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Experiencing the Meaning of Depression: Gender, 'Self' and Society

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by

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Julie Killingbeck

CHAPTER ONE

Introduction: Experiencing the Meaning of Depression:

Gender, 'Self' and Society

'I have finally accepted a medical diagnosis of clinical depression. I did not choose to take anti-depressants which were offered but did get the chance to access counselling. I can't put into words the feeling of despair and desperation, a feeling beyond comprehension; I felt like I was just hanging on by my finger nails, waiting to go quietly but screaming into some dark abyss that would lose me forever.

The tiredness and fatigue only fuelled the confused thoughts and negative cycle of self loathing. Everything seems so hopeless and pointless and I fully appreciate why people self harm or attempt suicide. I could just disappear, go far away where no one will know me and I won't have to try and be 'me' because that is lost to me right now. Thank God for my children, they keep me going. I felt quite sorry for the counsellor, having to sit and listen to me, tearful for no apparent reason, and struggling to answer the simple questions. My thoughts charging around my head, refusing to order and make sense, just a jumbled mess of nomadic thoughts, refusing to be reined into some sort of coherent sense. His easy non - judgmental manner calmed me and I found myself talking to him about things that I have long buried, pent up frustrations and why everything was so hopeless; so full of regrets for so many

things, the way I found myself in this state. But now I wonder, where am I in all this because if I was here I would not put up with this, I would take action, make decisions, tackle things head on, yet this 'self' the savior of 'me' is nowhere to be found at the minute – the odd glimmer now and again, quickly extinguished by waves of despair and hopelessness. I wish I could see a way forward, I just see a slog of getting through days'.

The narrative above was written by me, after the first session of counselling I received for what was diagnosed as clinical depression. Reading it back now, it's hard to believe that it is me. It certainly is not the 'me' of today. The diagnosis came as no surprise to me; I was 41 at the time but have experienced depression, to varying degrees many times over the years, probably, in hindsight beginning in my childhood. I have actively resisted being medically diagnosed with depression over the years, largely because I recognised the social stigma, the inherent assumptions about the individual that accompany the diagnosis and it was not how I felt about myself, it was not how I wanted others to perceive me. Up until recently I have kept my depression from most people, except those I trusted to not change their opinion of me, these were people I respected to understand what depression means and not to judge me in terms of my propensity to experience it. However, I have finally reached the stage where I can accept that my depression is a part of my 'self'.

Perhaps this is where my interest in mental illness in general, and depression in particular, stemmed from after I started as a 'mature' student in academia. This interest has culminated with the production of this thesis.

The brief autobiography has sketched out the influences of my background on the study and the reflexivity involved throughout the research process (Butler, R. 2001; Letherby, 2003). This is to recognise at the onset that this thesis has emerged out of my interest to better understand the phenomena of depression, and its impact on individual identity. I did not start out thinking I knew the answers to depression, on the contrary, I was looking to gain a deeper understanding of the experience and hoped to raise the awareness of the impact that depression has on individual lives. The interviews conducted as part of this study allowed individuals to tell their individual stories, each unique. This reinforced to me the fact that depression as an illness experience can have a profound impact upon 'self' and self-identity.

Depression can be devastating and its effect should not be understated. As a medical condition, depression is characterised by a distinct set of both physical and mental symptoms (ICD-10- see Appendix 1). However, the reality of the experience of depression is one that affects all aspects of an individual's life, the complexities of which can not be captured by reference to a list of symptoms. Individuals do not 'have symptoms' they experience the impact of bodily and mental changes:

they experience illness; in this sense depression can be recognised as an embodied experience of 'self'. Physical symptoms aside, depression is typically experienced by individuals in the first instance as frightening and threatening, a period often characterised by a tangible shift in self-identity that can range from initially 'not feeling oneself', to the subjective experience of a 'loss of self' (Karp, 1996; Charmaz, 1991).

This thesis will examine the meaning of the experience of depression for individuals and their sense of 'self' and self-identity. It will also explore the complexities and intricacies surrounding identity issues that emerge from the research. By developing a new approach to understanding the experience of depression and extending key theories in the field of identity, illness and gender, the thesis will explore the three key themes to emerge from the study. These themes are inextricably linked and related to issues of 'self', and self-identity. These themes are; the relational aspect of 'self' and self-identity; the embodied nature of depression as an illness experience of 'self', and the agency of individuals to resist and/or negotiate the ascription of social identity categories as definitive, totalizing aspects of 'self'.

The approach to understanding depression developed throughout the thesis illuminates aspects of depression that would otherwise not be considered. Furthermore, the experience of depression can help further our understanding of the complexities and intricacies of identity and highlight the ability of individuals to resist or negotiate the ascription of identity categories.

Theorising Mental Health

The majority of existing theories of depression in the field of health and illness rely heavily upon the concept of gender as a causal factor in the experience of depression (Busfield, 1996; Prior, 1999). As women have higher rates of diagnosed depression then it is assumed that the female gender identity (whether acquired through the undertaking of gendered roles, or socialisation into the female gender identity) is the key factor in their experiences. Gender, or in particular, the female gender identity- 'femininity' is reified as the 'why' of depression and has dictated the lens through which social research into the experience of depression should focus. This approach substantially and consistently reinforces the concept of depression as a distinctly 'female malady' and denies many men the legitimacy of their depression experiences.

If, however, as the research findings presented here suggest, we accept that gendered identity categories (female/male) have no essential nature; can we legitimately proceed to investigate evidence of their existence in terms of their impact on the experience of depression? Has research to begin on the premise they exist, whether as essentialism or constructivism, when they do not conform to either and are merely prescriptions of behaviour, morally charged, socially sanctioned and policed, and subjectively negotiable only within a social and political parameter? The continued reliance of this approach may be doing more harm than good for future theorising. It will be argued that to enrich our understanding of the depression experience research should be aimed

at investigating what identity *means* to individuals in terms of its impact on experiences of 'self' and self-identity.

It will be suggested that there should be a conscious recognition of the complexities of the subjective experience of identity, along with awareness that 'self' and self-identity can be multi-faceted and changing, meaning different things to different people. Focusing upon gender, which is but one aspect of self-identity, highlights the limits of proceeding to investigate depression and its impact upon 'self'. How legitimate is it to isolate one aspect of identity- gender, and focus upon developing a theory to account for its impact?

Identity & Depression

In more general terms of 'self' and self-identity, the work of theorists such as Karp, (1996) and Charmaz, (1991) examine either depression (Karp) or chronic illness/disability (Charmaz) in relation to its impact upon self-identity in general. As will become evident, both theorists argue that the impact of depression or chronic illness on an individual's sense of 'self' and self-identity results in the emergence of a new identity, a 'depressive identity' or a new identity that is (re)defined in relation to the illness/disability. However, contrary to this view, the findings from the research suggest that this is not necessarily the case in relation to depression. Individuals may accept depression as a part of their 'self' and self-identity, but importantly they refuse to be defined by their depression. Furthermore, they may actively negotiate where the

depression aspect of their 'self' will sit in terms of its relationship to, and impact upon, 'self' and self-identity.

The relative weaknesses of both the approaches above facilitated the account which is presented throughout the thesis. By developing the work of Butler, (1990), in particular in conjunction with the literature around illness and identity, the focus of the thesis has been on individual experiences of depression and its impact on 'self' and self-identity. The central theme throughout the thesis is an examination of the relationship between the 'being and doing' of identity, which for Butler, (1990), has remained largely at a philosophical level. The research study has, for the first time, applied and extended the theory of performance and performativity (of 'doing and being') to the experience of depression. This account hopes to deepen the understanding and meaning of depression in terms of its impact upon 'self' and self-identity, and consequently highlight the complex nature of depression as ultimately an embodied experience of 'self'.

Overview of the Thesis

Chapter Two: 'Identity, Subjectivity and the Experience of Depression', will provide a brief review of the literature surrounding identity categories in general before going on to examine the concept of gender identity in detail. The aim of this chapter is to highlight the extent to which the concepts of masculinity and femininity have been central in the maintenance of gender relations over the centuries. It will assess the

extent to which such categories remain useful in contemporary analyses given the fact that gender as an analytic concept has been shown to be historically and culturally specific. The analysis will highlight the constructed nature of identity categories and expose them as illusionary concepts with no meaning outside of the discourse that constructs them (Foucault, 1984; 1984a; Butler, 1990).

The chapter will then move on to consider the extent to which gender has been influential in the study and theorising of mental illness, highlighting the extent to which depression in particular can be seen to have been systematically gendered over the past two hundred years. This, it is argued, has led to a cycle of gender specific research that has simply reinforced the concept of mental illness in general and depression in particular as a distinct female malady. This approach effectively ignores the large numbers of men who do experience depression and denies them the legitimacy of their depression experiences and serves to render women synonymous with depression. Furthermore, this approach assumes that 'gender' and 'gender identity' are concepts that individuals can and do identify with, and further, that everyone experiences gender in some 'essential' given way.

To avoid falling into similar traps, the focus of the research has been to explore the meaning of depression to individuals in terms of individual experiences of 'self' and self-identity. As such, the thesis begins on the premise that while we are compelled to have identity, we do not

necessarily experience our subjective 'self', or our self-identity as ultimately defined by any one aspect of it, including gender.

Chapter Three: 'Methodology', will provide an overview of the historical and philosophical influences on current research methodology. The chapter highlights the essential differences between quantitative and qualitative approaches to the research process. The chapter will suggest that Quantitative research methodologies continue to be inherently influenced by positivist characteristics. As such the approach is not suitable to facilitate a richer understanding of individuals' experiences of depression and its impact upon 'self' and self-identity.

The chapter will then discuss the justification for adopting an Interpretivist methodology and the theoretical underpinnings of the study. It will go on to discuss the research methods adopted throughout the study and provide a brief biographical sketch of the individuals who took part in the study.

Chapter Four: 'The Dilemma of a 'Self': Experiencing the Meaning of Depression', explores the impact of depression on experiences of 'self' and self-identity. Developing and extending the work of Butler, (1990) to the experience of depression, this chapter will explore the impact that depression has on individuals' sense of 'self' and self-identity. It will explore the dilemma many people face when coming to terms with the fact that depression may well be a part of their 'self' and self-identity as

opposed to purely bio-chemical in origin. The chapter will highlight how the relational aspect of Butler's 'being and doing' of identity can be seen as central to understanding the experience of depression and its impact upon 'self' and self-identity.

As will become evident, during the experience of depression there is a breakdown of the reciprocal relationship between the 'being and doing' of 'self' and self-identity. Prior to this breakdown, experiences of 'self' are coherent and cohesive and the performance of identity is performative on both a subjective and social level. At this point individuals' experience what they regard as an 'authentic self' that is characteristic of their 'self' and self-identity. However, during depression the breakdown of the relationship between 'being and doing' identity results in individuals becoming consciously aware of the 'doing', or, the performance of 'self' and self-identity socially. At this point the coherence and cohesion that characterised experiences of 'self' and self-identity before depression are lost. It is at this point that individuals articulate what they are experiencing as a perceived 'loss of self'.

While the experience of a 'loss of self' may be frightening and threatening in the early stages of depression, once an individual has received and accepted a medical diagnosis of depression it can offer a brief respite period. At this point individuals may see the experience as a medical illness with little relation to their 'self' and self-identity. However, if and when depression returns in the future, individuals may well come

to accept that depression is a part of their 'self' and self-identity. This process can be seen as having three stages; the acceptance of depression as 'part' of 'self', the (re)negotiation of 'self' and the subsequent emergence of a 'newly aware self'. The 'newly aware self' is the result of the synergy created by accommodating depression as a part of 'self' and self-identity and is experienced as more in control of the experiences of 'self' and self-identity in the future.

Chapter Five: 'The Social Nature of the Depression Experience', focuses on the impact that the social sphere has on individuals' experiences of 'self' and self-identity during depression, in particular, their 'willingness' to fully embrace depression as part of their 'self' and self-identity. It begins by highlighting the social stigma that continues to be associated with depression and the influence this may have on general perceptions within society of the legitimacy of depression as an illness identity. The chapter then explores the impact that this can have on individuals who experience depression.

By further developing and extending the work of Butler (1990) and Jenkins (1996) the narratives of individuals who have experienced depression will highlight how the social censure of depression as an identity or an illness category within the social sphere can, and does restrict individuals' willingness to fully embrace depression as part of their 'self' and self-identity on a subjective level. Some of the key issues around the perceptions, social legitimisation and the possibilities for 'self'

on a social level will be explored in relation to research findings from Disability Studies.

The chapter will also highlight that while it is possible to recognise the crucial role that society has in the legitimization and sanctioning of identity categories on a social level, individuals can and do actively resist being defined by identity categories. Moreover, the influence of the social arena is not always the key factor that determines whether individuals are subjectively defined by identity categories. On the contrary, the narratives of individuals who experience depression presented within this thesis suggest that the social sanctioning of identity is not always sufficient to ensure the subsequent incorporation of identity categories as definitive aspects of 'self' and self-identity.

Chapter Six: 'Gender's Impact on 'Self'', During Depression explores the impact of gender on subjective experiences of 'self' and self-identity during depression. The chapter takes as its starting point the fact that we are compelled to have identity and that we may be compelled to have gender. However, it begins on the premise individuals' subjective experiences of 'self' and self-identity may not necessarily be defined by gender.

The narratives of the individuals taking part in the study are utilised throughout the chapter to highlight how some of the most dominant discourses surrounding the concept of gender and its influence upon the

experience of depression are reflected in the discourses of those taking part in the study. The chapter also examines the impact of gender roles and gendered identities on the subjective experiences 'self' and self-identity during depression.

As will become evident throughout the chapter, the experience of depression and its impact upon experiences of 'self' and self-identity may lead to individuals becoming consciously aware of gender and its impact upon their experiences of 'self' and self-identity (both subjectively and socially) for the first time during the experience of depression. The subsequent recognition that gendered social roles and gendered identities are externally imposed onto individuals, rather than a reflection of 'natural' gender identity offers individuals a further possible site of resistance to the ascription of identity categories. In this case, the opportunity to resist their experiences of 'self' and self-identity being defined and dictated by gender, both subjectively and socially.

Chapter Seven: 'Conclusion', brings together the key ideas presented within the thesis, highlighting how the study has further developed and extended the work of Butler, (1990), Jenkins, (1996) and Karp, (1996), to provide an account of the experience of depression and the impact it has on subjective and social experiences of 'self' and self-identity. The development of the theory allows for a deeper understanding of the complexities and the intricacies that are characteristic of the depression experience and its impact on 'self' and self-identity.

It is important to recognise, as the evidence suggests, that individuals do have the agency to resist being defined primarily in terms of socially constructed identity categories. It is also important to note that individuals can and do actively negotiate where identity categories will sit in relation to their subjectively experienced sense of 'self' and self-identity as well as their expectations and aspirations for 'self', and self-identity in the future.

The thesis will then suggest opportunities for applying the theory developed throughout the study to further research areas for scholars of identity. If gender and depression are aspects of 'self' that can be negotiated and performed, then it follows that other aspects of 'self', and self-identity can be performed with individual agency to resist the ascription of identity categories that are restrictive and definitive in terms of 'self' and self-identity.

CHAPTER TWO

Identity, Subjectivity and the Experience of Depression

The following chapter will provide an overview of the role that socially constructed identity categories can be seen to have on both individual and social experiences and expectations of 'self' and self-identity. It will then provide an in-depth account of how these identity categories are historically and socially specific, inherently political, and posited as central to our individual perceptions and experiences of 'self' and self-identity. It will achieve this by focusing specifically upon the identity category that has been identified with much theorising as a key defining aspect of experiences of 'self' and self-identity: the concept of gender.

The chapter will then discuss the central role afforded to the concept of gender in theories of mental illness in general, and depression in particular. In conclusion it will be argued that to gain a deeper insight into the subjective experience of depression it is necessary to listen to the experiences of both men and women. As such, the focus of the research presented within this thesis is the impact that depression has on individual experiences of 'self' and self-identity. The chapter will conclude that while we may be compelled to have identity, it does not automatically follow that we experience ourselves primarily in terms of gender. As such, any account of depression which aims to understand the complexities of the depression experiences should avoid being

drawn into theoretical assumptions that individuals necessarily experience their 'self' as inherently gendered.

Self-Identity

Identity categories are utilised as a means of classification within the social world. By assigning individuals to a particular category we subsume ambiguity, reinforce predictability and as such, create stability in the social order (Butler, 1990; Woodward, 1996; Jenkins, 1996). Identity categories can be, among other things; constructed, utilised, legitimized, negotiated, discarded, negated, privileged, reified, accepted and rejected all within society, and all through the complex interplay between the need to make sense of our social world and the perceived need to give meaning to our 'selves' (Eriksen, 1993; Jenkins, 1999; Roseneil & Seymour, 1999).

It is in the fundamental fabric of ideas about 'being yourself' that feelings, emotions, likes, dislikes, loves and hates are embedded and constitute the many experiences of 'self'. Friend, partner, colleague, or parent are just a few of the plethora of interconnected and interwoven roles that orbit our ideas about who we are in any one instance. Within each of these roles are individual ideas and expectations associated with 'being' in the role which in turn influence how we expect to experience these differing aspects of our identity, prescribing our ideas of 'normality' for 'self' and self-identity. For example, gender as an identity category establishes and 'normalises' a wealth of interrelated

behaviours and experiences that are associated with being a man or a woman (assertive,/passive, irrational/ rational and so on). These then influence how we think we should act and feel within other roles we occupy (Oakley, 1997; Connell, 1995). For example, the social role of 'parent' is gendered in as much as there are different expectations associated with being either a 'mother' or 'father' on both a social and individual level. These expectations then impact upon an individual's experience of 'self' within that role. The role of gender on experiences of 'self' during depression will be discussed further in Chapter 6.

People generally have a reference point about their 'self'; it is against this that they measure their ideas about 'core selves' – 'I'm an out going person' and so on. While going about their usual day-to-day life their expectations of self will vary within the differing roles they occupy during the course of their day-to-day lives. It is through the adoption of identity categories for self and others that 'normality' is shaped into existence and our 'selves' and our experiences are given meaning within society.

Identity Categories

Gender, ethnicity, age, disability, class, sexuality, are just a few of an array of categorisations we utilise on a daily basis in order to make sense of others, ourselves and ultimately, society. Recent developments within the social sciences reflect this emergent apparent need for self-reflection. A wealth of research and publications seek to make sense of society's concern with self-identity, highlight the political nature of identity categories, whilst simultaneously aiming to increase our

understanding and knowledge about the dynamics of the relationship between self, self-identity, and society; to name a few: Butler, (1993); Eriksen, (1993); Butler & Parr, (1999); Giddens, (1991); Hall & du Gay, (1996); Roseneil & Seymour, (1999); Woodward, (1997); Hockey & James, (2003); James & Hockey, (2007).

However, questions concerning the nature and experience of 'self' and self identity are not exclusively a feature of 'modern' society. Rather, ideas of 'self' and self-identity are culturally, historically and ideologically specific in the context in which they are rendered comprehensible (Mauss, 1938; Foucault, 1984; Logan, 1987). Although the concept of 'self' may have been conceptualised in a variety of guises; soul, essence and so on, there appears to have been a consistent tendency to see the 'self' as the central, defining feature of an individual throughout history (*ibid*).

Recent developments within the social sciences have witnessed the notion of a fixed, stable, core identity that is definitive in the constitution of individual identity lose credibility (Foucault, 1984; Butler, 1990; Hall, 1996). Rather, the complex and dynamic processes involved in identity formation have been highlighted, and the fragmented, in-process nature of subjective self-identity acknowledged (Giddens, 1991). Identity

construction is perceived not only as an active process, but also a conscious one:

“Identity is not ‘just there’, it must always be established”

(Jenkins, 1996:4)

Depending on the perspective involved, the apparently crucial importance afforded to identity at the present time can be argued to be either, a characteristic of ‘late modernity’ or ‘risk society’ which has manifest a ‘crisis of identity’ (Giddens 1991), or, as a definitive aspect of the ‘post modern’ world, where the notion of ‘identity’ (and the subsequent subjectivity that is alleged to accompany its incorporation) is perceived as socially constructed through discourse, given meaning and substance through a complex interplay of discursive practices (Foucault, 1984; Butler, 1990).

