterized as involving self-silencing, with a self-sacrificing focus on others' needs (Jack, 1991). This characterization of depression often involves being voiceless and fragile, in contrast to the emphasis on being strong among many black women (Beauboeuf-Lafontant, 2007). According to Beauboeuf-Lafontant, "[m]ental health and wellness, therefore, depend on a woman's realizing that the discursive sociocultural representation of her womanhood fails to incorporate her reality" (p. 30). She asserts that this approach to understanding the relationship between normative womanhood and distress would benefit from the inclusion of diversity of gendered experiences. Depression among women exists across cultural contexts whereby being informed of normative and dominant cultural scripts for distress within a culture help understand expressions and experiences of distress (Chentsova-Dutton, Ryder, & Tsai, 2014). Although the cultural construction of being a strong black woman is a compelling part of many black women's depression experiences, this mandate can mask their struggles. Similarly, cultural constructions of "fragile" middle-class white women may mask their agency and resistance in performing their gender roles.

Queer and transgender women also experience significant depression and suicidality. Transgender women's experiences of depression and suicidality are much higher than the general population (Hoffman, 2014). The existing research suggests the rates of depression reflect the lack of positive social support, discrimination, violence, stigma, isolation, lower income and education, and unemployment often experienced in transgender women's lives. Among women who identify as lesbian and bisexual victimization, homophobia, identity concealment, and a lack of social support often play a significant role in their depression experiences (Lehavot & Simoni, 2011).

Feminist scholars on trauma have long identified the significant sequelae of childhood abuse including sexual abuse and incest (Burstow, 2003; Courtois, 1996; Herman-Lewis, 1992). Women's accounts of depression highlight feelings of betrayal, hopelessness, and demoralization which they often associate with abuse, trauma, and disrespect in their social relationships (Hurst, 2003). Thus, addressing the issue of depression among women requires significant attention to the social context and discursive shaping of their experiences, particularly experiences of trauma and abuse in terms of how women cope, supports and resources needed, and the need for social change. Explorations of violence, race, and depression have found that the strong black woman discourse is a barrier to both acknowledging and seeking support for depression and that there is significant mistrust of the normative white health-care system due to systemic and cultural barriers. Further, there is a strong association between use of drugs and alcohol to self-medicate for depression and the effects of multiple and complex violence and trauma histories (Nicholaidis et al., 2010). A combined history of colonization, ongoing racism, violence, and poverty against First Nations women in Canada and the United States impacts on their well-being and puts them at risk of depression (Culhane, 2003; Handwerker, 1999). The link between depression and violence against women cannot be overstated (Herman-Lewis, 1992; Stewart & Israeli, 2003).

Self-Management Discourse, Responsibilization, and Neoliberalism

Gremillion's (2003) research on the dominant cultural *discourse of self-management* and how it plays out in women's efforts to control their bodies and lives can be extended to women's

experiences of depression (Brown, 2007b; 2014, 2017; Lafrance, 2009). The cultural imperative of self-management reflects a normative expectation that individuals discipline and control themselves. Women's focus on disciplining themselves often reflects the dominant self-management discourse central in normalization processes of self. Self-policing and self-surveillance can offer a sense of personal control (Brown, 2007b). Needs, desires, and the relaxation of self-management or self-surveillance exist in opposition to the "shoulds," "rules," and intensification of self-management. Feminist research has shown women often normalize their experiences of depression, explaining depression in a way that ensures they would not be seen as "insane," "mentally ill," "weak," or "inadequate as women" (Scattolon, 2003). Women often watch themselves being watched through the eyes of others to ensure they perform in the world as "good" women. Depression as a gendered experience is, at least in part, perceived to be a problem of self-management or failure to cope with unhappiness and distress. The need to speak of distress or discontent can be seen to seep outside the boundaries of adequate self-regulation (Bordo, 1993).