Structuralism & Late Modernity

The Structuralism approach asserts that the ‘self’ has taken on increasing importance in ‘late modernity’ (Giddens, 1991). The perceived stability of the social world is allegedly called into question as tradition and the notion of certainty and continuity begin to lose credibility. The continued expansion of Capitalism, the emergence of trans-national companies, changes from manufacturing based economies to service based economies and the restructuring of employment possibilities in

relation to work/paid employment, have all served to undermine ideas of a 'job for life'(Woodward, 1997:16-18).

The accompanying 'consumer culture' and an array of mass media have facilitated both a global and a local awareness of the 'self' in an unprecedented manner (Freidman, 1990). The cumulative effect of these processes, it is argued, leads not only to a rise in the importance afforded to 'individuality', but also the perception of 'self' as a reflexive project', for which the individual is responsible" (Giddens, 1991:75). As established identities are increasingly perceived as under threat, the more important it becomes to salvage or negotiate a new identity (Eriksen, 1993:76).

The 'reflexive' self is constantly monitoring their individuality, anticipating the need for adaptation. 'Self' monitoring is not however, conducted to achieve a deeper understanding of some 'authentic self' through self-reflection. Rather the object of the exercise is to consider the 'self' you *could be*, with the "aim of building/rebuilding a new coherent and rewarding sense of identity" (Giddens, 1991:75).

For Structuralism then, the present day 'reflexive self' is conceptualised as the result of progressive historical and cultural change which has influenced how individuals relate to their 'self'. Self identity is not a fixed, central defining quality that constitutes the individual; on the contrary – the individual actively constitutes self-identity. Increasingly, and in an

unprecedented manner, we are inundated with possible selves, called upon to reconsider who we could be, enticed with the possibility of fashioning a 'self' of our choosing (Roseneil & Seymour, 1999).

However, it is important to note that not only has identity taken on a whole new meaning in the present day, it has also been politicised in an unprecedented manner. Certain identities are not readily available to all, to be moulded and negotiated without implications; implications that can have a direct impact on the legitimacy of self-identity. Britton, (1999) for example, highlights that for certain 'Black' 'British' individuals, the legitimacy of their identification as 'British' is denied as a direct result of their skin colour being 'non-white'. 'British' as an 'identity' then, is bound up within the politics of exclusion, and not readily available to all. As Roseneil & Seymour, (1999:2) note:

"All identities are not equally available to all of us, and all identities are not equally culturally valued. Identities are fundamentally enmeshed in relations of power".

Post-Structuralism & Identity

It is the very same 'relations of power', that proponents of Post Structuralism seek to highlight when theorizing identity (Pilcher & Whelehan, 2004; Weedon, 1997; 1984; Smart, 1985). Refuting the notion of some 'essential self' and the idea of a unitary definitive 'self',



the Post Structuralism account posits the concept of 'identity' as fragmented and multi-faceted.

Furthermore, Post Structuralism begins by questioning the very concepts of individualism and identity, by relocating the analytic gaze away from that which appears self evident (i.e. the existence of the 'individual' and the preoccupation with 'identity'), to the processes involved in the production of such 'reality' initially (Foucault, 1984, Butler, 1990). A central element in this approach is the deconstruction of the concept of identity in all its guises, and the exposure of the discursive practices within which identity's perceived legitimacy is articulated. The aim of post-structuralism then is to direct attention to the powers invested in the discursive constitution of identity categories, and importantly, the political significance of 'difference' (McNay, 1992).

Identity & Difference

"Above all, and directly contrary to the form in which they are constantly invoked, identities are constructed through, not outside, difference".

(Hall, 1996:4-5)

The re-conceptualisation of identity categories as constituted through difference highlights the inherently political nature of identity and, in doing so, uncovers the powers invested in their constitution.

The constitution of any 'identity' entails, as a prerequisite, a marking of boundaries to establish exclusively what it is not (Eriksen 1993; Hall, 1996; Woodward, 2000). The boundaries that render identity intelligible, by providing a reference for identification, simultaneously 'mark' 'difference'. This process has the effect of not only excluding that which it is not – it also has the effect of 'marking' the identity outside of itself – in relation to itself. The resultant polarization invites not only the appearance of opposites, but also a definitive hierarchy. These binary oppositions, e.g. woman/man, black/white, good/bad and so on, when articulated within the discursive power relations characteristic of wider society, assume the appearance of opposites.

This in turn fosters not only perceptions of difference, but also ideas about legitimacy and perceived superiority. One side as 'normal' and 'good', the other side as constituting what is 'not normal' and by definition 'not good' (Hall, 1996:5). The resultant construction of the 'Other' this ensures, reinforces the apparent 'natural' nature of identity and legitimises identity boundaries as discrete and distinct, when in reality they are social constructs rendered tangible through dominant discourses.

The fact that we are compelled to 'have' identity reinforces the need to identify what we are, real or imagined. Identification with a particular category may be the result of perceived similarity with a group, based on difference (Jenkins, 1996; Eriksen, 1993). This similarity may only be

comparative 'sameness', and not identification. However, what the individual believes they are *not* may underscore similarities and serve to reify the notion of a distinctiveness of the self as unique: simultaneously similar and different. However, while both socially and politically identity categories can be central to definitions of 'self' in subjective terms, they can also be recognised as having their foundations in the social sphere (Jenkins, 1996).

Social self and social identity

For Jenkins, (1996) 'self' and 'identity' are constituted in and through social interaction. Identity formation is the result of the relational dynamic of reflexivity between the 'internal and external dialect' (Jenkins, 1996:50). Put simply, it is not enough to assume an identity, rather the incorporation of a social identity into a 'self-identity' involves the complex social interplay of legitimating and validating the identity the individual seeks to adopt on a social level.

This projection of social identity may involve behaviours, speech, dress and so on, all of which foster life to social categories, which in turn, once accepted (or rejected) socially, has the reflexive capacity to give meaning and substance to 'self'. It is, according to Jenkins, (1996:50-51), through the experience of identity and social identity that the 'self identity' is rendered comprehensible to 'self'.

This theory can be seen as reflecting Butler's, (1990) ideas around the 'doing' of identity, through the individual's 'performance' of roles that are pre-scripted within society. The social aspect of identity, the 'doing' of identity, creates, for Butler, the appearance of 'being', evoking ideas of essentialism, when in fact, 'there is no doer behind the deed' (Butler, 1990:). However, where Butler can be criticised for denying individuals' agency, Jenkins,(1996) allows a focus on how and why individuals take up and invest in certain identities, and further, how the subjective 'experience' of identity is crucial; an aspect that is lacking in Butler's account.

Subjectivity and identity

For Jenkins, (1996:48-49) the self is a *primary* identity on which all other identities are anchored. Self-hood is established from infancy as a result of social interaction and experiences. These experiences help to ground knowledge of 'self' and provide a base for more complex subjective identity formation:

"Self-identification involves the ongoing to-and-fro of the internal-external dialectic".

Jenkins, (1996:50)

Identities for Jenkins, have their base in the social world and the social interaction of individuals constitutes the experience of 'self', as a result of mediation/negotiation through the *primary* self. This theory reflects

the ideas of de Beauvoir (1949) and allows for a 'self' that is malleable; in a very real sense, one becomes 'oneself' through the complex relationship between the reflexive dynamics of the experience of social interaction and the experience of self.

While it is possible to recognise that ideas of 'self' and 'identity' are inextricably linked to social interaction, as detailed by Jenkins, (1996); Mead, (1934); deBeauvoir, (1949), care should be taken to avoid replacing biological determination with social determination and subsequently imposing a measure of 'essentialism' on the concept of identity. Butler, (1990), also stresses the manner in which social aspects of identity, the 'doing of identity', invariably evoked notions of essentialism in one form or another. Self-identity may be socially constructed and maintained, but it does not need to rely on the notion of an 'inner self' that is a definitive and determining aspect of self identity. This can be unhelpful in terms of theorising possible sites of resistance and agency for individuals who are assigned to particular identity categories, with little or no choice, for example, gender and/or ethnicity.

However, as discussed earlier, developing Butler's, (1990) key ideas around the 'performance' of identity, allows the location of identity categories to the social sphere without the ascription of some 'essential' self: where the 'doing' of identity is perceived as 'evidence' of 'being', of interiority, when in fact the 'deed' is everything (Butler, 1990). While Butler's theory may deny agency, it does allow for identity to be

theorised taking into account the crucial role that social interaction has in identity formation: experiences in the social world can influence whether identity is granted or denied legitimacy, both on a subjective and social level.

However, the social processes involved in the construction of self-identity are not necessarily as clear-cut as simple acceptance/rejection on the part of the social/individual level. As discussed earlier, not all identities are equally available to all; identity is highly political and fraught with constraints.

The constraints on the availability of identity categories have been well documented in research surrounding gender, ethnicity, age, disability and so on (Butler, 1990; Eriksen, 1993; Roseneil & Seymour, 1999). However, while notions of 'self' and 'selfhood' may be central in the social and subjective experience of 'self', ideas about 'who we are' in terms of 'selfhood, identity is not only experienced on a social level. People do foster ideas of a 'core self', and this suggests that Jenkins concept of a *primary* self may have some theoretical credence. Jenkins sees this *primary* self as being:

"...understood as offering a template for all subsequent identities, offering a stem stock on to which they are grafted"

(Jenkins, 1996:49)

The way forward?

This poses potential as a starting point for theorising the impact of depression on self identity for the following reasons:

- It avoids reverting to 'essentialism' while addressing the fact that people do have ideas of 'authentic self', which will be discussed below;
- The theory allows the multi-faceted nature of identity to be theorised in relation to the complex interplay between the social and individual: that is, *the experience* of identity can be explored;
- It allows *the experience* of depression to be explored by allowing the recognition that not only is identity multi-faceted, but our experiences of 'being' and 'doing' identity are influenced by social expectations;
- Finally, and perhaps more importantly, subjective experiences, the 'being' of 'doing' identity can be explored without privileging certain identities, i.e. gender, as the central defining, determining feature of 'self'.

This account of a primary identity is useful to comprehend the changing and multi-faceted nature of self-identity and the manner in which the individual 'self' can negotiate and shape the experience of identity. Social identity in this light can be seen as reflexive and malleable, rather than static categories with little room for subjective interpretation of what it *means* to have identity.

The individual interpretation of identity may or may not be accepted socially, but does allow for resistance, choice and importantly, agency. For example, the choice (which may be constrained, but remains a focal point of resistance) of how to 'do' identity, or accept/reject certain aspects of an identity highlights that there is no 'essential' quality, identity is multi-faceted; changing and evolving, constantly shaped by experience. While experiences of each facet of identity will be different, the 'experience' of identity is mediated through ideas of an 'authentic self'.

The 'authentic self' or, the 'being' of identity can be recognised as the social and individual expectations and aspirations that substantiate the experience of 'doing' identity¹. The relationship between the 'doing and being' of identity is what transforms the 'doing' or, 'performance' of identity, into a lived, subjective experience of 'self' that is experienced as 'being', as the 'self' of identity'. Importantly, when the 'doing' of identity fails to elicit the previous subjective experiences associated with 'being' to validate the experience, then self-identity, and 'self' may well be experienced as 'lost'.

Summary

Identities as individual subjective realities, are socially created / constructed, and may, to a certain extent, be negotiated, through discursive practices. They may appear wide-ranging and all

¹ These can be recognised as having their foundations in Butler's, (1990) social scripts, or, the social sanctioning and censoring that accompanies the social construction and legitimisation of identity categories.

encompassing, but in reality can be limiting, restrictive and highly political (Roseneil & Seymour, 1999). A crucial point however, is the fact that identity and self-identity involve the perception of rendering individuals and their behaviour coherent and predictable (Jenkins, 1996). Furthermore, identities can only gain meaning and legitimacy with individuals who are willing to invest in them.

Whether 'self-identity' or 'gender identity' is socially constructed or socially compelled, essential or non-essential in nature, or, only given meaning through discourse, for identity to '*be*', *it has to be experienced* as identity on a subjective level: it has to be subjectively acknowledged as 'self', and accepted as 'self-identity'.

This is where social theory can lack the sophistication to account for 'self' and 'self-identity' as subjectively experienced. This is especially the case when experiences of 'self' and the 'doing' of identity become problematic, as is often experienced on a subjective level during the experience of depression.

Problematisations

The idea that identity categories shape both experiences and perceptions of 'self' has been criticised as side-stepping the issue of how and why notions of 'self' and identity categories are constructed and the political aspects involved (McNay, 1992; Foucault, 1984; Hall, 1996; Roseneil & Seymour, 1999). It is argued that while theory may expose

the manner in which identity is constructed within a range of discursive possibilities, the idea of 'construction' brings the concept to life, as if it were a tangible reality, simply because it appears to have always 'been' there (Foucault, 1984).

However, this is not necessarily the case as Foucault, (1984) highlights, 'identity' has not always 'been there', on the contrary, the very notion that 'identity' has to be 'thought about', dwelt on; the fact that we are compelled to think about ourselves as defined by an 'essential self' and judged by a 'moral self', has not always been the case (*ibid*). The emergence of the concept of 'self' and the subsequent rise of 'individualism' has created the climate for the 'natural' nature of identity to be inscribed on an individual level. The fact that identity cannot exist outside of discourse does nothing to detract from the 'reality of self' that individuals experience on a subjective and social level.

People do seek to make sense of their 'self' and society and they generally do this by reference to some idea of an inner self that is unique, unitary, bounded and experienced on a subjective level as 'authentic': it is how individuals navigate both their inner and social worlds. This does not, however, mean that theory has to take as its starting point the existence of 'self' in essential terms. Rather, it is important to acknowledge that individuals are 'compelled' to have identity; this does not detract from the fact that it cannot exist outside of discourse. It does not necessarily bring about the 'end of the subject', as

post-structuralism accounts have been accused of, (Salih, 2002:12-14), rather, it places the 'subject' and the experiences of the 'subject' in the centre of theory.

The following section will then provide an in-depth account of how identity categories can be seen to be not only historically and socially specific, but also inherently political. The section will examine how certain identity categories become established as a 'natural' and an essential part of 'self' and self-identity. Once established these concepts are posited as definitive aspects of 'self', something we have little choice in, as they are legitimised and sanctioned socially as 'natural' experiences of 'self' and self-identity. It will achieve this by focusing specifically upon the identity category that has been identified within much theorising as a key defining aspect of 'self' and self-identity and instrumental in experiences of 'self': the concept of gender.

Theorising Gender

"Gender connects to everything, and everything is gendered."

(Synnott, 1993:41)

The following section will provide a historical account of how constructions of gender as an identity category have become entrenched within much theorising within the social sciences. It will also highlight the extent to which identity categories can be seen to be

culturally, historically and politically significant when sanctioned and legitimised through the dominant discourses within society. Further, the extent to which the concepts of masculinity and femininity have been central in the maintenance of gender relations within the wider socio-political arena will be discussed, along with an assessment of the extent to which such categories remain useful in contemporary theoretical analyses of identity.

Gender Studies

Gender studies, the study of masculinities and femininities has, in recent years, been most notable for the extent to which it has highlighted the elusive nature of the very concepts it seeks to define and analyse.(Butler, 1990; 1997; Fuss, 1989; Hearn, 1996; Petersen, 1998) Indeed, research has, perhaps, been most fruitful in the manner in which it has highlighted the extent to which our knowledge of the relationships between the two sexes continues to be based on the search for difference; whether as 'essence' or 'sex-roles'(*op.cit.*). The search continues for very good reasons, as much feminist theory has shown consistently over the years the extent to which the relationship that exists between the two sexes is permeated with power differentials. These act to place 'females' in an oppressed social position, characterized by discriminatory practices that rest on assumptions of 'natural' differences which are articulated to ensure the justification and legitimization of the 'natural' social order (Walby, 1990; Oakley & Mitchell, 1997; Humm,1992). As the vast array of research continues to

search for the manner in which these concepts shape our social existence it also highlights the extent to which masculinity and femininity are matters of both social and political concern.

The search for causal explanations which seek to address this power differential generally follows this trend, and the study of gender usually, though not exclusively, (Butler, 1990; Fuss, 1989; Connell, 1995) involves the study of 'femininity' or 'masculinity' as distinct and oppositional categories, wherein the perception of one is relational to the other.

The Historical Context

This section will provide a brief outline of the construction of masculinity and femininity as the basis for gender differences in a historical context to establish the foundation for a critical evaluation of current theories of masculinity and femininity. The discussion will then move on to examine the relative usefulness of these categories in contemporary analyses of gender, and suggest that there appears to be a need to move away from normative categories such as 'masculinity' and 'femininity', towards an approach which can account for difference in a more beneficial manner in future research projects.

Initially though, it is of crucial importance to establish what 'gender' as a concept for analytical purposes within this thesis will mean, and highlight

the distinctions between concepts that will be utilised throughout the paper, namely; sex, gender, and gender identity (femininity/masculinity).

Sex, Gender & Gender Identity

Sex, gender, and gender identity are terms that are salient within theorising gender relations, although, as will be seen, how these terms have been conceptualised in relation to the alleged differences between the sexes, has been subject to various definitions. The one constant factor though, has been the extent to which the terms have been articulated to divide the biological bodies within societies as distinctly different corporeal entities, and provided the basis for the categorisation of the sexes into male and female (Laqueur, 1990).

Sex, the biological corporeality of the body as male or female, judged by evidence of the corresponding external genitalia as defining a male or female body is generally regarded as evidence of a 'natural' order of difference, and a defining feature of the 'sexes' (Butler, 1990; Oakley, 1972; Laqueur, 1990). The significance of external bodily appearance is allegedly supported by reference to chromosomal and hormone differences between the two sexes (Oakley, 1972; Shilling, 1993). These apparent differences have not only been utilized to polarize the sexes, but also to assert and institutionalize heterosexuality as the 'normal' expression of sexuality; that is, a 'natural' desire for the opposite sex (Butler, 1990).

Gender is the term which is used to distinguish the sexes as different by reference to behaviours, personality traits, and the social roles that are believed to correspond to one's biological sex (Oakley, 1972). A clear dualism is evident which typically privileges the male gender; masculinity, whilst simultaneously denigrating the female gender, femininity. The male gender is alleged to be: rational, independent, strong, intellectual, and associated with the mind and reason. In contrast the female gender is considered; irrational, dependent, weak, both morally and intellectually inferior, and associated with embodiment and emotional weakness (Synnott, 1993; Bailey, 1993; Oakley, 1997).

Gender identity can be defined as an individual's sense of their 'self' as either male or female (Oakley, 1972; Connell, 1985)). Gender identity has typically been conceptualized as mirroring the biological division between the sexes. As such, masculinity has become institutionalized as the 'natural' identity a male should identify the 'self' with (*ibid*). Conversely, it is asserted as 'natural' that females identify their sense of 'self' with femininity. However, this is not always dependent on the biological sex of the body, that is, a 'male' body does not automatically ensure the identification of an individual as 'male'/'masculine' or 'female'/'feminine'. However, the extent to which gender identity and biological sex have been politically utilized to naturalize the polarizing of the sexes as opposites, and inherently heterosexual, is evident from the manner in which any deviation from what is constructed as 'normal', in relation to gender identity, sex, and sexuality, has historically, been categorized as

deviant, targeted as a social 'problem', and subjected to various attempts at control by political intervention ² (Foucault, 1970 :43; Plummer, 1981: 63; Weeks, 1989). As such, male body/masculine gender identity, and female body/ feminine gender identity and 'natural' opposite sex desire are conceptualized as 'normal' (Butler, 1990).

To summarise, sex, is generally taken to refer to the biological materiality of the body; gender as a set of behavioural and personality traits that distinguish males from females; and gender identity is usually taken to refer to an individual's sense of themselves as male/masculine, or female/feminine.

In Western societies, sex, gender and gender-identity are central to the social organization of the sexes. It is taken as unquestionable that there exists two distinctly different biological bodies, and this fact is utilised as the basis for arguments; both in support of natural differences, and by those who stress the role of social expectations in gendering bodies. However, it is important to note that what we regard as 'fact' is by no means necessarily unquestionable. Rather, our interpretation of gender is the product of a distinct epistemological basis that is culturally and historically specific. This is highlighted by the manner in which conceptions of gender relations have changed throughout history.

² This is clearly evident in the manner in which same-sex desire became categorized as characteristic of a deviant individual, a distinct pathological form of sexuality within Western society in the nineteenth century. See Foucault, 1978.

Sex, Gender & Gender Identity: The Historical Context

The only stable characteristic of the relationship between the sexes throughout Western history has been the privileging of the male/masculine identity in relation to the female/feminine identity. The notion of two distinct biological sexes is a relatively recent concept (Laqueur, 1990). However, gender, as defined by the presence of different and oppositional male and female identities, has a long and sustained history (Synnott, 1993).

This ideology can be traced back to early Greek philosophy, notably in the distinctions evident within the binary tables of opposites put forward by Pythagoras, who, according to Synnott, (1993: 40) "... institutionalised the theory of the two sexes as opposite". The symbolic nature of the tables ; that 'man' is all that 'woman' is not; good, pure, and as such, superior, provided justification for the ordering of the sexes in a hierarchical manner, a relationship in which females were 'naturally' inferior. Importantly though, although biological appearance assigned an individual to either a male or female status, the distinction was one of alleged moral and intellectual superiority, and not necessarily based upon biological differences. However, the era marked a crucial point in which the sexes were, for the first time, classified not simply as 'different', but, 'opposite'. (*ibid.*).³

³ The Pythagorean table of opposites, "according to Aristotle" 384-322 BC, (Synnott, 1993: 40; 10) contained 10 organizing principles, which were equated with either sex: "Limit, Odd, One, Right, Male, Resting, Straight, Light, Good, Square, or; Unlimited, Even, Plurality, Left, Female, Moving, Curved, Darkness, Bad, Oblong" . (Aristotle *Metaphysics* 926; 1984:159; Cited in Synnott, 1993:39-40)

The extent to which the dualism in early philosophical thought influenced Christianity is evident in the persistence of dualism which manifests as not only legitimization for the socially superior position of males, but also the justification for the oppression of women.⁴ The church managed concurrently to position 'man' not only as the creator of life, and so nearer to God, (as such morally superior), but also as 'naturally' the master of his wife (Synnott, 1993). The power of the church to define the 'natural' order of society and the fact that the foundation of the Christian faith rests firmly on the creation fable of Adam and Eve was effectively utilized to justify the unequal relationship between the sexes.⁵

The Christian faith asserted a clear definition of the mind (or 'soul') as separate from the body; not only separate from the body, but distinct and superior: 'spiritual' (Synnott, 1993). As such, it is perhaps not surprising that justification for the political and social order of society was not based explicitly on biological bodily difference, but on what was argued to be the fundamental moral and intellectual superiority of males as opposed to females. That is, on the mind as opposed to the body; 'gender' as opposed to 'sex' (Laqueur, 1990). This is an important note, since as shall be seen, gender, sex, and gender identity, although central to the political justification of the social organization of the sexes in patriarchal society, and a focal point for resistance, are not fixed,

⁴ For a more detailed account of the influence of the dualism evident in early Greek philosophy on early Christianity see Synnott, 1993, Chapters 1 & 2

⁵ A fable which it is argued, serves to discredit and devalue women by highlighting women's apparent moral weakness whilst simultaneously invoking a fear of female sexuality (Daly, 1991 45, Wooley, 1994)

stable or universally definable concepts; rather, they are historically and culturally specific.

The alleged moral and intellectual basis of gender differences established and legitimized in earliest doctrines of Christianity became firmly entrenched and remarkably tenacious, persisting throughout the first millennium and well into the second (*ibid*). However, the seventeenth century was to mark the emergence of a new epistemological era (May, 1996), and a marked decline in the power of the church to continue its mandate of power in defining the 'natural' social order.

The Emergence of the Sexed Body

The notion of differences between the sexes having their basis in the corporeal body began to emerge in the seventeenth century. Prior to this period medical science had declared the existence of one sex, but (unsurprisingly) the female sex were conceptualized as an inferior version of the male equivalent (Laqueur, 1990). The Enlightenment movement of the era increasingly privileged reason and rationality and asserted scientific knowledge as the only legitimate way forward to discover 'true' knowledge (May, 1996). Medical discourse, with its base firmly entrenched within scientific discourse, increasingly gained legitimacy in the search for 'true' essential differences between the sexes, a quest that had previously been the exclusive domain of the church (Connell, 1993: 186; Shilling, 1993:44; Turner, 1995:18-36). The

subsequent categorization of the sexes as biologically distinct⁶ was to provide a 'rational' explanation and justification for the inequalities between the sexes.

The seventeenth century witnessed the rise of 'scientific' medicine, a profession which increasingly pathologized the female body as 'naturally' predisposed to illness as a result of their apparent female biological inferiority (Turner, 1995 :90-94; Ehrenreich & English, 1979 :90-92). The concept/idea of pregnancy, childbirth and menstruation became increasingly medicalised and scientific 'facts' and theories emerged reinforcing the notion of the inferior biological constitution of females. Furthermore, throughout the eighteenth and nineteenth centuries, women's apparent femininity, with its inherent propensity to illness, was increasingly incorporated into emerging psychiatric discourse as mental illness, and utilized as a legitimate reason for excluding women from the male dominated public sphere (Showalter, 1987:134; Turner, 1995: 90-94).

Gender Order: The Public and the Private

The eighteenth and nineteenth centuries had witnessed dramatic changes within the economic, demographic and social structure as the technical advances of the industrial revolution gathered pace. The population became concentrated in the rapidly expanding towns and cities as factories and workshops increasingly became the hegemonic

⁶ See, Laqueur, (1990)' Making Sex'; Chapters 4 &5 for a detailed account.

form of production and a key source of income (Tonge, 1993:274). These developments displaced the family home as a unit of production and were to mark the emergence of a distinct public (work) and private (home) separation (Grint, 1991:71; Sayer & Walker, 1992:43; Turnaturi,1987:256).

By the middle of the nineteenth century the introduction of legislation which regulated the paid employment opportunities of women in factories, workshops and mines, reflected the dominant medical ideology of women as the physically weaker sex (Turnaturi, 1987: 264). It also restricted the ability of women to be financially independent since these jobs were the best available in terms of wages paid and hours worked (Walby, 1990:192).

Restrictions on employment for women were by no means the only manner in which women became delegated primarily to the private sphere.⁷ The prevailing ideal of femininity was the delicate, affluent lady, unequipped for the rigors of the public sphere, requiring the most sheltered domestic life, and totally dependent on her husband (Bordo, 1988; Ehrenreich & English, 1979:93-99).

The biological and ideological construction of the female as naturally inferior was further legitimated as notions of 'childhood' and the apparent

⁷ The ideology that positioned women within the private sphere was initially primarily adopted by the upper and middle classes, by the end of the nineteenth century this ideology had filtered down to the working classes as the role of the home as a 'haven' and in particular the role of the 'housewife' in cultivating and maintaining the home increasingly gained social status. See Turnaturi, (1987).

need for full-time motherhood became established at the turn of the nineteenth century. This reinforced the polarization of the sexes and further served as the basis for keeping women within the domestic sphere, as full-time housewives and mothers, dependent on men (Wolf, 1990). This ideology was increasingly strengthened by the emergence of a hegemonic masculinity that included the ability to sustain a dependent wife and family ⁸(Connell, 1995, 196-197; Walby, 1990: 105).

The ideal of the 'natural' female constructed within this period was a powerful means of polarizing the sexes. The ideal of femininity was firmly equated with embodiment (Showalter, 1987; Shilling, 1993; Synnott, 1993). Men, conversely, continued to be associated with the mind, reason and rationality and, as such, evidence of 'natural' male superiority (*ibid*). This substantially reinforced the relationship between the sexes as both justified and legitimate.

Politically, there were substantial gains to be made by contrasting a biologically inferior and mentally unstable femininity with the epitome of reason, rationality, and intellectual superiority which was the dominant masculinity (Laqueur, 1990: 152; Turner, 1995: 90-94). The rise of first wave feminism in the late eighteenth and the mid- nineteenth century ⁹(Humm, 1992) had led to an increasing critique of inequalities between

⁸ For a more detailed account of changing masculinity throughout this period see Connell, 1987, and 1995, Chapter 8.

⁹ Mary Wollstonecraft (1792) *A Vindication of the Rights of Women* is cited by Humm (1992: 4) as the first full political argument to seek to address the social and political subordination of women in Britain.

the sexes, and medical discourse thus provided not only justification for those inequalities, but apparently irrefutable evidence.

It is also around this period that the notion of individualism increased, and “the concept of an autonomous self” emerged (Connell, 1993:186). This provided increased justification for claims that there existed distinct gender identities, with the male identity equated with ‘sciences and reason’ and female identity with ‘nature and emotion’ (*ibid.*).

Throughout the nineteenth century biological sex became firmly established as the natural basis for gender identity. A female body meant a feminine nature, an essence which resided in the sexed body and manifested itself as ‘femininity’, a sex-role characterized by ‘feminine’ characteristics: demure, dependent and inferior. In contrast, the male body was symbolic of a masculine essence, and was characterized by ‘masculine’ sex-role characteristics; reason, rationality, independence, strength, confidence and superiority (Synnott, 1993:49-54; Bordo, 1988:103).

This brief sketch of the differing historical contexts in which gender differences have been articulated highlights the extent to which definitions of sexual differences are ultimately determined by the culture and epistemological foundations of the given era. These will undoubtedly influence what is perceived as the ‘natural’ order of society, and will ultimately be utilized as political justification for power

differentials implicit in gender relations, which have, invariably in a western culture, involved the oppression of the female sex.

The notion of distinct biological gender difference as the basis for opposite gender identities established by the end of the nineteenth century proved remarkably tenacious. Any apparent contradiction to the 'natural' differences between the sexes that posed potential for any substantial reconceptualisation was effectively neutralised. As we have seen, responses to the challenge made for more equality between the sexes by feminists during this period led to the female sex being classified and pathologized as inferior to men, both mentally and physically, and firmly positioned within the private realm of domesticity.

Gender Order: Contradictions

Although the challenge to masculine privilege in calling for a more equal society was scientifically and politically neutralised as opposing the legitimate order of society, the women's movement was not the only apparent threat to the masculine heterosexual ideal during this period. By the late nineteenth century the homosexual had emerged as a distinct identity to challenge the heterosexual masculine ideal (Weeks, 1989).

The subsequent medicalisation of homosexuality during the era can be seen as a direct response to the threat posed to institutionalised heterosexuality as a means to explain same-sex desire. Medicalisation

rendered such behaviour susceptible to a 'cure' and substantially reinforced the notion that such behaviour was a deviation from 'normal' heterosexuality. (Foucault, 1978: 38-43; Plummer, 1981:86) It was also around this period that there emerged growing interest in sexuality on the part of sexologists and theories emerged which would substantially reinforce the concept of distinct gender identities.

'Sexual inversion' was one such theory that was to have a direct impact on the denigration of homosexuality. Originally theorized by Ulrichs in Germany during the 1860-70's, sexual inversion basically asserted that homosexuality could be explained by 'Urning'. This theory argued that same sex desire could be explained by the existence of a 'feminine' mind 'locked' inside a male body, and conversely, a 'masculine' mind being 'trapped' inside a female body (Bristow, 1997). This conception laid the basis for the stereotype of the effeminate homosexual male, and, by contrast, the 'masculine' lesbian (Weeks, 1989: 104; Showalter, 1990: 23).

By imposing a gender identity that was opposite to the biological sex of homosexual/ lesbian individuals it was possible to explain the apparent physical attraction to the same sex (*ibid*). Furthermore, by asserting that homosexuals possessed a gender identity that was distinctly feminine, the ideological message was clear; these were by no means 'real' masculine men, thus the heterosexual masculine ideal remained intact. Sex, gender and gender-identity subsequently became both naturalized,

and potentially pathologized, and the relations between the genders justified as 'natural'.

As we have seen, sex, gender and gender identity are inextricably linked in definitions of masculinity and femininity and serve to sustain a crucial imbalance of power. Perhaps more importantly, it is evident that the concepts are of both social and political importance.

Early Twentieth Century Gender Relations

The first half of the twentieth century remained a relatively stable period in which the gender order that had been firmly entrenched in the previous century remained, despite the economic and social upheaval induced by two World Wars.

During the First World War women were recruited to work in what had been exclusively male occupations in engineering, railways, shipyards, and so on, as well as munitions and armaments factories. The transition of women from the private to the public sphere, was, however, made out of necessity rather than choice (Grint, 1991:85-87; Walby, 1990: 161-162), and was by no means perceived as a permanent state of affairs. On the contrary, women were recruited on the understanding that their participation in the male domain was to be restricted to the 'war effort'

and that they would be removed from their positions as soon as the war was over and the men returned (Walby, 1990:192).¹⁰

During the inter-war period there were attempts to exclude women from paid employment, particularly as the depression deepened (Grint, 1991:86-87; Walby, 1990: 50-51). Although the public – male /private - female distinction became firmly re-established, there were significant changes in respect to the social status of women. The extension of limited franchise for women in 1918, and the achievement of equal franchise with men in 1928, meant that women were, for the first time, recognized as politically significant citizens of the state (*ibid.*), a social status that would render any future attempts to exclude women from the public sphere unattainable, at the level of state intervention (Walby, 1990: 161-162). However, equal voting rights did not render secure equality for women. The gender order established during the preceding centuries persisted after the First World War with women primarily located in their 'natural' positions in the private sphere of the home.

At an ideological level, the war had served to magnify notions of essential differences between the sexes. As far as gender relations were concerned, there were substantial gains to be made. There is, perhaps no greater display of male aggression and dominance than in times of war (Connell, 1995). Furthermore, women were maintained predominantly in their 'caring' role. Women were called upon to nurture

¹⁰ See Grint, (1991:85-88) for a more detailed discussion of the attempts to maintain male dominance in the workplace during the First World War.

the economy; the country; the war effort, as well as care for the home and children until the return of the men, who were, of course, primarily perceived as protectors of the country, the women and children and of freedom.

However, the Second World War was to have dramatic implications for the established gender order. Women were once again 'allowed' into what had previously been regarded as exclusively male roles. Jobs that had been identified as 'man's work' were filled by women, who proved that not only were they quite capable of 'men's work', they also enjoyed their new found independence. In a 1944 survey "... 61 to 85per cent of women...certainly did not want to go back to housework after the war" (Wolf, 1990:63).

The government once again came under pressure from the male dominated unions to introduce legislative measures to ensure that women were 'permitted' to work for the duration of the hostilities, but would be displaced once the men returned (Walby, 1990: 162). Although such legislation was passed, it was never implemented, (largely due to women having secured voting rights), and marked the end of the era in which the state would directly intervene in the restriction of paid employment for women (*ibid*: 192).

However, despite the fact that the state could no longer legitimately intervene to exclude women from the labour force, in reality, the end of

the war saw one million women being sacked or leaving their jobs in Britain to make way for the returning men (Wolf, 1990:63). The ideological campaign aimed at 'getting women back in the kitchen' where they 'belonged' was based firmly on appealing to essential differences and 'natural' gender identities and gender roles for men and women (*ibid.*).¹¹

Housewife, mother and wife became the ideal essential activities of femininity, and these were of course, centred on the male 'head' of the household. The role of the wife was to make her husband and children as comfortable as possible (Showalter, 1987; Connell, 1995). The genders were, once again, distinct yet complementary, socially established as 'natural' and politically utilized as justification for inequalities that remained.

The institutionalization of a biological basis for differences between the sexes was to provide the basis for the legitimization of the sexes as distinct and opposite, with clearly defined roles in society as a result of biological determination. Concepts of masculinity and femininity as essential identities at the core of the sexed body, which manifest the different sex-roles of men and women in society, were further entrenched as evidence of a 'natural' difference. This was to form the

¹¹ Advertisements in women's magazines were testimony of the covert campaign to 'get women back in the kitchen' and largely stressed the importance of maintaining female identity as distinctly feminine. During the war advertisements stressed the need to remain feminine. An advertisement for face cream stated : " We like to feel we *look* feminine even though we are doing a man sized job.....so we tuck flowers and ribbons in our hair and try to keep our faces looking pretty as you please" (Cited in Wolf, 1990 :63)

basis of the social organization of the sexes, and be articulated as justification for women's unequal position within the political, civil and economic sphere.

However, the emergence of second wave feminism and the rise of the gay liberation movement in the 1960's were to present a serious challenge to the stability of gender relations. These developments posed an unprecedented attack on the legitimacy of the 'natural' and inevitable social, political and sexual relations of wider society, as the very ideal of 'biology as destiny' was seriously undermined (Edwards, 1990: 113; Oakley, 1972; Wilton, 1996: 127)

Second Wave Feminism

"'Sex' is a biological term: 'gender' a psychological and cultural one. Common sense suggests that they are merely two ways of looking at the same division. In reality this is not so. To be a man or a woman, a boy or a girl, is as much a function of dress, gesture personality, as it is of possessing a particular set of genitals. *This rather surprising contention is supported by a number of facts...*"

(Oakley, 1972: 158 my italics)

Ann Oakley's, *Sex Gender & Society* (1972) is credited as the first major work in the social sciences that offered a major critique of the biology as

destiny approach to gender identity and highlighted the extent to which gender identity is the product of social forces rather than biological ones. Although the distinction between 'gender' and 'sex' had been addressed in a number of earlier texts (Oakley, 1997: 330-31), it had largely been appropriated to stress the polarization of the sexes as separate identities. The stress placed on the final sentence of the above quote is to highlight the impact that this critique was to have within the social sciences. The very fact that the social sphere influences the construction of gender identity is, today, not considered surprising at all. On the contrary, much present theorising takes this assumption as its starting point. (Davis *et al* 2006; Butler, 2004; Jackson & Scott, 2002).

The impact of much theorising by feminists during the late 1960's and 1970's was monumental as regards the concepts of sex, gender and gender identity, and represented the emergence of a new epistemological basis for theorising gender relations (Oakley, 1972; 1997). Social constructionist theory was to seriously undermine the dominance of biological explanations for gender differences and paved the way for an analysis of the manner in which gender roles, assigned on the basis of biological differences, create and sustain the social organization of the sexes.

Sex/Gender Roles

The basic thesis of Ann Oakley's, *Sex, Gender & Society* (1972) was that gender acquisition is the result of a socialization process in which

male and females are culturally conditioned via the socialization process within families, schools and early childhood to take on what is constructed within society as the appropriate 'gender' role. This process begins from the very early childhood. Male and female children are treated differently, with girls being socialized to be emotionally more expressive, dependent and nurturing. In contrast, boys are socialized to be independent, assertive, and un-emotional (*ibid*). According to Oakley, this process ensures the continuation of the segregation of the sexes as distinct, and the justification of the social order. Whilst the existence of distinct male and female roles had been evident for centuries, the importance of Oakley's work was to challenge the existence of 'natural' 'sex roles' for women and men that were the result of inherent biological determination, and the assumption that sex roles were necessary for the health of both the individual and society (Connell, 1995: 23).