Gendered and racialized experiences of depression among black women may be further shaped by the strong black women cultural discourse in some specific ways. For black women, the "good woman" often reflects the "strength mandate," thus being seen as weak can be intolerable. Beauboeuf-Lafontant observed in her research with black women that they were reticent to speak "about the painful and hidden aspects of living up to the image of strength" (p. 35). She identified two important dimensions of the concept of strength and being a strong black woman: "hardship as a cornerstone of Black womanhood and the intensification of feminine demands to be selfless caretakers of others" (p. 35). Dealing with struggle and adversity is often expected among black women, and the strength mandate restricts voicing injustices in their lives. At the same time, Beauboeuf-Lafontant notices that black women often have awareness of the negative effects of internalizing the strong woman mandate when they observe the impact of dealing with adversity and taking care of others on their mothers, sisters, and friends.

For many women, compliance with the social performance of the "good woman" might suggest that everything is fine, while their experiences of depression might reveal otherwise. Beauboeuf-Lafontant (2007) found that black women holding to the strength mandate often conceal their struggles keeping up a façade, so that no one knew or could disapprove. For women who internalize the strength mandate, the cultural logic of self-management may be intensified. Even though experiences of depression among women may be shaped by a cultural logic of self-management, they may also defy and resist it just by rendering it visible. According to Marecek (2006), "depression is not something people have, but a set of practices authorized by the culture through which people express to others they are suffering" (p. 303). Importantly, how women express their suffering has many influences.

Scattolon and Stoppard (1999) found that women managed their depression and distress, determined to "get on with life" in ways consistent with social constructions of the "good woman." Efforts to continue on as usual, to "get on with life" may not only conceal the distress but the life context in which it has arisen. They found that dominant "ideals and practices of the 'good woman' or the discourses of femininity regulated their sense of self and everyday life and shaped women's understanding of depression" (p. 205). Women report they often force themselves "to go on" for the sake of others (Scattolon, 2003). However, women described how their depression also got in the way of being able to continue on "as usual" with their daily lives, including roles they felt they were expected to fill such as taking care of their family's needs and having the energy to look after their appearance. Lafrance and Stoppard (2006) found that, in the process of constructing a nondepressed self, women often let go of dominant narratives of "the good woman."

The Canadian mental health campaign *Depression Hurts* emphasizes people taking control of their depression through medical help and improving their ability to help themselves. However,

government strategies that encourage the enhancement of self-management and coping strategies have been critiqued (Marecek, 2006). While this mental health campaign attempts to destigmatize depression, its underlying ideologies contribute to the continued gaps in their understanding of why women are unhappy and distressed in the first place, and reifies the ongoing social emphasis on women's self-management of depression in order to perform their daily lives. Lafrance (2007) notes that the combined focus of biomedical and psychological approaches to depression emphasizes therapy and self-management, which not only reiterates expert intervention and individual pathology but decontextualizes the political, economic, social, and discursive shaping of women's experiences of unhappiness and distress. Understanding and challenging the discursive and political way in which depression and women's subjective well-being is languaged and contextualized and the corresponding pathways they adopt in an effort to improve their control of the management of depression, will I suggest, mean needing to confront the very ideologies that underlie mental health campaigns that while attempting to address the stigma of depression, focus substantially on self-management or regulation.

Mental health campaigns which seek to improve people's ability to help themselves, while excluding their experiences of oppression in the worlds in which they live, plays into the individualizing, decontextualizing, and personal responsibilization for the causes and treatment of depression. The focus on individual responsibility within neoliberalism emphasizes self-regulation, self-management, and self-surveillance. Although we participate in our own ruling when we police ourselves, responsibilization involves a particular kind of obedience (Foucault, 1980; Shamir, 2008). Obedience to, responsibility for, and participation in ruling among the "docile body" or social actors is subjectively experienced (Foucault, 1980), ironically, as feeling empowered through social constructions of the valuable and good self—those seen to be in control, well regulated, managed, and valued. In other words, self-worth and identity become tied to one's capacity to self-govern in alliance with neoliberal social governance. The neoliberal social and political economy is organized around social relations that do precisely this. According to Lemke (2001), "[n]eo-liberalism is a political rationality that tries to render the social domain economic and to link a reduction in (welfare) state services and security systems to the increasing call for 'personal responsibility' and 'self-care'" (p. 203).