Rather, the work highlighted the extent to which definitions of masculinity and femininity were culturally variable and so questioned the validity of a biological basis for the concepts. Further, it also highlighted the extent to which such roles were political, ensuring the socialization of girls and women into an oppressive social position that was restrictive. The alleged legitimacy of these roles also provided justification for discriminatory practices within both the public and private sphere which subsequently ensured the continuation of masculine privilege (Connell, 1985: 262-3). By highlighting the inadequacies of the sex-role theory approach to explain the different social roles of men and women, and

stressing the role of cultural and social conditioning in maintaining such roles in society, Oakley introduced the concept of 'gender roles', an analytical distinction that would provide the basis for a shift in the epistemological foundation of future theorising within gender relations.

To summarise, gender role theory stresses that the impact of socialisation into a distinct gender identity (characterised by gender specific behaviours and personality traits), creates and sustains the alleged 'differences' between women and men. These 'differences' are manifest in the social context of society, whereby certain behaviours are prescribed as gender specific, and in turn determines that men and women in society undertake different roles. Gender differences are manifest as the result of social and cultural processes, not, as sex-role theorising would claim, as the result of biological determination.

Gender role theory has been developed quite extensively to account for gender relations. It offered an analysis that allowed both male and female roles to be conceptualized in a dynamic relationship, challenged the notion of essential difference that was biological in basis, and posited the socio-political arena as the means through which change could be affected to redress the inequalities (West & Zimmerman, 1991: 15-16). This was to be achieved by challenging stereotypical assumptions surrounding the ideals of gender roles, and calling for political intervention to effect change by providing anti-discriminatory

legislation and institutionalizing equal opportunities within the educational system and workplace (Connell, 1985: 262).

The increasing body of feminist literature extensively utilized the social construction of gender differences during the 1970's, although the manner in which these roles impacted on the lives of women (to ensure the continuation of female oppression) were interpreted in a manner of ways by different feminist perspectives: Marxist Feminism, Liberal Feminism, Radical Feminism, to name a few¹². The relative gains made by the feminist movement can not be understated; although many inequalities continue to exist in the relations between the sexes, there has been marked improvement. However, the usefulness of stressing the social context of a gender role approach to gender and gender identity has been increasingly challenged in recent years.

Gender Roles - Critique

One of the main weaknesses to be identified with gender role theory is the manner in which there is an unquestioned assumption that gender roles are automatically reproduced at an individual level (Connell, 1995). As such, the gender role becomes the expression of a gendered identity, which in of itself is said to be a result of socialization into such a role. The assumption that male and female roles have set characteristics, which in turn determine definable gender identities, utilizes 'experience'

¹² The varying perspectives evident in feminist theory encompass a vast range of literature, which will not be evaluated within this paper. Humm, (1992) provides an introduction to the many different strands that have evolved historically, as well as providing an account of the relative gains made by the feminist movement. A brief account can be found in Walby, (1990: 2-5), and Oakley, (1997)

to explain gender difference and, paradoxically, gender differences to explain the contrasting 'experience' of the sexes (McMahon, 1993: 689, Scott, 1988: 4)

Furthermore, by stressing the need to question 'roles', this theory confirms rather than contests the existence of essential difference between the sexes. It also effectively minimizes the: "economic, domestic and political *power* men exercise over women", (Connell, 1985: 264, italics original) by privileging role performance in the quest for a more egalitarian society, rather than directly questioning power relations that set the context for the continuation and legitimization of such roles (*ibid.*). As such, while opposing a biological essence for masculinity and femininity as distinct gender identities, this theory reverts back to essentialism; biology as destiny is replaced by the social as destiny (Fuss, 1989).

A further weakness identified with sex/gender role theory is the extent to which it fails to account for the manner in which the role performances are assigned meaning, and as such, assigned a gendered significance in daily interaction (West & Zimmerman, 1991; Butler, 1990). This critique will be developed in more depth later, but it is important to note that the extent to which roles are gendered is dependent on the categorization of certain behaviours, associated with such roles, as gender specific within the context of social interaction.

As we have seen, the extent to which masculinity and femininity, and subsequent gender relations, are the product of some inherent 'essence' that is the result of biological sex differences has been effectively criticized. Since the late 1960's feminist theory has consistently highlighted the extent to which gender is socially shaped rather than the result of simple biology. And further, theory has highlighted the extent to which concepts of masculinity and femininity constitute an inherently political relationship, which serves to render females into an inferior social position with relatively less power than men in both the public and the private sphere (Oakley, 1972; 1997; Humm, 1992; Walby, 1990). What is clearly apparent, is that while definitions of gender identities vary historically and culturally, men's "...relative power, authority and status compared to womenstay much the same" (Segal, 1993:626)

Gender role theorising marked a fundamental questioning of the social organization of the sexes as natural and (even with the weakness highlighted) represented a direct challenge to the manner in which sex, gender and gender identity were conceptualized. These developments were invaluable, in that they laid the foundation for subsequent theories to take the role of social expectations in the construction of gender differences as their starting point.

In a similar manner in which Oakley, (1972) had questioned the apparent common sense assumptions that were at the heart of gender relations, so new theories emerged which targeted the very concept

which, to a large extent, (though not exclusively e.g. de Beauvoir, 1949) had remained relatively unproblematised: the acquisition of a gender identity.

Psychoanalytic Theories of Gendered Identities

The extent to which gender-role theory relied on the notion of socialisation into a distinct gender identity, without offering a coherent explanation as to why individuals internalized a specific gender identity was a major criticism associated with role theory. The apparent overstatement of the effects of socialization led, as we have seen, to claims that it merely replaced biological determination with social determination. This opened the arena for investigation into how distinct gender identities became incorporated into individual psyches which manifest as masculine / feminine identities. The work of Freud was to be central in the manner in which the internalization of a gendered identity was theorized to be the result of a dynamic relationship, between the unconscious, and the social world. This is most often the case in the relatively new field of 'men's studies' or 'masculinities' (Hearn, 1993; Connell, 1995; Edley & Wetherell, 1996).

Basically, Freud theorized that initially both sexes have no defining essence of masculinity or femininity, rather, as children the general tendency was more indicative of bi-sexuality, as the libido (sexual energy/drive) could be directed at any object (Stevens, 1994; Gross, 1992: 594-600). However, as the child passes through the stages of

personality development the libido becomes directed at different zones of the body (Oral, Anal, Phallic, Latency Genital). For Freud, the Phallic stage was crucial for the development of gender identity, which was dependent on the satisfactory resolution of the 'Oedipus Complex' (*op.cit.*).

The 'Oedipus Complex' is characterized by the male child's unconscious sexual desire for his mother. He becomes fearful that his father will discover these desires and castrate him; to resolve this tension he identifies with his father, internalizing a male gender identity (Gross, 1992). However, for girls, the successful resolution of the equivalent process the 'Electra Complex' takes as its starting point the girl's realization that she does not possess a penis. This realization leads her to believe that she has already been castrated and the subsequent development of 'penis envy' (*ibid.*). The apparent feelings of inadequacy that result from the realization that the girl does not possess a penis are transferred at an unconscious level into the desire to have a baby, and so the focus of her attention shifts towards her father in the hope of fulfilling this desire. The resolution of the complex is achieved when the girl realizes her desire for a penis is not to be realized and she subsequently identifies with her mother (*ibid.*)

Freud's theory of personality development has been subjected to a number of criticisms, not least because of the phallocentric nature of his account (Chodorow, 1978; Walby, 1990:111-112). The theory offers an

account of women's apparent inferiority at an internal and unconscious level due to the fact that she does not possess a penis. To reduce the apparent difference between the sexes to the basis of the possession of male genitalia, is to appeal to biology once again to justify social inequalities. Further, the theory moves the level of difference to one not only fixed in the biological reality of the body, but also the individual nature or 'essence' of individuals. This substantially reinforces the legitimization of concepts of definable, distinct and essential gender identities.

However, the theory has been praised as offering an insight into the complex processes that are involved in the construction of masculine and feminine identity and its influence is present in contemporary analyses of the construction of masculinity (McMahon, 1993; Connell, 1995: 10). However, the extent of the weaknesses inherent to the theory has led to subsequent feminist reworkings of Freud's account which, while maintaining the relative importance of the unconscious in gender identity construction, seek to address the phallogentric assumptions implicit within it.

Feminism and Psychoanalysis

Object-Relations theory, is largely credited to the work of Chodorow, (1978) and outlined in *The Reproduction of Mothering*. As the title suggests, the aim of Chodorow's work is to offer an insight into the

“social structurally induced psychological processes”(ibid: 278) that ensure the reproduction of women as mothers, which she argues is by no means dependent on the experience of ‘penis envy’ (ibid.). The basis of Chodorow’s account rests on the assertion that the development of a distinct gender identity takes place in a ‘pre-Oedipal stage’ which determines “different forms of ‘relational potential’ in people of different genders” (ibid: 279).

Basically, Chodorow argues that the division of labour evident in parenting, wherein the mother has almost exclusive responsibility in the rearing of children, leads to a pre-Oedipal stage in which the mother becomes the first love object of the child. However, she maintains that women develop a closer relationship with their daughters because they experience their daughters as more like themselves.

Conversely, because they recognize that their sons are opposite to themselves they push them out of the close pre-Oedipal relationship. As such, the female child identifies with her mother and emerges from this stage with an ingrained capacity for empathy and nurturing which is incorporated into their sense of ‘self’. In contrast, the effect of exclusion from this pre-Oedipal stage renders the male child to become more individuated, with little capacity for empathy. Furthermore, the male child, in his struggle to accept the breaking of this close bond, subsequently represses and denigrates all that is female. This manifests

in the psychological need for male superiority and dominance over women. The effect of this process of gender identity formation results in distinct gender difference:

“The basic feminine sense of self is connected to the world, the basic masculine sense of self is separate”

(Chodorow, 1978: 283)

Whilst the aim of Chodorow's work was to offer an account of the reproduction of feminine gender identities her work has been incorporated into studies of masculinity (Connell, 1995; Hearn, 1993; Edley & Wetherell, 1996; Petersen, 1998). The apparent strength of the study is that it offers an insight into the continuation of gendered identities, especially an explanation as to why women continue to regard 'motherhood' as a defining characteristic of 'feminine' identity. It may also account for the persistence of male dominance over women at an individual level (McMahon, 1993: 678).

However, there are a number of weaknesses with the theory. Initially, the manner in which the study is used to provide a causal explanation of gendered identities ignores the fact that there are more differences among each sex than between them (Connell, 1995). The fact that women have, and continue to undertake more responsibility in parenting does not render the process *i.e.* 'parenting' a definable and stable concept. Furthermore, Chodorow's over emphasis on the emotional

'nurturing' aspects of 'motherhood' neglects the actual physical realities of parenting, and the fact that not all 'mothers' are predisposed to be 'nurturing'. On the contrary, many mothers find the task of parenting daunting and far from 'natural'.

Furthermore, the claims that men are, by definition, unrelational, fails to account for the fact that men's involvement with childcare, although typically is not as time demanding as women's, is often likely to involve playtime or family outings, which may be more relational in context (McMahon, 1993). Moreover, evidence suggests that parenting styles are not simply reproduced in children; rather they can result in opposing interpretations of masculinity (Heward, 1996).

Perhaps more importantly, as far as gender relations are concerned, psychological theories such as this can be seen as diverting attention away from the wider socio-political arena in which gendered identities are produced. Adopting an approach that seeks causal explanation at an individual personality level, diverts attention from the wider socio-political arena in which identities are legitimated and justified; the manner in which male dominance becomes legitimate, and subsequently institutionalised remains unproblematic (*ibid.*).

As we have seen, the persistent quest to uncover causal explanations in the reproduction of gender identity at an individual level is far from straightforward. By asserting the existence of a gendered identity

internalized in early childhood, these theories can be seen as reverting once again to essentialism; that there exists at an ontological level, a 'gendered self'. This in turn can then be utilized to justify the existence of distinct and oppositional categories of identity.

The extent to which biological theories, role theories and psychological theories of gender relations revert, to varying degrees, to some sort of essentialism is quite apparent. This, as we have seen, can be assumed to occur as a result of biological differences, socialization differences which involve the undertaking of certain roles, or, the development of a distinct masculine or feminine personality.

Whatever approach is adopted however, there still remains an implicit assumption that the categories of femininity and masculinity are definable categories which can be utilized to differentiate between the sexes. An examination of the theories surrounding gender identity formation serves to highlight the extent to which the relationship between the two concepts is fraught with the unequal distribution of power, which privileges the male identity at the expense of the female identity.

However, the implicit assumption that 'woman' or 'man' could be defined by reference to some internal 'essence' that would unite males with masculinity, and females with femininity, became increasingly called into

question throughout the 1980's and the usefulness of the categories were frequently called into question.

Difference and Gender Politics

As we have seen, much theorising that sought to question the continued oppression of 'women' relied, to varying degrees, on the assumption that *all* females identified with 'woman' as an experiential existence in much the same way. Women, as a collective entity, it was assumed, all experience oppression. As such, a political agenda was needed to challenge the socio-political and sexual order of society to improve the social and material position of 'women'. Similarly, the emergence of men's studies and masculinity took as their starting point the existence of a definable, relatively stable identity; men were 'men'.

However, this approach came under increasing criticism during the 1980's as feminists from a wealth of backgrounds questioned the validity of a universal category which they could identify with (Bordo, 1990; Bailey, 1993; Nicholson, 1994). This apparent dissatisfaction with the category 'men' has also surfaced in recent attempts to theorize masculinity (Heam, 1996; Petersen, 1998)

It has become increasingly apparent that a simple category cannot account for different experiences of oppression within feminist theorising. Gender may well be of significance but there are other dimensions to an individuals' social identity that impact on their sense of

'self', for example: 'race', ethnicity, age, disability, social class, sexual orientation and religion. These dimensions not only shape an individuals' experiences within the social sphere, they also influence their sense of 'self' (Baca Zinn *et al*, 1986; Bordo, 1990).

Furthermore, a simple 'additive' approach, where the discriminatory practices that are apparent towards gender are also compounded by, for example, racism, or ageism, cannot adequately account for the different experiences people have or how this impacts on the sense of 'self'. There are also so many wide-ranging possibilities inherent in this manner of theorising (e.g. young, black, middle class, disabled, male, heterosexual; old, white, disabled, lesbian; working class middle aged female heterosexual) that it is futile to appeal to some essential femininity or masculinity with which individuals can identify. Thus, the conclusions drawn by many theorists argued that categories such as 'woman' and 'man' are normative and regulatory classifications that ensure the segregation of the sexes and reinforce the naturalization of gender differences (Bordo, 1990; Butler, 1990; Nicholson, 1994; Hearn, 1996; Petersen, 1998).

The inherent problems associated with feminism's reliance on what was increasingly regarded as a normative and regulatory classification 'women', has been the focus of much criticism. These developments have posed quite a substantial threat to the legitimacy of feminism's claim to represent *all* women. This has led to an awareness that to seek

a stable and coherent definition of 'women' is largely unattainable; there is, it would seem, no clear defining essence that constitutes what it is to *be* a woman, and there are no gains to be found in attempting to define what a woman *ought to be*. (Butler,1990:1). Similarly, substituting 'women' for 'woman' or 'men' for 'man', in an attempt to recognize differences still evokes a measure of essentialism. (Fuss, 1989:4; Petersen, 1998).

Rather than seek to account for difference amongst the categories of 'women' and 'men', which serves to highlight the elusive nature of 'what it is to be' male or female, it is, perhaps, time to shift the focus of investigation to the question: "What is a woman?" (de Beauvoir, 1949: 13).

'The Second Sex'

The question of 'woman' as a distinct identity was the focus of Simone de Beauvoir's ground breaking work, *The Second Sex* (1949). This highly influential work initially raised the question "what is a woman?"(*ibid*.13). For de Beauvoir, this question was essential in assessing women's social position in relation to men. She argued that the significance of the historical conceptions of 'masculinity' as naturally superior in the relations between the sexes represented an implicit dualism:

“man defines woman not in herself but as relative to him; she is not regarded as an autonomous being...He is the subject...she is the Other.”

(de Beauvoir, 1949:16)

The significance of this text in relation to theorising gender relations lies in the claim that ‘one becomes a woman’. This allows the conceptualisation of gender identity as neither biologically, socially nor psychologically determined since it implies that ‘becoming’ a woman (and by definition, also ‘becoming a man’) is a process that involves individual awareness of differing possibilities, and as such, is by no means fixed. If one ‘becomes a woman’, then it does not follow that this process is necessarily dependent on the sexed body, nor does it imply the presence of an internal psyche that is necessarily gendered.

Rather, it focuses attention to the social significance of gender, and allows an insight into how gender ‘identities’ are policed and reproduced, without reverting to essentialism. That is, without asserting an internal gendered identity that is characterised by ‘feminine’ or ‘masculine’ personalities that subsequently influence behaviours. The fact that the process of ‘becoming’ a woman is sanctioned by society and not necessarily by the individual allows the theory to avoid the social determinism of a concomitant subjective gender identity.

Butler: Sex, Gender and Gender Identity

The influence of de Beauvoir's, *The Second Sex* is evident in the development of Judith Butler's argument in *Gender Trouble*, concerning

gender and gendered identities (1990:8). Critical of the manner in which the continuation of the binary opposition between the sexes maintains its grip in the conceptualisation of gender relations, Butler provides a radical reanalysis of sex, gender and gender identity which, she asserts, ensures the reification of the sexes as natural and opposite, and provides justification and legitimisation for the continuing dominance of the 'heterosexual matrix' (Butler, 1990). For Butler, the continual reliance on the opposing categories of male and female not only ensure the continuation of male dominance, it also ensures the continuation of institutionalised heterosexuality.

Butler's argument is complex and some of the key themes that form the core of her argument are concerned with the institutionalisation of heterosexuality. For the purposes of this study some of the main concepts will be highlighted and evaluated to assess their usefulness in the future of theorising gender relations. However, the study will not specifically address the construction and institutionalisation of heterosexuality (Butler, 1990:35-78); rather, the focus will remain on the construction of gender identity.

One of the main themes of Butler's thesis is the notion of 'binary oppositions' (1990:6-13) and the reproduction of gendered identities. Here, she draws attention to the 'gendering' of sex, arguing that the notion of the body as having a relative existence before being inscribed with gender is crucial in the sex, gender, and sexuality relation. By

positioning the body as a pre-discursive entity, one that is self evidently the bearer of 'sex', then 'evidence' of 'difference' will always exist. Even adopting a social constructionism approach that examines ways in which gender is socially produced, will fail to adequately account for the manner in which gender is perceived as 'mirroring' the corporeal reality of the body. That is, there will be an implicit assumption that two distinct genders exist that correspond to the body, even if those genders are the product of socially discursive practices (*ibid.*).

This however, raises the question of the sexed body as being evidence of a gendered identity. Here Butler points to the way in which the notion of a sexed body, that is pre-discursive and so somehow outside the realms of social construction, is called into question when historical evidence suggests that 'gender' preceded the sexed body (Laqueur, 1990). The implications of this mean that it is quite plausible that:

"the distinction between sex and gender turns out to be no distinction at all... It would make no sense, then, to define gender as the cultural interpretation of sex, if sex itself is a gendered category"

(Butler, 1990: 7)

As such, Butler argues that there is no clear definitive reason as to why the male body, or the female body, should be indicative of a gendered individual. The fact that the sexed body takes on significance primarily through the construction of a gendered identity, (even if it is socially,

historically or culturally constructed) is, however, (importantly as far as gender relations are concerned) implicitly rendered significant “only in relation to another, opposing signification”. (*ibid*: 9). The significance of this argument is the manner in which it stresses the extent to which sex, gender, and gender identity, are normative categories, through which the inequalities between the sexes have been utilized to foster legitimacy, justification, and normalization of distinct gender identities. In attempting to theorise gender relations by continual reliance on the perceived stability of categories (sex, gender, sexuality) that are but themselves restrictive, normative and regulatory, there emerges the distinct need to reassess the extent to which attempts to uncover causal relationships serve to reinforce their continuation.

As we have seen, the concepts of sex, gender, and gender-identity, are by no means fixed and stable. Rather they are the products of distinct social, cultural, and historical significance, rendered intelligible through epistemological foundations of different eras. The fact remains that, while the interpretation of these categories varies, they have, invariably been articulated to ensure the continuation of two separate gendered identities as the ‘natural’ order of things. Further, their articulation has, to varying degrees, been harnessed to provide justification for the wider socio-political arena in which the sexed body is assigned a gendered significance.

Performativity

A further central theme that is salient in the work of Butler is the notion of 'performativity' (Butler, 1990; 1997). Whilst the idea of 'performativity' may appear similar to gender role theorising (i.e. the idea of individuals undertaking certain social roles defined as gender specific on the basis of certain behaviours, that stem from the socialization into a distinct gender identity), Butler stresses that there is no 'gendered' self that is the basis for the performance of these roles (Butler, 1997:402). Rather, she claims "there is no *doer* behind the deed, the deed is everything" (1990:25)

In an attempt to discover the manner in which gendered identities are re-produced on a daily basis at an individual level, Butler sets out to show that gender, is in fact, constructed through specific bodily acts which are elicited through the enactment of pre-existing social scripts, and policed by means of social censure (Butler, 1997:402). The fact that the body is only known through its gendered appearance leads Butler to argue that the body 'becomes' its gender through a series of bodily styles and acts which are consolidated through time: One is not simply a body, but in some very key sense, one "does' one's body" (Butler, 1997: 404).

The manner in which one 'does' one's body then, ensures the continuation of gender, but is also a means by which resistance is possible. Butler maintains that although there are, to a large extent pre-determined 'scripts', as to what acts and behaviours are constitutive of

a gendered performance, these are open to reinterpretation, and as such, through re-enactment, the possibility of change; as such, the 'scripts' become a focal point of resistance (*ibid*: 402).

However, the extent to which these 'performances' are policed by means of social censure for behaviours which challenge existing scripts, coupled with the social sanctioning of 'correct' performance, serves to reify the very notion of essentialism; reinforcing the *apparent* 'naturalness' of gendered identities (*ibid*: 405).

Whilst the notion of 'performance' has been theorized in relation to self, notably in the work of Goffman (1959:28-82), Butler distances herself from what she regards as Goffman's notion of an 'interior self', that takes on a variety of 'roles' in complex social interaction on a daily basis (*ibid*: 412). Whilst for Goffman the interior self is not a fixed and stable identity, but rather, is conceptualized as an active agent, carrying out social 'role' performances that constitute social reality, for Butler:

"..[the]... self is not only irretrievably 'outside', constituted in social discourse, but the ascription of interiority is itself a publicly regulated and sanctioned form of essence fabrication. Genders then can be neither true nor false, real or apparent. And yet, one is compelled to live in a world in which...gender is stabilized, polarized, rendered discrete and intractable".

(Butler, 1997 :412)

For Butler, a consideration of these issues draws attention as to the extent to which notions of gender identity are normative ideals, rather than necessarily descriptive features of identity. Furthermore, the performance of gender leads to the conclusion that one *is* a gender, as such performance can be said to constitute the appearance of essence; performance is performative, *not* the expression of an internal gendered self. This is an important distinction in Butler's work; if there is no pre-determined gender identity to which acts can be attributed then:

"...gender identity would be revealed as a regulatory fiction... gender cannot be understood as a role which either expresses or disguises an interior 'self', whether sexed or not"

(Butler, 1997: 412).

For Butler then, in brief, the answer to 'what is a woman?' has to be outside, constituted in discourse, there is no inner essence that characterizes individuals as gendered. As such, definitions of 'woman' or 'man'; or 'women' 'men' can be defined, in a sense, as the awareness of what one *should* be, or *ought* to be, which impact on the subjective experience of oneself as a 'woman' or 'man'. This exterior construction of gender identity does not constitute identity; rather it *prescribes* what a gendered identity should be.

Butler: Critique

However, it should be noted that Butler's arguments concerning 'performativity', and the idea of a gendered self that is, in many respects, constituted outside the self, is not without weaknesses at a theoretical level. The notion of an 'exterior self', fails to address the issue of embodiment, of a 'self' located within a corporeal reality that is the body; a body that continues to be gendered, whether, discursively, socially or biologically. Research suggests that the body has become a prime symbol of the self, both to an individual and society in recent years (Shilling, 1993; Synnott, 1993). This raises the question of the legitimacy of theorising the 'self' as a disembodied 'self'. One may 'do one's body', but in a key sense, research suggests that the 'self' is inextricably bound up with perceptions of the body (*ibid*).

The very fact that individuals are defined and categorized as either 'male', or 'female' on a bodily basis within society may well impact on subjective conceptualisations of the 'self'. This in turn may impact on perceptions of the self, what one feels one should be, on the basis of living on a daily basis, primarily, as a 'gendered' body. As long as bodily appearance remains the prime symbol for categorizing individuals as men or women, it would appear futile to attempt to theorize gender in terms of a self that bears no relation to the body (Hall, 1996).

A further and crucial criticism of Butler's theory is around the lack of agency afforded to the individual (McNay, 2004; Silah, 2002; Kirby,

2006). For Butler, the performance of gender is performative, there is no subject that is gendered, only the performance of individuals in line with the pre-existing social scripts, the 'naturalness' of which are reinforced and policed through social censure (Butler, 1990).

Butler allows possible sites of resistance through challenging these 'scripts', and acknowledging performances that challenge the assumption of 'natural' essential qualities of gender – qualities that are perceived as guiding individuals to 'be' their gender. However, the theory does not account for how the social censure which polices the maintenance and legitimisation of these roles will be addressed McNay, 2004; Silah, 2002; Kirby, 2006).

Specifically, if the policing and sanctioning of gender and gender identity is ensured through the social censure of the performance of gender, then surely society, will seek to ensure its continuation. This may be achieved through re-establishing boundaries, and identifying and categorising 'Other' ways of doing gender as identity deviant, reinforcing the categories as regulatory ideals that serve the continuation of gender as a normative category. Given the manner in which sex, gender and gender identity have been discursively harnessed and politically utilised throughout history and within the discursive practices of differing epistemological foundations (Hall, 1996, Foucault, 1976, 1984, 1984a), then it would appear naïve to assume that an awareness of the

discursive practices will necessarily ensure the downfall of 'gender' as a normative and regulatory category.

The theory also fails to address the ability of individuals to actively negotiate the extent to which identity categories impact on their sense of 'self' and self-identity (as noted above). The account also fails to recognise the fact that not everyone experiences their 'self' or self-identity as primarily defined in terms of gender, or may actively resist the ascription of gender identity, and other identities (Connell, 1995). As noted earlier, criticisms of feminism and men's study were largely concerned with the use of the term 'man' or 'woman' to convey a collective identity they could or would identify with (Baca Zinn, *et.al* 1986; Bordo, 1990; Nicholson, 1994). To assert a theory that assumes individuals are unwittingly 'duped' by the apparent 'authenticity' of gender and caught up with not only producing gender identity through performance but also inadvertently reproducing the means by which the performance can constitute their 'self' fails to allow for agency of individuals to negotiate the extent to which they allow, if at all, gender to define their sense of who they are, or their self-identity (McNay, 2005).

Moreover, the relationship between the 'doing' and 'being' of gender and gender identity is taken as unproblematic. That is, as discussed earlier, for Butler, performance is performative; the 'doing' of gender creates the appearance of essence insomuch as the performance is taken as the outer projection of an inner 'self' that is inherently gendered: the essence

of performativity. However the theory rests on the implicit assumption that the relationship between the 'doing and being' identity is reciprocal and self-sustaining. If there were no relationship between the two concepts (doing and being) then one could not exist without the other. However, there is no attempt to address what the experience of 'self' and self-identity would be like if this relationship breaks down. This aspect of the theory will be developed and expanded further in the thesis.

Furthermore, the theory fails to address the complexities around the manner in which gender has been conceptualised in other disciplines, for example, within the field of anthropology (Johnson, M. fc.). It also fails to recognise the relational aspect of 'self' and 'gender' and the fact that gender is experienced as a lived social relation (McNay, 2004).

This need not, however, detract from some of Butler's key arguments, rather it highlights the need to examine not only the contradictions that exist between the 'self'('being' and 'doing') and social expectations, but also how individual embodiment impacts on such evaluations.

While the basis of Butler's theory remains largely at a philosophical level it will be developed and extended further throughout the thesis to offer an empirical account of the impact of depression on an individual's sense of 'self' and self-identity as an embodied experience.

Summary

Sex, gender, and gender identity have been key concepts in attempts to theorize relations between men and women. These concepts have been shown to be historically, culturally, and socially specific. However, the constant theme throughout, irrespective of changes in how these concepts are conceptualized, has been the continued appeal to the notion of men and women as distinct opposites. There is considerable political potential for justifying the relative power inequalities that exist in gender relations by polarizing men and women. However, it would appear that rather than questioning the extent to which these concepts determine the social oppression of the females in relation to men, there exists a need to question the validity of the very concepts that are utilized in such analyses.

Gender identity is not fixed, stable or definable; this is evidenced by the extent to which criticisms of feminism's use of the concept 'women' came largely from 'women' (Baca Ziinn, *et.al*; Bordo, 1990; Bailey, 1993; Nicholson, 1994). While gender performance is undoubtedly central to the social organization of the sexes as distinct and separate, we cannot simply assume that gender is a central, salient feature of an individual's sense of identity. Rather, gender theorising has constructed and reified it as such. This also has implications for theorising in related fields that have taken gender and gender identity as a relatively unproblematic starting point to develop theories to address gender differences; this is particularly evident in the field of the sociology of mental illness.

Sex, Gender & Mental Illness

The influence of theories of gender and gendered identities, including the impact of sex roles and more recently, gender roles, are evident in the development of theories that seek to address the gender discrepancies in the rates of mental illness experienced by women and men (Chesler, 1972, Broverman *et.al* 1970, Busfield, 1996; Prior, 1999, Stoppard, 2000). The central role afforded to the influence of sex, gender, and sex /gender roles on the experience of mental illness has a long and sustained history (Showalter, 1987; Ussher, 1991). However, interpretations of the impact of sex and gender on the susceptibility of individuals to experience mental illness have been culturally and historically specific (*ibid*).

The following section will discuss the problematic nature of traditional attempts to theorise the relationship between gender and mental illness rates. It will then suggest that conventional theories of the dynamic relationship between gender and mental illness continually fail to offer any realistic hope of resistance and change by continuing to evoke the concepts of masculinity and femininity as essential qualities of women and men.

'Queering' Mental Illness: Performativity, Gender and Diagnosis

Research into the power of psychiatric discourse to label and treat mental illness has addressed two key areas that have been identified as problematic; 1. The 'cause' of mental illness, indeed whether the term

can be used legitimately, and 2. The reasons for the apparent gender differences. The aim of this section will not be to evaluate theories of mental illness; rather it will draw upon the concept of mental illness as relatively unproblematic in the context of this discussion. Of course the concept of mental illness is far from unproblematic, and has been subjected to numerous evaluations and criticisms which is, in itself, a vast area.¹³

Gender & Mental Illness

Mental health statistics show consistent gender differences in diagnosed rates of mental disorder amongst women and men since the emergence of psychiatry as a specialist category with a mandate over the diagnosis and treatment of those deemed mentally ill (Showalter, 1987).¹⁴ The nature of mental illness has changed dramatically since the mid-nineteenth century.¹⁵ However, the aim of this section will be to address

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The power of psychiatry to label an individual as being mentally ill has been subjected to a number of criticisms, the most influential of which can be seen in the challenge to policy and practice that emerged during the 1960's from a number of theorists, often grouped together, as the 'anti-psychiatrists', in particular, Szasz, T (1973), Laing, R.D., (1965) and Scheff, T. (1966). Szasz is perhaps the most radical in his total rejection of the term mental illness, arguing for a reduction in the powers afforded to psychiatry (in particular the power to forcibly incarcerate, detain and administer medication). In a powerful and persuasive manner Szasz argues that the bulk of psychiatry's field is nothing more than the medicalisation of 'problems with living' that the majority of us face living in a society that increasingly stresses individualism and materialism as the means for personal happiness.

¹⁴ The history and debate surrounding the over-representation of women within mental health statistics has been subject to a wide range of studies, Showalter 1987, Ussher, 1991, Scull, 1993, 1989, to name a few. They tend to be feminist accounts (with the exception of Scull and Busfield, 1996) and so argue specifically and convincingly, that women are over represented as a result of patriarchal and misogynist society's attempts to justify the social control of women.

¹⁵ The history of the emergence of psychiatry and changing conceptualizations of mental illness will not be dealt with in this thesis but Foucault's account in *Madness and Civilisation* (1971) and the work of A. Scull (1993) are perhaps the most influential accounts, although they do not specifically address gender as problematic.

current trends in mental health statistics regarding gender differences, which at present suggest that women dominate the categories of depression and anxiety at a rate in excess of 2:1 of men. Conversely, men dominate in the categories of affective disorders, alcoholism, drug abuse and anti-social personality disorders.¹⁶

Given the bio-medical dominance that has existed within psychiatry since the mid- nineteenth century, it is perhaps not surprising that initially women's apparent propensity to madness was regarded to be a direct result of their biology. The female body was theorized as a weaker, inferior comparison to the superior male, a potential site of dangerous hormones over which women were seen to have little if any control (Skultans, 1975; Showalter, 1987). The ideological implications of this are summed up in the following quote by Elaine Showalter:

“Victorian psychiatry defined its task with respect to women as the preservation of brain stability in the face of almost overwhelming physical odds”

(Showalter, 1987: 74)

While still relatively influential, the bio-medical foundation of psychiatry has increasingly been called into question, particularly by sociological

¹⁶ I will not be examining trends in what is regarded as 'real madness', psychoses, schizophrenia although the diagnosis involved in these disorders has been argued to be gender specific (women diagnosed for displaying aggressive tendencies, violence, shouting etc... men more likely to be labelled for showing passive emotions, crying, dependency etc...(Chesler, 1972, Ussher, 1991), primarily because statistics tend to show an equal distribution of the disorders amongst women and men.

accounts which emerged highlighting the impact of the social on mental illness rates.

Early research (reflecting the current gender theories of the time) typically looked to what was then referred to as sex-roles for explanations in gender differences, generally viewing the actual existence of mental disorders as relatively unproblematic and statistics as a true measure of rates (reflecting the dominance of bio-medical assumptions of pathology as aetiology). In effect, women were considered to suffer more mental illness than men (Broverman *et.al* 1970; Grove & Tudor, 1973; Brown & Harris, 1978). Explanations for women's over representation within statistics generally came to the same conclusions: women are more likely to be labelled as suffering from mental disorder because of the result of the socialization into the female sex-role, which again was taken as relatively unproblematic (Broverman *et.al* 1970; Grove & Tudor, 1973; Brown & Harris, 1978).

Initially, theories did not problematise the apparent 'facts', so in effect they were, in an attempt to find a causal explanation, arguing that women's social position made them 'mad'. For example an early review of studies into the frequency of mental illness in adults suggested that the changing nature of the female role, witnessed by a marked decrease in family size and a deskilling of the housewife role would invariably lead to women experiencing stress, and as such they would be more likely to suffer from mental illness (Gove & Tudor, 1973; Brown & Harris, 1978).

Clearly there are a number of problems with the studies, not least the refusal to acknowledge the extent to which the role of full-time housewife has been constructed and legitimized as 'natural' for women, and the ideological implications of this; that if a woman is not happy within a heterosexual marriage, caring for children, doing housework, often working as well, in essence, 'performing' her feminine role, then she 'must be mad' (Chesler, 1972; Showalter, 1987).

Social roles, or more specifically gender roles, assigned on the basis of biological sex impact on what is considered 'normal' behaviour and thoughts, but this is not simply on the part of psychiatric judgments of mental health, it is also subjective. In most cases a gendered identity is central to self-identity as a man or a woman (that is, as masculine/feminine), and individual subjective conceptions of mental health.

Although not explicitly, these studies were in effect stating that the female gender role was responsible for making women mentally ill (Broverman *et.al* 1970; Grove & Tudor, 1973). This was the foundation of a long and sustained feminist critique aimed at the role of psychiatry in labelling women as 'mad' and the impact of gender roles (as constructed within patriarchal society) on judgments and treatments of mental health. In essence, femininity, imposed upon women, was

identified as the causal explanation (Broverman *et.al* 1970; Chesler, 1972; Grove & Tudor, 1973; Brown & Harris, 1978; Showalter 1987).

Feminism & Mental Illness.

The first major study to investigate the extent of sexism within psychiatry was the extremely influential study by Broverman *et al.* (1970). Briefly, the study concluded that cultural stereotypes that appeal to natural and fundamental concepts of femininity and masculinity are accepted and internalized by mental health professionals, and influence the process of evaluation and diagnosis of mental illness. Central to these evaluations are normative judgments of behaviours, emotions and thoughts (associated with gender roles) considered appropriate and mentally healthy for men and women.

However, the study concluded that the description of a mentally healthy adult conformed to the masculine stereotype (independent, assertive, and so on) whilst the feminine stereotype (emotional, dependent, passive) was regarded as psychologically unhealthy. In essence, to be a mentally healthy woman was to be a mentally ill adult. Conversely, if women did display behaviours and thoughts associated with the healthy adult (and masculine stereotype) they were likely to be regarded as mentally ill, placing them in a no win situation (*ibid*).

The impact of gender roles has been and continues to be central in debates and theories surrounding mental illness. Within feminist

research without doubt the most constructive theory has been Phyllis Chesler's, *Women and Madness* (1972) who developed the work of Broverman *et al.* not only from a distinctly feminist perspective, but also incorporated an anti-psychiatry line, arguing that not only is psychiatry inherently sexist in its assumptions of mental health, it also acts as an institution of social control, policing the maintenance of gender roles in society whilst specifically devaluing the female role, as it is constructed in patriarchal society.

Chesler acknowledges that this has implications for men and women; men who totally or partially reject their male gender role are likely to be judged as being mentally ill, as are those who display any behaviour associated with the female role (e.g. emotional displays -weeping, or passivity and dependence). However, for Chesler, women are in a no win situation because if they attempt to reject their sex role they are labelled as mentally ill, but, unlike their male counterparts they are rehabilitated, with the aim of socializing women back into the female role, which is itself devalued and indicative of mental illness. Note though that in line with her anti-psychiatry stance, the actual reality of mental illness is dismissed or romanticized.

Key theories since Chesler's account have adopted a similar vein, that is that psychiatry is sexist in its assumption of mental health and that gender roles are central to the maintenance of gender differences in mental health statistics. And further, they imply by definition, that there

exists clear, distinct gendered identities, constructed around biological differences (Busfield 1989a; 1996; Showalter, 1987; Ussher, 1991; Prior, 1999).

However, Chesler has been criticized by Allen (1986), on methodological grounds, particularly the use of mythology to convey her argument and further, her reliance on statistics and diagnosis of schizophrenia, in support for her argument. Certainly today, although feminists continue to argue that schizophrenia is more likely to be diagnosed in women who display overtly traditional masculine traits such as hostility, aggressiveness and so on, there are at present no significant differences between male and female rates. Surely any feminist account of mental illness that seeks to uncover power relations within psychiatry must be addressing the areas where women and men are dominating the statistics, and questioning the reasons, the implications and issues of power and control.