For Lemke, the recoding of social mechanisms of exploitation and domination involves shifts in regulatory mechanisms to those of self-regulation, whereby individual's self-control is linked to "political rule and economic exploitation." In his study of Foucault's ideas on neoliberal governing, Lemke reminds us that governing is not about forcing or coercing people but about creating techniques of power "where techniques of the self are integrated into structures of coercion and domination" (p. 204). These techniques require and encourage individuals to actively construct and modify themselves often under the guise of "self-fulfillment." Neoliberal notions of resilience, self-esteem, and empowerment reflect the responsibilization of depoliticized self-management and self-regulation. This responsibilization is consistent with Morrow and Weisser's (2012) critique of the limitations of the notion of "recovery" suggesting that "the imperative to recover is viewed simply as an extension of the neo-liberal agenda" (p. 34). Further, the focus on "recovery" involves a self-management expectation that one will comply with the biomedical expert. The imperative to recovery coexists with the imperative of self-management and responsibilization. Overall, the notion of recovery focuses on the individual and is inadequate in addressing social and structural inequities with a lack of attention to race and gender (Weisser, Morrow, & Jamer, 2011). There continues to be gaps in the research literature and approaches to understanding and working with mental health distress, at least in part, because of the problematic ideologies that underpin social campaigns which emphasize responsibilization. Moreover, these gaps are an outcome of the widely held and frequently disseminated idea that while women may find various ways to manage their lives, how they cope and at what expense is perceived of as

unimportant. No doubt, women are differently impacted by the imperative of self-management. Arguably, the intensification of social inequities may deepen this struggle at the same time that the responsibility is no less. As Morrow and Weisser (2012) argue, a social justice approach to the demands for recovery must recognize interlocking oppression and dimensions of power and how little control some people involved with the mental health system experience in their lives. Dominant culturally available discourses about distress inadequately capture the creative ways women story their depression (McKenzie-Mohr & Lafrance, 2011). While women often struggle to give meaning to their experiences within these discursive frameworks, they find ways to resist culturally dominant stories and create new accounts. Negotiating dominant discourses often involves both compliance and resistance as women seek to provide accounts of their own experiences (Author, 2007a, 2007b, 2007c, 2014; Lafrance, 2009).

The Politics of Emotion and the Grip of Neoliberal Culture

Like the body, emotional life is in the grip of cultural practice (Brown, 2014). Under the influence of dominant self-management discourse, women may rigorously monitor themselves—how busy they are, how accomplished, how strong, or how productive—as evidence of either making the grade or failing or being good enough. Self-management and surveillance are structured by dichotomized either/or assumptions in policing the self, including, good/bad, in control/out of control, good enough/not good enough, powerful/powerless, strong/weak, being productive/unproductive, active/lazy, and successful/failure. In this culture of restraint, emotional self-management schemas allow little if any room for stepping out of line. Such emotional regimes require a tightly controlled subjectivity. In the case of anorexia, a powerful social example, the perceived absolute sense of control often established through intense surveillance and deprivation is the ultimate prize, so valuable, so desired that one will die for it. In contrast, the sense of losing control is often devastating and terrifying (Brown, 2014).

I have suggested above that from a material-discursive paradigm, emotions are tied to both cognition and the body—and all exist within social worlds of meaning and politics. In contrast to the depoliticization and naturalization of emotions, Ahmed's (2004a, 2004b) view that emotions are cultural practices leads her to ask: "what do emotions do?" (p. 4). Arguably, depression needs to be tightly controlled within neoliberal emotional regimes. The dominant culture of self-management shapes the expectations and performance of emotion management. Within a postmodern informed social constructionist lens rather than an essentialist one, we can acknowledge rather than avoid, the emotional or feeling life that people often experience as driving the narrative thread in their problem stories or struggles. These emotional threads are inseparable from the meaning we associate with lived events. Critically, these thick influential emotional threads are not simply individual, but cultural practices, which for example, shape political action, war, and nationalism (Ahmed, 2004a). According to Ahmed (2004a), "emotions 'matter' for politics; emotions show us how power shapes the very surface of bodies as well as worlds. So in a way, we do 'feel our way'" (p. 12). Once we enter the realm of meaning making, we are in the social realm, and, thereby, the political. As we seek to make sense or meaning of our life experiences, we necessarily move beyond a one-dimensional notion of emotional embodiment that results in the essentialism of emotion and enter the cultural politics of emotion as subjectively and intersubjectively experienced in daily life.

Thus, emotion is not innocently or privately subjective (Brown, 2014). While extra-discursive in its ability to produce material observable effects and experienced as embodied, internal subjective reality, emotion is inextricably entwined in the social meaning making processes of experience and life itself. Hochschild's (1983) notion of the "managed heart" refers to the social managing of emotion. As we begin to shift away from binary constructions of emotion as either cognitive or embodied, or as essentialist, pregiven, asocial, and internal, versus socially and politically

constructed, there is a need to both recognize and understand how we are simultaneously emotionally embodied cognitive subjects and that emotions are always social things and as such socially constituted (Ahmed, 2004a; Turner, 2009). Sociology draws our attention to "feeling rules," the notion of emotional labor, management, and performance of emotion consistent with cultural norms; the impact of status and power; and the management of emotions for social cooperation and control of conflict (Turner, 2009). Emotions are gendered as we can see by the discouragement of expression of anger, strong opinion, conflict, or "being selfish" among women and girls, and fear, humiliation, and vulnerability among men and boys. Emotions are also racialized as can be seen in the expectation faced by many black women that they should appear strong which often requires the masking of struggle, vulnerability, and pain. Further, economic inequities and poverty have a way of stealing people's sense of hope and believing in possibilities. Depression speaks of unhappiness/sadness, pain, discontent, isolation, disconnection, and struggles with life and often renders women feeling hopeless, disempowered, shutdown, and voiceless. This description seems to resonate across many women's experiences and the systemic and structural inequities that shape the contexts of their lives.

Epistemic Injustice and the Dangers of Speech

Given the conflation of self-management and intersectional gendered discourse in women's lives, how do women tell their stories of depression? What is at risk? Does dominant language and framing fit their experiences? There are, indeed, many dangers associated with speaking about depression including anxiety about acknowledging and disclosing depression, the challenge to one's public image, fear of being judged or thought less of, being seen as weak, or having the depression experience minimized, fear of child welfare, and the potential impact on work. It might also involve speaking about the differences between what others expect and what women may actually need, or speaking about injustices and unfairness. For many women, so much effort goes into performing notions of the "good woman" and acting as though everything is fine even when it is not, it can be a deep emotional risk to express what they are actually experiencing and the supports they are needing. For many women, depression is experienced as a kind of "nameless misery" (Gattuso et al., 2005). This is especially true, when there is an overall inadequacy of existing frameworks or language for storying depression and being heard when telling one's story. Beauboeuf-Lafontant (2007) suggests that "Black women experiencing or at risk for depression exist in a conceptual void" (p. 46). The internalized strength mandate experienced by some black woman makes little space for them to address the difficulties in their lives and their actual vulnerabilities. "The strength discourse normalizes struggle, selflessness, and internalization strategies that compromise the health of Black women" (p. 46). Further, "[i]f, as the silencing paradigm suggests, depression is the result of socially and culturally sanctioned self-silencing, health researchers should cast a suspicious eye toward the observed use of being strong as a healing mechanism among depressed Black women" (p. 46). Fricker (2003) refers to this conceptual void associated with inequity and oppression as *epistemic injustice*.

All stories are not treated as equal or given the same validity. The notion of epistemic injustice exposes how the construction of knowledge, power, and truth is at play in determining which stories are taken up as truth in dominant culture and how alternative accounts are rendered invisible. Epistemic injustice means that people are accorded varying levels of credibility as they convey their knowledge and often struggle with making sense of their own social experiences as knowers (Fricker, 2003).[2] When women's stories resist or challenge taken-for-granted ideas, it makes them harder and riskier to tell, and too often stories which resist normative expectations are not easily or readily heard. This is similar to the tightrope talk that McKenzie-Mohr and Lafrance (2011) describe.