Although writing in the early 1970's, clearly influenced by the anti-psychiatry arguments of the 1960's Chesler adopts a rather pessimistic approach and a perspective that sees the power of psychiatry reflecting ingrained misogyny on the part of all men, with it acting as some monolithic apparatus of social control, affording women, along with men, little if any resistance (Chesler, 1972:33). For example, she claims that she "discovered that neither men nor women liked women, especially a strong or happy woman" (*ibid*: 222). Further, and similarly as pessimistic,

Chesler argues that the excess of women within mental health statistics is to be understood not simply in the objective oppression of women or the alleged help seeking nature of the female role, but also in the context of recent social trends with the result that :

“...there is less and less use, and literally no place, for them {women} in the only place they ‘belong’ - within the family. Many newly useless women are emerging more publicly into insanity.”

(Chesler, 1972: 33)

Further in her analysis Chesler develops a theory based on sex-roles but is blatant in stressing the alleged animosity, ambivalence and open hostility that is afforded to women. She adopts an approach to the power of psychiatry that raises as many questions as it provides answers.

Chesler's assertions reflect an array of research findings that suggest that socialization into sex specific gender-roles has a major impact on the mental illness rates of men and women (Broverman *et.al* 1970; Grove & Tudor, 1973; Brown & Harris, 1978; Showalter 1987; Ussher, 1991). To summarise the argument, women socialized into displaying emotions more readily are subsequently more likely to seek-help and advice for what they regard as ‘mental’ problems. Women are expected to be emotional, vulnerable and dependent; men on the other hand are socialized not to display emotions or discuss ‘emotional’ problems and are expected to be strong, independent and assertive. Men continue to

be associated with reason, rationality and control, women with irrationality, unreason and lack of agency. This process ensures that by definition women are 'madder' than men (Broverman *et al.* 1970; Busfield, 1996; Chesler, 1972; Cochrane, 1983).

Again this approach offers little in the way of resistance to individuals and fails to account for any changes that have taken place in constructions of gendered identities (masculinity/ femininity) and of behaviours that are considered socially acceptable within such roles. Furthermore, and perhaps more importantly, it neglects to critically analyse the very concept that is asserted as the main instigator of gender differences ; the concept of gender itself, and the extent to which it can be perceived as a product of social and cultural construction (Butler, 1990, 1997), rather than a natural quality.

Sex-roles, or gender roles and gendered identities are undeniably of central importance in any understanding of mental illness differences between men and women, and Chesler's theory has, as Allen, (1986) claims been the foundation for subsequent theorising concerning gender and mental illness, in the works of Brown & Harris, (1978), Miles, (1988), and a number of others. Implicit in their analysis is the effect of socially constructed gender roles, the norms associated with them and how they impact on the diagnosis and categorization of mental illness.

However, as Allen (1986) notes, psychiatry may well be riddled with sexism, but that fact is a reflection of wider society at large and will undoubtedly impact on any diagnosis of mental illness. However, and importantly as far as the possibility of resistance is concerned, psychiatry can be guilty of an ingrained sexism, of sexist normative assumptions regarding the mental health of women, but this fact can be contingent to, and not constitutive of psychiatry (*ibid*:86-108), and so offers the possibility of change.

Certainly Chesler (1972) herself was echoing sexist assumptions concerning the sex-roles of women, especially the claim that women have been rendered useless “in the only place they ‘belong’- within the family” (Chesler, 1972: 33). Whilst it is possible to recognize the statement needs to be placed in the context of the time it was written, when politically women were more oppressed than today, it is asserting that there exists a ‘natural’ female role, as wife, mother, housewife, and that this is the only role that women can legitimately hold in society. Implicit in this statement is an assumption of essential femininity that manifests itself as a perceived natural role for women.

This would appear to contradict the emphasis she places on the effects of socialization into the female role, as it is constructed (a role that is perceived to be inherently destructive of mental health) which suggests an awareness of the extent to which gender roles are socially constructed. Yet Chesler produces a deterministic account, that whilst

identifying the nature of social construction still stresses a 'natural' role for women that centres on her role as wife and mother. As such, within mental health theorising, gender *per se*, becomes naturalized as an essential quality, albeit a socially constructed concept, and as such escapes serious critical analysis.

This substantially fails to note the possibility that these roles can be opened up for negotiation and offer a site of potential resistance for women, and further that whilst mother and wife may be identities with which women can identify they are by no means exhaustive, nor definitive. Self-identity, as relatively recent feminist theories highlight (Nicholson, 1994; Sawicki, 1988; Bailey, 1993), is by no means fixed, nor is there any ground to be made by appealing to some sort of essential femininity that women can and do identify with, and that subsequently makes them 'mad'. Indeed, as Butler, (1997) argues, regarding the political interests of feminism

"it is primarily political interests which create the phenomena of gender itself ...without a radical critique of gender construction feminist theory fails to take stock of the way in which oppression structures the ontological categories through which gender is conceived."

(Butler, 1997: 413)

Hilary Allen (1986: 90), points to three weaknesses that she believes have hindered feminist research into the gendered nature of mental

illness, which if addressed may well offer a means of developing the strengths of gender role theorising whilst allowing the possibility of conditions for resistance and the opportunity for change. The weaknesses identified are three theoretical standpoints adopted by feminist research in the field:

1. It is assumed that without the refusal to accept any possibility that women may be more vulnerable to mental illness as a possible explanation for their over-representation then it can not be a feminist account.

2. It is assumed that any theory of gender and mental illness can not be theoretically adequate unless the subsequent explanation of women's psychopathology is theorized in terms of institutionalized sexism.

3. There is assumed the need to attribute blame to men in general and patriarchy in particular for the theory to be political.

Allen (1986) argues that these three assumptions are not necessary for a feminist analysis of the politics of psychiatry yet there is, as she argues, every reason to take seriously the pervasiveness of psychiatric sexism. However, it is fundamentally unhelpful to claim that psychiatry has the maintenance of sexism and gender roles as its main aim. Rather, it will offer a more fruitful project to "acknowledge that women's apparent over-representation within psychiatry may have multiple origins

and need not be susceptible to any grand and unifying explanation" (*ibid* :107).

Contemporary Gender Role Theory & Mental Illness

The influence that 'sex-roles' theory has had on theoretical developments since Chesler's publication is evidenced by its central position in an influential text regarding gender and mental illness, Busfield's (1996) *Men, Women and Madness*. Busfield openly advocates Chesler's sex-role theory (brought up-to date as gender role) as a working theory which acknowledges the extent to which sexism is responsible for the gendered nature of mental illness rates.¹⁷ At first sight the theory would not seem too problematic; it would be impossible to deny the effect of socialization into gender specific roles and the internalization of a gendered self-identity that may follow from this.

This process ensures that perceived 'norms' are internalized at a very early age and usually involve constructions of what constitutes 'natural' masculinity and femininity. Even the most politically correct parent can't prevent the effect of socializing with peers, social discourses such as, television, newspaper, magazines, where gender identity is constructed and reconstructed; where bodies take centre stage shaping and constituting our beliefs about men and women as essentially different – complementary, yet polarized, as biologically determined 'natural' social

¹⁷ Busfield's (1996) theorization of mental illness also incorporates Foucault's (1971) emphasis that madness became conceptualized as a loss of reason and rationality, the manner in which women are denied reason and rationality, the attribution of agency and control (usually denied to women but regarded as inherent in men) and an inability to perform gendered social roles.

order. In effect we become 'gendered individuals' through the discursive social possibilities available to us.

As discussed earlier, the fact that masculinity and femininity are social constructs assigned to male and female bodies has become established in social theory and the problematic nature of the manner in which masculinity and femininity are theorized has been the subject of a warranted criticism (Butler, 1990). Yet with regards to mental illness, social research continues to follow the trend that has been firmly entrenched, wherein gender studies of mental illness involves either women and the problematic nature of femininity, or women's mental illness as a social construct, and a means of social control. This substantially 'normalises and naturalises' the over-representation of women within studies (Ettorre & Riska, 1998:4).

As far as men and 'madness' goes, there is a neglect of men and mental illness in the sense that their apparent manifestations of madness; alcoholism, personality disorders and so on, are seen as the result of some essential male characteristics that are internalized throughout the socialization period, a natural extension of the male sex role (Busfield, 1996; Ettorre & Riska, 1998; Pilgrim & Rogers, 1993:37-43). This also fails to account for the large numbers of men that are diagnosed as suffering from depression and anxiety, which in general consists of a far greater number than the men diagnosed within the categories identified by theory as 'male categories' (Busfield, 1996 : 17).

This trend reinforces and naturalizes the polarization of the sexes as essentially different. Research in gender studies tends to be men's studies, masculinity's, men's health, and so on (Hearn, 1996; Petersen, 1998; Connell, 1995), or women's studies, femininity and women's health (Robinson & Richardson, 1997; Ussher, 1997), substantially weakening any attempts to theorize gender relations. It has become legitimate to examine either women in relation to men, society and social institutions, or conversely, men in relation to women, society and social institutions. This appeal to essential differences evokes and sustains a polarization of the sexes.

Rather than seeing psychiatry as some dark monolithic force, shaping our thoughts and actions, theories seeking to address the gendered nature of mental illness rates may wish to question why 'gender' and gender identity are not subjected to the radical critique within mental health theorising that it has warranted elsewhere (Butler, 1990; 1997; Fuss, 1989; McNay, 2005). If gender identity does not necessarily imply that individuals have some 'essential' defining sense of 'self' that is gendered, then it is futile to begin theorising on the basis that gender identity is a central and defining feature of self-identity.

Certainly research has tended to take gendered stereotypes as their starting point, for example, feminist research into depression has highlighted women, because women appear to get labelled as depressed more than men (Busfield, 1996; Showalter, 1987; Ettoree &

Riska, 1998). This may seem a legitimate approach but it ignores the large numbers of men that do experience depression and how an understanding of their experiences in relation to, or in comparison with women's experience may actually heighten or enrich our understanding of the workings of the power of psychiatry to label individuals. Are men as constrained as women, are they afforded more resistance to the label solely on the basis of their gender identity as feminist theorists such as Chesler would argue, or does the impact of gender role identity render it harder for them to seek help, as such they are more constrained than women?.

In a similar vein, research into male mental illness tends to reflect stereotypical assumptions of men as not emotional in the same way that women are (Ettorre & Riska, 1998). For example, compared to the relatively large field of feminist research into women and madness there is little research that has investigated men and mental illness. Of those studies that examine men and mental illness they generally conclude that men are as likely to be labelled as mentally ill as women (Busfield, 1996; Pilgrim & Rogers, 1993). However, it is asserted that the combination of sexism within psychiatry and the impact of gender role socialisation results in men's madness take different forms. These behaviours, drug abuse, alcoholism, anti-social behaviour and so on are all behaviours that are considered an extension of the traditional 'normal' male role (Prior, 1999:77-95; Busfield, 1996).

Again, this reinforces and legitimises the notion of essential differences between men and women, i.e. 'masculinity' and 'femininity', as ascribed to biologically male and female bodies. This notion of differences substantially reinforces a cycle of gender specific research which seeks to assign the 'cause' of mental illness as either femininity or masculinity (whether inherent or constructed). These concepts continue to be central to judgments and diagnosis (both objective and subjective) of mental illness.

To summarise, conventional theories of gender and mental illness have followed a distinct male/female sex/gender roles differentiation to account for differences in the diagnostic categories of mental illness. There also exists an implicit assumption that the over representation of women is a result of some essential femininity that can effect not only the material conditions under which women live, but also shape the manner in which they respond to the pressure deemed constitutive of that feminine role.

'Gender roles' and 'gender identity' have been extensively utilized in theorising gender differences in mental health statistics, yet there are a number of weaknesses that need to be addressed, highlighting the need to direct attention to the epistemology of mental illness, in particular to its implicit reliance on concepts of masculinity and femininity to explain differences in mental health statistics.

Furthermore, theorising mental disorder in the manner that has become customary is at best superficial, lacking insight and understanding of the concept; at worst it renders insignificant the embodied experiences of the people that suffer mental illness.

Mental illness has a profound impact on the lives of both women and men; it is an intensely personal experience that impacts across all areas of an individual's life, the complexities of which can not be captured through a reliance of evoking some form of essential 'femininity' or 'masculinity' as a causal factor; particularly in relation to women's apparent propensity to experience depression.

Gender Identity & Depression

Depression is generally considered to be regarded as a mental illness characterized by feelings of despair and sadness, of loss and hopelessness (Hammen, 1997; Allen, 1986:92; Busfield, 1996: 90-94). The excess of women labelled as suffering from depression is theorized by reference to sex/gender role socialisation and further the unquestioned assumption that women are more likely to internalize any psychological difficulties, whilst men typically express any psychological problems externally by excessive alcohol consumption, drug use or anti-social behaviour (*op.cit*).

The reliance on 'gender roles' and 'gendered identities' utilised in theories of gender and depression has influenced the extent to which the

theory has tended to stress the emotional aspect of depression at the expense or neglect of the impact of the physical symptoms of depression: tiredness/fatigue, weight loss/gain, sleep problems, lack of concentration to name a few; – gender neutral symptoms that affect most sufferers to greater or lesser degrees.

Focusing on the emotional aspects of the experiences of depression has legitimised a narrow focus on gender-identity as a causal factor; a gender identity that conforms to the age old stereotype of women as more emotional and vulnerable, unstable and dependent, in contrast to the stereotype of men as rational and assertive, independent and stable. This approach substantially reinforces appeals to 'natural' difference and affords little hope of change. Perhaps most importantly is the manner in which this approach detracts attention from the impact of mental health in terms of the lived experiences of the many women and men who experience mental ill health. For these individuals a mere check list of symptoms can never hope to capture the holistic experience or the profound impact that mental illness has on their day to day lives.

Of course it would be extremely naive to advocate a neglect of the real and tangible problems and constraints that women continue to face and institutionalised sexism no doubt still impacts on the lives of many women, either directly or indirectly. However, as noted earlier, the concept of gender and gender identity has repeatedly been called in to question in recent years and the usefulness of the concept continually

challenged in the studies of both femininities and masculinities (Baca Zinn, et. al. 1986; Bordo, 1990; Butler, 1990; Bailey, 1993; Nicholson, 1994; Hern, 1996; Petersen, 1998).

To continue to privilege a concept that has been called into question, i.e. 'gender identity' as the key aspect of cause and experience of mental illness is superficial and only fulfils the legacy that biology is destiny (sexed bodies become gendered bodies, gendered bodies become the bearers of gendered identities).

Conclusion

Sex, gender and gender identity are historically, socially and culturally specific concepts that have been utilised over the centuries to legitimise the notion of the sexes as discrete and separate categories, complementary, yet opposite. The ensuing relationship between the sexes has been characterised by the privileging of the male 'masculine' over the female 'feminine'. There is considerable political potential for justifying the relative inequalities that exist in gender relations by polarising the sexes. However, it would appear that rather than questioning the extent to which these concepts determine the social oppression of women in relation to men, there exists a need to question the validity of the concepts that are utilised in such analyses: if there are no gendered identities then there can be no justification for the privileging of one over the other.

Self-identity and gender identity, are not fixed, stable or definable; this is evidenced by the extent to which criticisms of feminism's use of the term 'woman', came largely from women (Baca Zinn, et. al. 1986; Bordo, 1990; Butler, 1990). Developing the work of Butler (1990), it is possible to recognise that the 'performance' of gender is undoubtedly central to the organisation of the sexes as distinct and separate. However, it is not possible to assume that gender, or gender identity are central, defining, or even salient features of an individual's sense of 'self' and/or self-identity. Rather, gender theorising has reified it as such.

While the concepts of gender and gender identity have been repeatedly called into question and their usefulness as valid heuristic tools challenged, they remain remarkably tenacious. Whilst there is political potential in utilizing the concepts to challenge the inequalities between the sexes, there remains the danger of reifying the very concepts that perpetuate such inequalities. The subsequent essentialism that emerges can do more harm than good politically (Butler, 1990). This is clearly reflected in the field of gender and mental health which have taken gender and gender identity as the starting point and utilised the concepts of sex, gender and gendered identities unproblematically. This has served to reinforce the existence of gendered stereotypes of masculinity and femininity and the concept of gender identity as 'essential' qualities (whether biologically or socially determined) and causal factors in the experience of mental illness.

Whilst the context of Butler's arguments remains largely at a philosophical and abstract level, it does possess potential for the future theorising of identity issues and will be developed and extended throughout the thesis to develop a deeper understanding of the impact of depression on subjective experiences of 'self' and self-identity.

In order to achieve this, the following chapter will lay the foundations for the study by discussing the philosophical, theoretical and methodological background to the study, along with a discussion of the research methods adopted during the research process. It will also provide a brief biographical account of the research participants.

CHAPTER THREE

Methodology

“There comes a time....when one begins to lose sight of the fact that sociology is about people; that all of the classes, genders and ethnic groups are comprised of people who are engaging in the world”

(Mohammed, 1993:208)

Is it possible to comprehend a ‘society’ without people and could we ‘know’ people without society? Could we experience ourselves, or identify others without society? The answer of course, is no. The two concepts, ‘people’ and ‘society’ may appear to identify different things, but they are inextricably linked. People are not ‘just’ people, they are, and it is argued, now more than ever, ‘individuals’ with ‘individuality’- a sense of a ‘self’: and self-identity (Roseneil & Seymour, 1999; Jenkins, 1996; Giddens, 1991). This sense of ‘self’ and self-identity is granted meaning and substance and ultimately is sanctioned and validated both within and through society (Butler, 1996; Giddens, 1991; Hall 1996; Jenkins 1996; Logan, 1987).

How we make sense of our ‘selves’ and of ‘others’ takes place within the social arena through the categorisation of ‘self’ and ‘others’, it is what guides us through our social and subjective lives. Gender, ‘race’, ethnicity, age, class, sexual orientation, are just a few of an array of

categorisations we utilise on a daily basis in order to make sense of others, ourselves, and ultimately, society. Recent developments within the social sciences reflect the extent to which society has been subject to theorisation in the quest to make sense of our 'self' and society. A plethora of research and publications seek to make sense of society's concern with 'self', self-identity and the social arena; while simultaneously aiming to increase our understanding and knowledge of the dynamics of the relationship between 'self', identity, and society, to name a few: Foucault, (1984); Butler, (1990); Eriksen, (1993); Giddens, (1991); Hall & du Gay, (1996); Roseneil & Seymour, (1999); Woodward, (1997); James & Hockey (2007).

It is through the process of social research and the production of theories and empirical evidence that the knowledge base of the social sciences expands and extends our knowledge of 'self', 'others' and society. The relationships, tensions and conflicts that are characteristic of 'self' and society are revealed in more or less detail, from different perspectives, often fuelled from different political agendas. They all seek to tell their explanations, 'their truth', and 'their story', for the phenomena they are investigating.

The following chapter will highlight the different methodological approaches that can be seen to underpin the research process. Beginning with a brief historical overview of the philosophy of the social sciences, the chapter will then provide an overview of the two dominant

methodological approaches to research, commonly identified as either quantitative methodology or qualitative methodology. It will then discuss the epistemological base and the theoretical basis which has influenced the design of the study. Methods of data collection and analysis will also be discussed. The chapter will then move on to provide a brief biographical sketch of the individuals who took part in the research study and discuss the researcher's role in the research process.

Before beginning the discussion of the two main methodological approaches to social research, it is useful to sketch a brief history of the philosophy that has underpinned and influenced the development of current research methodologies.

Philosophy of the Social Sciences

The historical origins of the philosophy of science can be seen to date back to ancient Greece in the work of Aristotle, (284-322 BC) who is credited with being a pioneer in speculating about 'the nature of things' (Smith, 2000). Aristotle was interested in the collection of systematic information and an inductive–deductive view of the process. This approach is based on the idea of observing what happens in the social and physical world and then deducing as to why it is happening. He was also credited with being the first to consider what is meant by causality, and aimed to distinguish between accidental and causal correlations (*ibid*). This approach was based upon the assumption that collecting factual data through observation would allow for generalisation and

causal correlations to be established; and so increase the observational data base. This inductive –deductive approach was to be developed further into the hypothetical-deductive model to accommodate the introduction of hypotheses testing and deduction, which was beginning to take place in the natural sciences during the seventeenth century. These developments became influential and helped establish the foundations for future theorising about the social world (*ibid*), and were further developed by the work of Descartes, (1596-1650).