McKenzie-Mohr and Lafrance's (2011) research on living well after rape and "recovering" from depression, respectively, draw on DeVault's (1990) description of *linguistic incongruence*. This linguistic incongruence turns storying their experiences into *tightrope talk* (McKenzie-Mohr & Lafrance, 2011). In listening beyond the words, we can challenge the dominant discourse and work toward the development of alternative and more helpful narratives (DeVault, 1990), through creating space for disqualified aspects of the story (White, 2001). Women often try to find a way to make sense of their experiences within dominant social narratives which provide inadequate accounts of their experiences and tend to reify oppressive dominant discourse, including blaming, shaming, and pathologizing women. As women rely on the dominant cultural discourses available to them, they may join with unhelpful pathologizing deficit-based stories about their themselves (McKenzie-Mohr & Lafrance, 2011). These dominant deficit-based stories are internalized, and women may inadvertently adopt these self-descriptions. For example, while some women describe receiving a diagnosis of depression and being prescribed medication serves to legitimize their experiences, they may also believe that their experiences go beyond this medicalization (Lafrance, 2007). In this way, dominant discourse can be described as *injurious speech* (Butler, 1997; Madigan, 2003), which creates uncertainty in women's accounts of experiences (including depression, anxiety, abuse, violence, trauma, eating disorders, substance use). This incongruence of the dominant discourse with women's actual experiences of depression ultimately fails women (McKenzie-Mohr & Lafrance, 2011). Lafrance (2014) argues that feminism must continue to "work toward naming otherwise invisible aspects of women's lives and to highlight women's attempts to speak beyond dominance" (p. 156).

Butler's (1997) notion of the injurious speech of dominant social discourse—for instance, "you are worthless," "you have nothing to be depressed about," "you caused the violence," "nobody cares," or "it isn't as bad as you say it is"—can also make one *linguistically vulnerable* as it shapes what can be said by and to whom. The dominant discourse of mental health issues women struggle with is injurious not only in terms of its truth claims but in constraining what can be said by women themselves. It involves "discursive capture" whereby alternative viewings or stories are disqualified (Strong, 2012). When depression is seen as weakness or a lack of resilience, it is injurious. Madigan (2003) illustrates the powerful way in which individuals internalize harmful dominant social stories that get taken up as truths about themselves. He suggests that counterviewing injurious speech acts can be used to unpack and challenge unhelpful discourse. This counterviewing practice is useful in a critical unpacking of the discursive relationship between self-management and gendered discourse related to depression and important to social work practice.

In an effort to counterview injurious speech, I adopt the notion of *encoded feeling speech* as a way to describe how women construct and tell their stories to minimize the danger involved. Talking about depression is most often deeply encoded, as the experience is primarily positioned as individual and emotional. This encoded speech renders invisible the discursive and social dimensions of women's depression and hides what emotions do as a cultural practice (Ahmed, 2004a). Through encoded feeling speech, the focus remains on individual emotion, while the mobilization of emotion within the political and social is obscured. Further, moving past modernist approaches that often essentialize emotion and dichotomize emotional and thinking life necessitates situating experiences and descriptions of emotional life as social. Deconstructing this encoded speech is a valuable entry point for recognizing how the management of feeling life is tied to the discourse of self-management (Brown, 2014; Foucault, 1980). It is often deeply connected to self-surveillance, management, and regulation and specifically to whether one is resilient enough. The encoded feeling talk of depression leaves women focused on their own subjective experience, on their ability to manage depression, in such a way that is disconnected from the discourses and realities that produce and reproduce the feelings characterized as depression. Remarkably, emotional life is often treated, as just is, to be validated and legitimized as authentic experience outside of the impact of the social world (Brown,

2007b, 2012, 2013). Clearly, experiencing a lack of power and control over one's life through experiences of violence, marginalization and oppression are often part of depression experiences. Yet being dissatisfied with one's life too often becomes "what is wrong with me" or "what did I do to deserve this"? The story becomes *emotionalized*, and this is reflected in a focus on individual change and "resilience" to the exclusion of social justice considerations that contend with social inequity and oppression. Responsibilization and self-management discourse may then shape how women believe they should manage their experiences of depression in their lives.

The encoded feelings speech can be shifted or disrupted by recognizing the negative effects of the dominant social discourses of depression, gender, and self-management. When encoded feeling speech is entangled in processes of self-management/regulation, the discursive, controlling, and coercive aspects are not immediately evident. Our participation in our own ruling is obscured in this entanglement (Brown, 2014; Foucault, 1980). According to Ahmed (2004b), "[r]ather than seeing emotions as psychological dispositions, we need to consider how they work, in concrete and particular ways, to mediate the relationship between the psychic and the social, and between the individual and the collective" (p. 119). Women use the language of feeling because the emotional aspects of the encoded feeling speech are compelling, powerful, and often overwhelming and because it is the language available to them. The encoded speech is often not fully transparent, it partially conceals (to oneself and others) and cryptically shapes a safe way of speaking—speaking in code—speaking more safely. Just as the encoded feeling speech often feels deeply personal and subjectively meaningful—the heart of experience—one is deeply subjectively invested in the speech. Yet, if we double listen, listen beyond the words, we can unpack the political and social aspects of encoded feeling speech (White, 2007). Ahmed (2004b) discusses how we need to be aware that "emotionality involves movements or associations whereby 'feelings' take us across different levels of signification, not all of can be admitted in the present" (p. 120). Counterviewing depression can create counterstories which untangle how the emotional, cognitive, and discursive are co-implicated within coded feeling speech such as "feeling depressed" and its many associated encoded speech acts. The discursive way in which women take up the subject position of "being depressed" can be untangled.

Encoded feeling talk is central to "experience near" and more situated accounts in women's self/body talk and is "known and familiar." According to White (2007), "experience near" descriptions reflect people's everyday language and understandings of their lives and are influenced by their immediate history. This does not mean though that the experience near and the known and familiar are outside the social or extra-discursive. The experience near language of "feeling shame," "feeling guilty," "feeling weak," "feeling inadequate," "feeling out of control," "feeling hopeless," "feeling depressed," "feeling alone," and "feeling useless" are, however, codes or feeling speech for the conflation of emotion, cognition, and dominant social discourse. As feelings are central to "experience near" accounts in people's lives, heightening critical attention to the socioemotional terrain in the social construction of dominant unhelpful narratives may assist in the creation of counterstories.

Feminist Narrative Social Work Practice: Deconstructing and Externalizing Depression

The deconstruction of stories or narratives involves an externalization process which separates the person from the problem (Morgan, 2000). This social justice–based process reduces labeling, pathologizing, and blaming the individual and instead emphasizes the historical and social construction of "the problem." We need to externalize women's emotion/feeling talk in order to unravel the encoded feeling speech about depression from dominant self-management/regulation discourses and, ultimately, to create more helpful counterstories. Through challenging or destabilizing the discourses which fuel emotional experiences of depression, feminist narrative therapy can explore

what the depression means to women and how it came to mean this. Feeling "like a failure," "weak," or "not being good enough" when trying to manage depression arises from socially constructed ideas of what is normative and acceptable self-management for women. The discursive shaping of emotional experience needs to be unpacked.

By untangling the discursive, emotional, and contextual, other possibilities and alternatives may come into view. This can allow for both the discursive and emotional shifts necessary to create counternarratives of depression which resist the oppressive dominant discourse of self-management and demands of emotional self-regulation (Brown, 2014; McKenzie-Mohr & Lafrance, 2014b). While counternarratives of depression may not in themselves be a panacea for depression, they may offer better understandings of the social influences that shape experiences of depression and open up spaces for alternative, and perhaps more helpful, ways for women to see themselves, their lives, what they need, and how they cope with depression.