Descartes is credited with the addition of rationalism in the quest to establish the universal scientific ‘truths’ of the social and natural world (May, 1996:11). Descartes argued that since individual perceptions of what constitutes or is experienced as ‘reality’ is variable, it becomes impossible for any social or physical reality to be known with any degree of certainty. Since experience is an unreliable measure of reality then it cannot be a satisfactory basis for knowledge. For Descartes:

“The basis for knowledge is reason...as long as the individual believes that they are ‘something’, then an ‘I’ can be said to exist. This is a basic truth and the foundation for knowledge”

(May 1996:11)

The privileging of reason in the search for ‘scientific truths’ was further strengthened with the empirical underpinnings that were emerging from the hypothetico-deductive approach that was establishing the role of

experimentation in hypotheses testing for generating empirical data within the social and physical world (Smith , 2000:8).

Influenced by the work of Descartes, and in particular the idea that 'the basis for knowledge is reason' (May, 1996: 11), Immanuel Kant (1724-1804) developed the search for universal truths further, through the addition of 'reason' and empiricism to the hypothetico-deductive model of social research (*ibid*, McNeil, 1990:49). These developments were to flourish during the Enlightenment period.

The Enlightenment

It was around the seventeenth century that the search for universal 'truths' about individuals, the social world and nature, gathered pace; a period that is now referred to as the Age of Enlightenment (May, 1996). This period is characterised by a shift in general thought, that moved away from, and challenged existing conceptions that had been, up until that point, dominated by the views of the church and Christianity. Explanations for social phenomena during this period were allegedly characterised by irrationality and superstition (Crotty, 1998:185; May 1996:10-15).

The Enlightenment era saw the emergence of a new set of ideas that were to change the nature of the established order of things. The key ideas and changes that took place during this period have been identified as: the emergence of the autonomous individual, capable of

acting in a conscious manner; the quest for universal 'truth' which was to be obtained through interacting with social and physical reality; a belief in the natural sciences as the legitimate way to conceptualise the social and physical world; and the accumulation of systematic knowledge (Crotty, 1998: 184-188; May, 1996:8). During this period the systematic collection of data provided empirical evidence and facilitated the accumulation of further 'scientific' 'truths'. This helped to establish key discourses as superior and powerful in the quest for universal 'truths' about the social and physical world. During this period, perhaps the most notable field of science to become firmly established as the 'truth' was the field of medical science (Foucault, 1973).¹⁸

Positivism

The philosophical assumptions that evolved during the enlightenment that prescribed the methodological processes to facilitate the search for scientific 'truths' about the social and physical world, are generally referred to as positivism (May, 1996; Smith, 2000, Jones, 1993; Clarke, 2001).

Positivism as a research philosophy and theory is underpinned by the assumption that, similarly to the world of natural science, society,

¹⁸ During this period 'scientific' theories began to emerge that were utilised to 'confirm' women as inferior, both biologically and mentally to men. There were also 'scientific' links firmly established between female sexuality and female 'madness' during this period (Showalter, 1987; Ussher, 1991).

individual behaviours and phenomena (within the social and physical world), can be studied using objective, value free methods that will uncover universal laws, or 'truths' about behaviour. From this perspective, behaviour is seen primarily as the result of external pressures acting upon individuals as they unwittingly go about their daily lives. The aim of research is to make predictions about behaviour and society through establishing causal correlations between the phenomena observed and the behaviour outcome. Data is collected systematically and analysed statistically to provide scientific evidence to inform the empirical evidence base. From this perspective, only research that is carried out under strict operationalised conditions, using objective and standardised research tools to test hypotheses is capable of generating robust, reliable and valid data that can be generalised to the research population (Smith, 2000; McNeill, 1990; Gilbert, 2001). These processes are based upon the hypothetico-deductive model of research discussed earlier.

Karl Popper & Falsification

The hypothetico-deductive model of research at the heart of positivism was not without its critics. Perhaps the most well known of these was Karl Popper (1902-1994) who criticised the traditional view of the hypothetico-deductive approach and established an alternative view. For Popper, rather than science and knowledge progressing further through the testing and proving of hypotheses to strengthen their claim to 'truth'; the search for 'truth' would be better served by attempting to 'falsify' their

hypotheses. This is because, according to Popper, all observation is theory laden and further, there is no overarching or absolute 'truth' waiting to be discovered (Smith, 2000; Gilbert 2001; Crotty, 1998:31-33). As such, a theory can never be completely verified in the sense that experiments 'prove' it to be correct, but it can be falsified. If the theory is falsified it is proven to be incorrect and it is this process that scientists should be striving for when carrying out research: to falsify the theory, not reinforce it.

However, the views of Popper have been criticised by Thomas Kuhn (1922-1998). While Kuhn agrees with Popper's assertion that science cannot arrive at an absolute truth, he disagreed about the role of falsifiability. Kuhn identified mature branches of sciences as having a 'paradigm' that has been accepted as a set of guiding principles and assumptions that underpin the manner in which research is undertaken (Smith, 2000:13-17; Gilbert, 2001:25-26, Crotty, 1998: 34-37):

"For scientists in general, the prevailing paradigm is the matrix that shapes the reality to be studied and legitimates the methodology and methods whereby it can be studied".

(Crotty, 1998: 35)

For Kuhn, the prevailing paradigm is taken for granted within the scientific community and any early attempts to displace it will be quite

readily dismissed. However, if the existing paradigm becomes increasingly challenged by new ways of thinking and proves inadequate to deal with these challenges, then a paradigm shift takes place (Crotty, 1998: 35):

“To be accepted as a paradigm a theory must seem better than its competitors, but it need not, and in fact never does, explain all the facts with which it can be confronted”

(Kuhn, 1970: 17-18, cited in Smith, 2000: 15)

This view is different from Popper's in that Kuhn suggested that scientists avoid trying to falsify their theories, and that this (proving theory) is a necessary part of science. When current theories are challenged a competing paradigm may appear which will in turn establish itself as a 'normal science', bringing with it a new set of assumptions, methodologies and methods. As such, it is not so much the search for truth through falsifying theory, but rather, the continued search for truth through paradigm shifts that characterises science.

Positivism has had a major influence in the social sciences; indeed it was the established paradigm for much work in the social sciences and continues to inform much social research today. The general principles and assumptions of positivism are generally characteristics of the research perspective that has become generally known as quantitative research methodology.

Methodological Approaches – Quantitative Methods

The methodological approach adopted when undertaking research will undoubtedly influence the design of the study; it will also be instrumental in deciding which methods are used to collect data. The philosophical underpinnings of quantitative social research are those associated with positivism. As discussed above, positivism, with its base firmly entrenched in science, adopts the view that society can be objectively studied and measured in much the same way as the natural sciences. Furthermore, it assumes that there are similar universal laws that govern social and physical life. The aim of research methodology from this perspective is to design research to be as objective and value free as possible (Clarke, 2001; McNeill, 1998)

Quantitative research is designed to facilitate using research tools that can supposedly and systematically collect objective data that is free from any bias from the researcher. Typical research methods include surveys, structured interviews and experiments (Burton, 2000a; Simmons, 2001; Manstead & Semin, 1988). The aim of the research is to gather data that can be quantified and analysed statistically. Statistical analysis allows the interpretation of causal relationships between phenomena and behaviour and provides empirical data as evidence to substantiate the findings of the research (Gayle, 2000; Proctor, 2001a). Through adopting a systematic approach to the design of the research and the research tools, this approach aims to produce research findings that are valid, reliable and generalisable to the research population (Gilbert,

2001; McNeil, 1990). The research process is standardised and operationalised and the study sample is scientifically selected to ensure a representative sample that is statistically capable of ensuring that the findings are generalisable to the general research population (Arber, 2001; Burton, D, 2000).

Research tools suitable for use with quantitative methodologies include carefully designed questionnaires (Simmons, 2001; McNeill, 1990), observations and operationalised experiments' where variables are identified, controlled and manipulated by researchers under strict laboratory conditions (Manstead & Semin, 1988; McNeill, 1990:52-58; Jones 1993:130). This methodology asserts that social life and the actions of individuals can be investigated to produce robust and reliable empirical evidence that is generalisable to the population on whom the investigations are based.

The positivist/quantitative methodological approach to concepts of mental health for example, has allowed clearly definable sets of symptoms to be classified and categorised and subsequently transformed into a scientific medical diagnosis of mental illness. It also collects and systematically records statistics on those who experience mental illness. This is undertaken to establish how prevalent mental illness is within the general population. It also helps to build a detailed picture of the numbers of people who experience mental illness and highlight any discrepancies; for example, the over-representation of

certain groups (i.e. women are over-represented in the category of depression, Busfield, 1996; Ussher, 1991). However, a quantitative approach, with the focus on objectivity and the systematic collection of data cannot tell us *why* there are differences in the diagnostic rates. Perhaps more importantly, while the positivist influence can produce a set of definable 'symptoms' that, taken together result in the clinical diagnosis of depression, it cannot begin to address the issue of what it is like to *experience* depression. The inability of positivist/quantitative approaches to social research to establish the 'why' of behaviours and the importance of the experience in the understanding of social life has also been criticised.

Positivist/Quantitative Methodology – Critique

The positivist paradigm became firmly established within the social sciences, and remains very influential in study design and methodology associated with quantitative research up to the present day. However, it did come under increased criticism in the field of sociology during the 1960's (Jones, 1993; Crotty, 1998). The key criticisms levelled against positivism as a methodological approach to social research are summarised below.

Positivist philosophy sees people responding to external pressure, or reacting to stimuli in a manner that can be objectively measured and quantified. This, as discussed earlier, can be seen as reflecting a desire to mirror the natural sciences in the quest to make social enquiry a

legitimate science based discipline, capable of uncovering universal laws that govern society and the behaviour of individuals (Crotty, 1998; May, 1996; Smith 2000). However, one of the main criticisms to be levied at this approach is the validity of applying the principles of the research processes of the natural sciences to the social arena (Fielding, 2001). The natural sciences conduct research on the characteristics, properties and relationships of inanimate physical objects. The subject matter does not have any level of consciousness and as such it is relatively easy to remain objective and standardise research methodologies.

However, how applicable is this approach when you have a subject that is conscious, thinking, reacting and experiencing? (Crotty, 1998; Fielding, 2001; Jones, 1993). Is it realistic for example, to state that individuals involved in a research experiment are responding only to the variables that the researchers are manipulating? What about the effects of other stimuli on their experiences? Individuals' experience situations through a range of interacting phenomena; they interpret, interact and assign meaning (Smith, *et al.* 1995). Meaning can be shaped by emotion, reason, logic, memory, anticipation, perceived vulnerability, threat, liberation or empowerment. People are complex, embodied, perceiving individuals, and their experiences take on meaning and substance in the social context in which they live their everyday lives (*ibid*).

Furthermore, how much of positivist research is actually based on value free, objective principles, when the process is theory driven? As such, the research process is necessarily underpinned by a set of assumptions that will undoubtedly influence the design of the study, the methodology and the methods used. Ultimately this will dictate what data is collected and how, the analytic processes involved to generate the results of the study, and eventually, the choice of empirical evidence to support the theory (Jones, 1993; McNeill, 1990). Not only does this have an impact in shaping the outcome of the study before it is undertaken, it also does not allow for the experiences of those involved and the impact of their experiences on the findings.

It is the very thing that the positivists find so objectionable – the subjective experiences of individuals that the interpretive perspective takes as their starting point. This school of thought adopts a qualitative research methodology.

Interpretivism/Qualitative Research Methodologies

Interpretivism is often linked to Max Weber (1864-1920) and in particular to his notion of *Verstehen* – or, understanding. Weber suggested that the social sciences are concerned with understanding the meanings behind social life, as opposed to the natural sciences preoccupation with explaining phenomena (Crotty, 1998). Interpretivism, as a philosophy is concerned with understanding how people make sense of their experiences within the social context of everyday life. It is concerned

with establishing how people interact and interpret the social world, what is given meaning and why (Jones, 1993; Crotty, 1998; Fielding, 2001).

Unlike positivist approaches to research which are typically theory driven, interpretivism methodologies are inductive by nature. That is, they have no hypothesis to 'test' as such; rather, they wish to observe phenomena in as natural a setting as possible, and then attempt to make sense of it. As such, in contrast to positivist methodologies, interpretivism research is not typically theory driven (Rice & Ezzy, 1999). While positivist methodology will establish clear boundaries about what is investigated and how, interpretivism researchers are generally more open-minded. This approach allows the findings that emerge from the study to establish the basis for any theorising that takes place upon completion of the study, (*i.e.* grounded theory, Strauss & Corbin, 1994). In this sense, while positivism may be seen as adopting a 'top-down' approach to research, interpretivist's generally adopt a 'bottom-up' approach (Miller, 1997).

Interpretivism research is generally conducted under the philosophical assumptions that include recognition that there is no universal 'truth', waiting to be established within the social world. Rather, it is recognised that 'reality' is subjective and different groups, and individuals within groups will have their own version of reality (Clarke, 2001). There is also a strong emphasis on investigating social phenomena in their natural setting to fully understand it (Fielding, 2001; Smith, 2000; Crotty, 1998).

This is fundamentally important to qualitative methodologies. One of the key themes underlying this approach is the importance of gaining an understanding of the symbolic world in which people live and make sense of their lives through interactions with others. This approach stresses the reflexivity of all social interactions in the construction of meaning and reality for individuals. Individuals' ideas of their 'self' and social world are not arbitrarily assigned. On the contrary, it is through assigning meaning and having that meaning confirmed or denied through social interactions with other people, that meaning is shaped into reality. From this perspective, individuals are aware of the potential of their 'self' as a symbol in social interactions. The reaction of 'others' to the symbolic 'self' in shared interactions can in turn have an impact upon an individual's view of 'self' and society. As such, experiences take on meaning, "as they become symbolically significant through shared interaction" (Rice & Ezzy, 1999: 18). The reflexive process inherent in all interactions highlights the extent to which the symbolic world is rendered comprehensible to 'self' and society (Crotty, 1998; Smith, 2000; Jones, 1993).

To gain a deeper insight into the lived and shared 'reality' of individuals, the interpretivist approach may see the researcher entering the social world of the individuals whose lives they are interested in researching. This is to facilitate an understanding of the context in which meaning is assigned and reality is shaped into existence (Clarke, 2001; McNeill,

1990; Jones, 1993). One of the key theories that ¹⁹ emphasise the importance of studying phenomena in the natural setting is participant observation.

Interpretive/Qualitative Research

Interpretive/qualitative research such as ethnography and participant observation allows an insight into how people, society and cultures interact to create the context in which people live and make sense of their daily lives (Fielding, 2001). Adopting this methodological approach allows the researcher to gain an understanding of how reality is shaped, given meaning and substance by individuals and society. It also allows an insight into the subsequent impact this has on individuals' perceptions of 'self', society and everyday life (Parr, 2001; Rice & Ezzy, 1999). The richness of data may not be 'scientific' in the eyes of positivist researchers, but in terms of validity, it should provide a unique understanding of the experiences of the groups being studied (*ibid*).

Sample Design in Qualitative Research

The nature of qualitative research methodologies means that samples do not typically attempt to be statistically representative (Rice & Ezzy, 1999). This usually means that sample size is not as large as those used in quantitative research and sample selection may include particular groups in society, or institutions (Fielding, 2001; Goffman, 1961). Most

¹⁹ There are other theories associated with the interpretivist philosophy and methodology, these include, symbolic interaction, phenomenology and hermeneutics. For a more detailed discussion on these methodologies see, Crotty, 1998: 71-111; Stevenson, 2000:21-32.

small scale research projects will have smaller samples and the selection criteria will be determined by the subject area and access to individuals by the researcher (Arber, 2001). However, there is guidance available as to differing approaches to sample selection in qualitative research (Rice & Ezzy, 1999: 42-48). The approach to sample selection will ultimately be influenced by the design of the research project.

Interpretivist/Qualitative Research Methods

Interpretivism, as a theory leads to the adoption of qualitative methodology, which in turn has its own set of research tools that are specific to the particular needs of the perspective. As discussed above, the focus of the research is to obtain a deeper understanding of experiences that make up the everyday lives of people and society. Research methods include participant observation (which may be overt or covert) and the qualitative interview (Fielding, 2001).

Participant Observation

Participant observation is a research method favoured by anthropologists; it is also utilised by qualitative researchers. It allows the research to take place in the natural setting in which the phenomena occur. The contextual layers that provide meaning and understanding to the behaviours of individuals, groups and cultures can be gradually revealed as the researcher learns the nuances of everyday ordinary life (Fielding, 2001; Creswell, 1998:180-186). It is also hoped that by being a part of the day-to-day lives of people the researcher will gradually

become part of the 'natural' order of things and minimise the effect that the researcher has on the setting (Fielding, 2001, McNeill, 1990). Participant observation is usually overt (i.e. the group in question know that the researcher is conducting a research study), though covert participation (i.e. where the group in question do not know they are being studied) does take place; though its use should be justified ethically (Fielding, 2001:149-151). The relative strengths of this method are the ability of the researcher to glean a wealth of rich data from the natural setting that the phenomena occurs in. While the findings from small scale studies do not allow the generalisation of the findings, they do bring a depth of understanding and validity to the findings (*ibid*, Creswell, 1998).

Qualitative Interviewing

The interview as a research tool in qualitative research is to be distinguished from the structured or semi-structured interviews that are generally utilised as a research method in quantitative research methodologies. The quantitative approach sees the interviewer asking the same questions in the same order, with an emphasis on the interviewer maintaining objectivity throughout. The questionnaire is designed to obtain robust and reliable data and usually will consist of closed questions throughout the bulk of the questionnaire (Simmons, 2001). In contrast, the interview as a research tool in qualitative research is usually largely unstructured (Fielding & Thomas, 2001), although there

is a distinction to be made between unstructured and focused (or in-depth) interviews (Rice & Ezzy, 1999).

Both interviews are designed to be non-directive and open-ended with the aim of establishing a two-way conversation that is as natural and informal as possible. The focused interview is in-depth, usually a minimum of an hour long, during which the focus is on the given topic, though there are no set questions. Rather, the interviewer will have an idea of areas or topics they wish to explore, but the interview is led by the interviewee and their responses lead the interview (Rice & Ezzy, 1999; Fielding & Thomas, 2001; Strah, 2000). This allows for an in-depth understanding of the topic from the point-of-view of the interviewee; it is their experiences that are important. The in-depth informal approach of the focused interview is particularly useful for exploring sensitive topics, which can by their nature require an informal approach from a researcher who is capable of empathising under the circumstances (Rice & Ezzy, 1999). This is particularly the case with sensitive topics where some interviewees may become emotional. The reaction of the interviewer is crucial in these instances and an ability to make the interviewee feel at ease and respected is crucial if the interview is to continue in a meaningful manner.

Once again, in contrast to the interviewer in quantitative research, who aims to minimise interviewer bias by remaining as objective and detached as possible (Simmons, 2001), the interviewer in qualitative

research actively engages in the interview process (Fielding & Thomas, 2001; Rice & Ezzy, 1999; Mason, 2002). While the focus is on the interviewee's own meanings and concepts, the interviewer has an active part in facilitating the 'conversation like' characteristic of the interview. This may involve the researcher contributing their experiences and giving their opinions if asked; however, the focus of the interview remains on the experiences of the interviewee (Rice & Ezzy, 1999; Strah, 2000) and developing a two-way conversation-like interview. The skill of the interviewer lies in their ability to engage in the interview with a relaxed and informal approach while remaining focused on the topic.