The following examples of counterviewing questions offer potentially new entry points in therapeutic conversations, where "the depression" is situated as something outside of the woman. The questions offered here first explore the influence depression has had on the woman and then explores the influence that she has on the depression. This example of the narrative process is by no means comprehensive but illustrates a movement away from problem stories to preferred alternative stories. Many other counterviewing questions can be asked in between this scaffold that provides more depth and specificity to the meaning of her experience and the contexts that plays a role in the depression. This scaffold of a therapeutic conversations presents ideas to explore and not meant to suggest that questions should be asked in a rigid or linear fashion. Further, on the therapeutic conversation, the client is also shaping the conversation and where it goes next. These types of counterviewing questions can be kept in mind as the client and the practitioner unpack the experience of depression together. This might include the history, context, and effects of the problem (the depression). They might explore what was going on throughout the woman's life, how has she experienced depression, how has it influenced how she sees herself, and shaped her sense of possibilities in life. Also, exploring when was depression the strongest and weakest helps to create a sense of what contexts might be contributing to depression. Importantly, these questions not only explore how women cope with depression and the importance of unpacking the influence of the depression stories on women and women's own influence on the depression stories, they highlight her sense of identity, how this emerged, and her attitudes toward self-care and self-compassion. They also examine the influence of the broader social and historical context on her life to ensure that social relations of power are not ignored. If for instance, sadness first appeared when she was a child experiencing abuse or trauma; the connection between depression and trauma should be explored (Morgan, 2000). If the social context is not addressed, we may contribute to individualizing the problem, disqualifying, and silencing important influential aspects of a women's stories.

The Influence of Depression

When did you first experience depression?
What was going on in your life at that time?
Tell me about the depression? What does it feel like?
How do you see yourself when you feel depressed?
Where have you learned this message?
How has the depression affected your life, relationships, work, etc.?
When has it been strongest?
What is going on at those times?
How do you cope with the depression?

What do you need in your life at these times?
What helps?
How do you take care of yourself at these times?
How are you able to get on with life when you feel depressed?
What does it take to cope with the depression?
What do people not understand about the depression?

Many women experience an ebb and flow of depression throughout their lives. It is useful to explore what helps her deal with her depression, and how is she able to get on with her life despite the depression. Exploring what she believes would need to change or be different in her life to minimize the effects of depression allows us to move past the self-management discourse to the realities and contexts of her life. This may include challenging and resisting dominant discourses which often require women to take care of others' needs at their own expense and addressing the impact of trauma, a lack of resources, racism, ableism, homophobia, and the stress of working in the labor force while also taking care of others. Cultural and social practices such as these can be named as practices which have shaped the influence of the problem in women's lives (Morgan, 2000).

The Influence on Depression

Are there times that you don't feel sad or depressed?
Can you think of a time that the depression was not there?
What was different about this time?
Were there other times?
What was different?
How were you able to have this influence over the depression?
How do you feel about yourself when you feel less depressed?
How were you able to keep the depression from getting worse at times?
Can you think of a time when depression might have gotten in the way but did not?
What happened?
What helped you at those times to have less or no depression in your life?
Who else noticed this?
What would it take to have less depression in your life?
How would your life be different if you were able to have more of those times in the future?
What would you need to be able to continue on in this direction?
What do you feel this says about what you hope for your life in the future?

Feminist narrative therapy may use these types of counterviewing questions to help develop counterstories. These questions unpack the experience and externalize the unhelpful story including the way in which feeling life and, thereby, feeling rules are manipulated through discourses that can have the effect of being coercive. Externalizing women's stories involves exploring the delicate tensions between compliance, agency, and resistance in the process of counterviewing and creating helpful counterstories that move beyond the oppressor/oppressed model of power (Brown, 2007c; Brown, 2014, 2017). Counterstories challenge self-management discourse tied to gender performance. In the process of constructing a "nondepressed self," research has found when women let go of unhelpful internalized dominant narratives in relation to caring work, they began to prefer not being constrained by those self-expectations. Women emphasized that "saying no," "letting go," and "self-care" were critical to not experiencing depression. Lafrance and Stoppard refer to this as resisting the "good woman" identity. Women often need to attend to their own needs to construct

a nondepressed self (Lafrance, 2007; Lafrance & Stoppard, 2006). Current research on how women manage depression in their day-to-day lives reveals women's agency and skill in the face of the challenges of depression, and it is important that social work practice encourages women to see the influence they have over depression and to have self-compassion for the depression experiences (Lafrance, 2009). This involves women being able to see how depression may make sense in their lives at times and that they can be both strong and vulnerable as they live their lives guided by a commitment to self-care and compassion rather than self-judgment and blame. At the same time, we equally need to acknowledge that shifting women's experiences of depression requires social changes about the expectations of women, the resources available to them and disrupting the responsibilization discourse.

Conclusion

This article supports feminist findings that resistance to gender expectation and counterstorying depression appears to be central in living outside the influence of depression. I have argued that as emotional experiences are, at least in part, tied to the dominant cultural discourse of self-management and gender, what is often taken up as individual struggle is deeply socially embedded. Therefore, externalizing depression stories such as "I am depressed," "I am weak," "It is my fault," or "I am not good enough" must unpack the inseparability of emotion and meaning within the larger social political culture of meaning making and the context of women's lives. This externalization can allow for alternative discursive practices to emerge that allow for the counterviewing of women's stories about their emotional lives. Alternative ways of storying depression may challenge limiting and oppressive elements of self-management, gender discourses, and depression, as well as acknowledge the ways that depression has influenced women's lives and the agency women have in managing or influencing depression. Feminist narrative approaches to social work practice offer a way to challenge the unhelpful discursive shaping of women's experiences of depression and help to create more helpful and less oppressive counterstories.

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Notes

1. I adopt McCall's (2005) approach to complex intersectionality, which adopts a deconstructive and critical approach to social categories (anticategorical) at the same time that she strategically takes up the interelatedness of the social impact of categories such as race, gender, age, sexual orientation, poverty, and (dis)-ability (intercategorical).
2. Teo's (2008) adoption of Spivak's notion of *epistemic violence* overlaps with Butler's (1997) notion of *injurious speech* and Fricker's (2003) *epistemic injustice*. All these terms illuminate the connection between hegemonic knowledge and power and the corresponding effects of silencing alternative accounts which contribute to and reify marginalization, oppression, colonization, and inequity. Epistemic injustice is a kind of violence that creates injurious speech, demanding that people conform to frameworks and explanations that do not fit and shaping how they can talk about and view themselves. Dominant discourses such as biomedical and empirical social-scientific research on women's mental health while interpretive are treated as facts and often as unquestionable truth. Such dominant discourse is often reflected in labeling, individualizing, pathologizing, and medicalizing women's experiences.

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Author Biography

Catrina Brown is an associate professor and Graduate Coordinator at the School of Social Work and is cross-appointed to Gender and Women' Studies and Nursing at Dalhousie University. Her work focuses on women's health and mental health issues, including "eating disorders", substance use problems, depression, trauma and post-trauma within a feminist postmodern/narrative lens. Her work centers on integrating critical theory into direct practice which is illustrated in her two co-edited books, *Consuming Passions: Feminist Approaches to Weight Preoccupation and Eating Disorders* (with Karin Jasper, Second Story Press, Toronto) and *Narrative Therapy. Making Meaning, Making Live* (with Tod Augusta-Scott, Sage, Thousand Oaks, California). Together Dr. Judy MacDonald and Dr. Catrina Brown are co-editing a book with contributors from the Dalhousie School of Social Work entitled *Critical Clinical Social Work: Counterstorying for Social Justice*. She is a private practice psychotherapist adopting a feminist, narrative, discursive and collaborative approach. She has contributed to a number of significant edited collections including Social justice and counseling (2018) edited by Pare and Audet; Doing anti-oppressive practice: Building transformative, politicized social work edited by Baines (2017) and Women voicing resistance. Discursive and narrative exploration edited by Lafrance and MacKenzie-Mohr which received the Distinguished Publication Award of the Association for Women and Psychology. She has also served on the Editorial Boards of a number of journals: *Narrative Work: Issues*, *Investigations, and Interventions*; *Journal of Systemic Therapies and Gender* and *Women's Studies.*