It is crucially important for the interviewer to stay positively engaged in listening to what the interviewee has to say and resist interrupting (Rice & Ezzy, 1999). Interviewers should become comfortable with silence as often the interviewee may need time to collect or crystallise their thoughts (*ibid*). If they feel rushed or pressured to say something at this point it may well undo any rapport that has been established. However, if a silence is uncomfortable then non-verbal cues are acceptable. These may include a reassuring nod, an expectant glance, or further verbal prompts, for example; 'I'm really interested, please tell me more' (Fielding & Thomas, 2001).

Qualitative Research Analysis

The research methods adopted for qualitative methodological studies often manifests large amounts of data to be collated and analysed. Data

collected includes field notes from observations, notes from interviews and transcripts from transcribed interviews. Making sense of the data is often time consuming and involves reading and coding data (Fielding J, 2001; Mason, 2002; Rice & Ezzy, 1999). There are computer programmes that can assist with qualitative data analysis, though the researcher will still have to code the data for input into the computer (Fielding, J, 2001; Stroh, 2000a). Once manually coded the data can be indexed and cross-referenced and emerging themes noted. Once this process is complete the researcher can analyse the findings and write up their end of project report. However, the analysis is still that of the researcher.

It is important that the researcher recognises their role, not only in the research process, but also in the analytic process. During the research process the role of the researcher is perhaps more evident, for example, in the choice of research topic and methodology. However, the analysis of qualitative data will be influenced by how the researcher 'reads' the data collected, which can be, literal, interpretive or reflexive (Mason, 2002: 148-150). The type of reading adopted by the researcher will also impact on what is counted as data, and subsequently what analysis takes place (*ibid*). Mason (2002) suggests that it is not unusual for qualitative researchers to read their data on all three of these levels (*ibid*: 149).

Interpretivist/Qualitative Critique

As might be expected, the main criticism to be directed at qualitative research methodology (typically from a positivist perspective), is that it is non-scientific in its approach to research (with its emphasis on subjective experiences), lacking in objectivity and as such the findings are not reliable or generalisable. The subjective stance of the researcher in qualitative research is also regarded as a weakness of the methodology (Fielding, 2001; Jones, 1993; McNeill, 1990).

The interview has been criticised as a research method in both quantitative and qualitative research. It is argued that whatever the design of the interview there will inevitably be some elements of researcher influence on the interviewee responses. As with researcher bias, it is argued that interviewees may well answer questions to suit what they believe the interviewer will want to hear (Fielding & Thomas, 201). However, much qualitative research can avoid this as much as possible by avoiding asking questions directly and adopting an approach that asks for an account of individual experiences (Rice & Ezzy, 1999).

Combining Quantitative & Qualitative Methodology

Quantitative and qualitative methodologies are often polarised as distinct and separate approaches to social research that are both mutually exclusive (Letherby, 2003; Clarke, 2001). It has also been suggested that quantitative research approaches have been equated with masculine values and positivism, while qualitative research has been

equated with feminine values and interpretivism (Letherby, 2003). According to Oakley (1998), this has resulted in a 'gendered paradigm divide' (cited in Letherby, 2003). While it may appear that the two research methodologies hold opposing and conflicting opinions as to what constitutes valid research that can best represent the 'truth', it is becoming increasingly common for a pluralistic approach to methodology to be utilised during research studies (Clarke, 2001; Sprague, 2005). Sprague (2005), calls for more researchers to recognise the benefits of combining methods and adopt a collaborative approach to research, and further stresses that "all researchers need a multi-method sensibility" when addressing research questions (*ibid*: 196). Combining research methods in this manner allows more flexibility in the design of research and opens up different possibilities in terms of what questions are asked in order to gain a fuller picture of the research phenomena being investigated.

In very general terms, a quantitative approach is often used to establish the bigger picture of the phenomena, that is, it is useful to establish 'what' is going on in a particular area. This approach can be useful to establish possible correlations between the research question and the impact of other variables, for example, the impact of gender, ethnicity, social class, sexual orientation and so on (Letherby 2003; Clarke, 2001). The qualitative approach in addition can be utilised to establish more in-depth knowledge, to gain an understanding of 'why' to the research

question (Sprague, 2005; Letherby, 2003; Clarke, 2001; Strauss & Corbin, 1998).

Summary

The relative strengths and weaknesses of some of the key methodological perspectives of quantitative and qualitative approaches to social research have been highlighted. The decision of which methodological approach to use will be decided by several factors. These include the nature of the phenomena being investigated and the theoretical perspective of the researcher. The following section describes the theoretical and methodological approach that has influenced the design of this study and the research methods utilised in the data collection process.

Methodology & Methods of the Thesis

The substantive issue being explored within the thesis is how individuals manage and experience depression on a day-to-day basis, and the impact that depression has on their experiences of 'self' and self-identity. The overall aim is to gain a deeper understanding of how individuals' experience the *meaning of depression*: what it means to them in terms of their 'self', their self-identity and their day-to-day lives. Because the research aim is to deepen the knowledge and understanding of individual experiences of depression it cannot be reconciled with a positivist approach.

The positivist approach to depression would be primarily concerned with the classification of a set of symptoms that would amount to a diagnosis of clinical depression. From this perspective the causes of depression are perceived as being as a result of bio-medical pathology, notably disturbances in the brain chemistry, with particular reference to imbalances in serotonin levels (Hammen, 1997; ICD-10).

However, the focus of this study is primarily concerned with individual experiences of depression and the meaning of depression. It begins on the premise that you can not reduce an individual's experiences of depression to a set of definable symptoms. People need to make sense of their experiences and experiences are always contextual. Symptoms are not just experienced as 'symptoms' in isolation and symptoms do not constitute experience. As the study will highlight, depression is first and foremost an embodied experience of 'self'.

As such, the philosophical foundations of the study are based upon an interpretivist/qualitative perspective. The aim of the research is to listen to the discourses people utilise to make sense of their experiences of depression and what they experience in terms of 'self' and self-identity.

The focus on the individual discourses reflects the Post-Structuralist theoretical influences of the study, in particular the work of Michel Foucault, (1973, 1976, 1984) and Judith Butler, (1990, 1993).

The Post-Structuralist perspective takes away the assumption that what we know and experience is in any way 'natural' or 'real'. Rather, it asserts that all experiences are the product of discourses. We can only know ourselves and give meaning to others through the discourses that are available to us. The dominant discourses within any given society dictate the 'truth' of that era (Foucault, 1972; Dreyfus & Rabinow, 1982). As such, all identities are the product of discourse. Discourse is utilised to legitimate, negate, censure and sanction identities on an individual and social level. Refuting the notion of some 'essential self' and the idea of a unitary definitive 'self', Post Structuralism conceptualises 'identity' as fragmented and multi-faceted as opposed to fixed and stable. The perspective begins by questioning the existence of the 'individual' and the preoccupation with 'identity' and focusing the analytic gaze towards the processes involved in the production of such 'reality' initially (Foucault, 1972; Butler 1990). A key theme to emerge from Post-Structuralism is the deconstruction of the concept of identity in order to highlight the discursive practices within which 'identity's perceived legitimacy is articulated (*op cit*).

This work is developed further by Judith Butler, (1990) who deconstructed the concept of gender identity. Butler, (1990) highlights the extent to which the concept of gender identity is a discursive 'normative' ideal, utilised effectively to ensure the continuation of the sexes as opposite and distinct. It is Butler's formation of the concept of the 'being and doing' of identity; the assertion that there is no essential

inner 'self' that is gendered', but rather, it is the enactment of social scripts that (re)creates the illusion of gender identity both subjectively and socially, that will be the focus of the study. The narratives of individuals who experience depression will be analysed in terms of the discourses utilised to make sense of their experiences of 'self' during depression. This, it is anticipated, will allow a greater depth of understanding about the experience of depression and the impact this has on individuals' sense of 'self' and self-identity.

Research Methods

The research method adopted for the research was the focused, in-depth interview. This was adopted as the method of choice because it is recognised as being suitable for gaining a deeper understanding of a topic, and particularly suitable for sensitive topics. As depression is a very personal and often distressing experience it can be recognised as a sensitive topic (Rice & Ezzy, 1999; Mason, 2002; Lee & Renzetti, 1993).

As is common in this type of interview, the research tool designed for the study was an interview schedule/guide that aimed to facilitate the interview to be a more informal, relaxed, two-way conversation type experience (*op cit*)²⁰. There are key skills needed on the part of the interviewer to achieve the type of rapport and relationship that will facilitate an arena of mutual trust and respect. This approach reaps the rewards of open and honest responses from the interviewee. Focused,

²⁰ The interview schedule/guide is attached in Appendix 1

in-depth interviews would not benefit from a detached, formal interviewer, or a set of pre-defined questions to guide the process (Rice & Ezzy, 1999:51-69; Mason 2002, 62-83). Rather, the interview should be led by the experiences of the interviewee; if something is important to them and their experience, then it is important to know (*op cit*). Using a flexible, unstructured approach to interviews allows the individual to tell their story, what depression means to them, their experiences and what is important about their experiences in their opinions. The interviews conducted were all based upon the principles of the focused, in-depth interview, with an interview guide that was there if needed to prompt for further information. However, all the interviews were lead by the experiences of the interviewee, and conducted informally in a relaxed atmosphere and were, without exception, carried out in the style of a two-way conversation.

Role of the researcher

Before I began the field work for the study I sat down and contemplated how I would approach the interviews I was about to undertake. I already knew that, given my methodology and theoretical basis, my aim was to carry out interviews that were as far as possible a natural interaction between two people. Given my own personal experiences of depression, I knew I had the empathy to understand what it was like to experience depression. However, I was unsure about whether I would mention it at the onset, or if I would should it arise in conversation. On the plus side I thought that if the individual knew that I had experienced

depression, they would know that I did understand what it was like to go through the experience. Then, on the other hand, I knew that depression is a deeply personal experience and it is hard to imagine that anyone can appreciate just how you feel. Most importantly, the interviews were about their stories, not mine and I was conscious that if we were to discuss my experiences then the narrative and the flow of the conversation might change. I decided that if I was asked about my own background I would be honest. In practice I believe very strongly that the fact that I had experienced depression allowed me a level of understanding and empathy that added to the richness of the data. The majority of those I interviewed stated that they felt it was impossible for anyone who had not experienced depression to understand what it was like, as a lived experience. I agree with them. If I had not had the experience of depression I believe I may have lacked the ability to genuinely empathise, which may have affected their willingness to be as open and honest as they were. More importantly, if I had gone along to the interviews with the intention of remaining objective, it would have been impossible to re-create the informal, relaxed atmosphere. On a more practical level, when tears came, we turned off the tape until we were ready to go again, no embarrassment, just mutual understanding, and I hope, respect. That would have been impossible to re-create if an objective and detached perspective was adopted.

Sample

The study sample could be described as the result of a combination of 'snowball' and opportunistic sampling (Arber, 2001: 63; Rice & Ezzy, 1999; 45-9). Initial contacts were made though through friends and family. While this approach may be open to accusations of bias, it is important to note the context in which the interviews were sought and the initial contacts made. The interviewees were approached and asked by people they trusted and that knew about their depression experiences. Although most of those approached agreed to an interview, two individuals did refuse. Once someone had agreed to an interview I phoned the individual to introduce myself and arrange the time and place.

Once the initial contacts through friends had been made, the sample grew as those taking part in research would suggest friends or family they knew who they thought might be willing to be interviewed. The fact that the interviews were an opportunity for individuals to tell their stories in a relaxed atmosphere, with respect for their experiences, made them willing to recruit others. Importantly, the fact that they had been initially approached by people they trusted and that knew about their depression experiences may have actually helped to minimise interview bias (Mason, 2002;65; Fielding & Thomas, 2001;133). Interview bias has been identified as a key issue to consider in the analysis of qualitative data (Rice & Ezzy, 1999; 53-54; Mason, 2002; 65; Fielding & Thomas, 2001: 133). However, the fact that the individuals taking part were asked

for their stories about their experiences, coupled with the fact that I had been introduced by people they trusted facilitated the relaxed and informal style of the interviews. This I believe allowed for an atmosphere of honesty and trust, evidenced by the very personal, often harrowing life experiences that people willingly shared during the interviews.

The interviews took place in a variety of private settings; these ranged from the homes of the individual being interviewed, to their workplace and several participants came to my home to ensure the interview was carried out without distractions, in private. There was no systematic scientific sample selection as such; this would have gone against the ethos of the study. The criterion for inclusion in the study was that the individual had, at some point in their lives, received a medical diagnosis of clinical depression. Twenty-three individuals were interviewed, sixteen (16) women, seven (7) men. As a small scale qualitative study, the number of individuals interviewed represents a sufficient sized sample that allowed themes and concepts to emerge (Arber, 2001; Rice & Ezzy, 1999:46).

The ratio of women to men was decided to reflect the trends in diagnostic rates, whereby women are in excess of men in the diagnosis of depression at a rate of around 2:1 (Busfield, 1996).

All the interviews were tape recorded with the verbal consent of the individual taken at the time of the interview. A copy of the interview outline is included in Appendix 1.

Analysis

Thorough notes were made as soon as possible after the interviews were complete. This was to record any salient features that emerged and to help provide the context for later analysis of the interview transcripts.

All interviews were transcribed and read through in conjunction with the interview notes taken around the time of the interview. Initially this was to record any key issues which emerged during the interview and hopefully fill any gaps in data that were missing in the transcripts when the recordings had sections that were inaudible. As the interviews progressed it was possible to chart key themes that were emerging from the study. Once the interviews were complete further analysis took place. Transcripts and notes were coded and themes were recorded. Once themes were identified they were grouped together and analysed to explore the discourses that were utilised and establish any links between the discourses utilised by the individual interviewee and their experiences of 'self' and self-identity. The results of the analysis are presented throughout the thesis.

Ethical Considerations

It is important to note that ethical principles have been strictly adhered to throughout the duration of the study (Bulmer 2001; Rice & Ezzy, 1999). All individuals were treated with the utmost respect throughout the duration of the study. The ethical principles of the British Sociological Association (1994) were kept in the forefront of the researchers mind. Individuals were informed of their right to withdraw from the research/interview at any time without giving a reason. They were also informed that they did not have to disclose anything they did not wish to and that there were no right or wrong responses. It was stressed to all individuals that it was their experiences that were important in terms of the research and that it was their stories of depression that the researcher was interested in.

Informed consent was obtained for all research participants and guarantees of confidentiality were realistic (Mason, 2002; 80-82; Bulmer, 2001: 49-50; Kent, 2000).

To ensure anonymity individuals were given a pseudo name and occupational status will be noted as 'working' or 'unemployed'. Age will be mentioned in the short biographies, but will not be included in the references to quotes (nor will profession). The reasons for this are two-fold. The first has to do with ensuring confidentiality, the second to do with avoiding categorising individuals. Assumptions, however implicit accompany all identity categories. It is my aim to tell the stories of

individuals, and that they be seen first and foremost as individuals. As such I purposely avoid assigning them to an identity category in the eyes of the reader. Rather, the aim is to see them as they are: first and foremost as individuals with their own sense of identity. However, this is not to suppose that the experience of depression may not be compounded by social experiences. Rather, it is in recognition of the fact that while the individuals' in the sample are from a range of varied backgrounds and differing age groups, they have experienced depression and it is the impact of depression on their sense of 'self' and self-identity that is the focus of the study.

The following short biographies are based on the information given at the time of the interviews which took place during 2001-2002.

The Individuals: (The Sample)

All the individuals taking part in the study classified themselves as White English, White Welsh or White British with the exception of one who identified as Trinidadian.

Mandy

Mandy was 39 years old, married with two children and works full-time. The interview took place in my home and lasted for one hour and forty-five minutes and was very informal with a relaxed and open atmosphere.

Mandy had experienced two diagnosed episodes of post-natal depression, the first of which she believes stemmed from the death of her mother and became progressively worse when she became pregnant and after the birth of her first child. The second diagnosed episode was quite severe and lasted for around four years. She was prescribed anti-depressants but didn't take them for more than a few days. She believes she has experienced several episodes since then, but not as severe, and she has not sought medical help during these periods. Mandy recognises that she has the potential to experience depression and as such has accepted that it is a part of her self-identity. However, she believes that her depression stems from external triggers, but the potential to become depressed lies within her self-identity. During the last experience of self-diagnosed depression Mandy self-medicated with herbal medicine and generally felt more in control of her potential to experience depression.

Terry

Terry was 42 years old, works full-time and lives with his partner. The interview took place within his home and was informal and relaxed and lasted just over one and a half hours.

Terry has experienced depression throughout his adult life. A later clinical diagnosis helped to diagnose in retrospect, earlier episodes of depression that had not been recognised as such at that stage. Having tried medical interventions (anti-depressants) and sessions with a

psychiatrist in the past Terry is now happier to take control over his experiences without medical intervention. He also had several sessions with a counsellor which he found more useful than medication. He accepts that depression is likely to be a part of his future and hopes to continue to be able to manage his experiences without having to refer back to the medical profession. For Terry, depression is accepted as part of his 'self' and self-identity and his previous experiences have made the possibility of future experiences of depression less threatening and more affirming of his identity.

Gemma

Gemma was 36 years old, works full-time and is married with children. Her first experience of depression was informally diagnosed by friends and she subsequently went to the doctors and received a medical diagnosis of clinical depression. The interview took place in a private office and Gemma was very open and candid about her experiences of depression.

Gemma believes that depression has been a feature of her life for a long time, but the diagnosis, received several years prior to the interview, has helped to provide an explanation for previous experiences in hindsight. She has been prescribed anti-depressants and taken them in the past and believes they did help her to recover. Gemma accepts that depression is a part of her self-identity and has made several

lifestyle changes with the aim of asserting more control over her experiences of depression in the future.

Anna

Anna was 27 years old, she works full-time and lives with her partner. She was diagnosed with depression six months before the interview, which took place in a private office, was relaxed and informal and lasted for approximately one hour.

Anna believes she may have had similar experiences in the past, but that these have been much milder and not diagnosed personally or professionally as depression. At the time of the interview Anna was taking anti-depressants and was hopeful that her doctor would begin to take her off the medication on her next visit. While Anna was hopeful that she would be able to return to 'self' after the depression has lifted, she noted that the experiences will stay with her. While depression may not be accepted as part of self-identity at this stage the impact of depression on self-identity was evident in the manner in which Anna noted the intensity of the experience on her sense of 'self' and self-identity. Furthermore, she noted that she had already made some lifestyle changes in the hope of preventing the reoccurrence of depression in the future.

Jane

Jane was 33 years old, works part-time, and lives with her two children. The interview took place at Jane's home while her children were at school. She was very relaxed initially, but did become emotional when reflecting upon her experiences.

She was first diagnosed with depression a few years prior to the interview, after her divorce. She was prescribed anti-depressants, which she took for around a year. She was also referred to a counsellor and had regular sessions for around a year. Jane does believe the combination of anti-depressants and counselling helped her through this period. Although this was Jane's first experience of depression it has had a dramatic impact on her sense of 'self'. She believes that the experience has changed her subjective experience of 'self' and her self-identity. It is an experience that has had a profound impact on her life and is one which will stay with her. She is unsure about whether the depression may return in the future.

Sue

Sue was 27 years old, works full-time and lives with her partner. The interview took place at Sue's home and was very relaxed and informal. The interview lasted approximately one and a half hours.

Sue's initial experience of depression was a couple of years prior to the interview which was 'unofficially' diagnosed by friends in the first

instance. Sue then went to her doctor and received an 'official' diagnosis of clinical depression. She rejected anti-depressants that were offered in favour of counselling, which she found very helpful. Sue sees depression very much as a part of her self-identity and has adopted various self-help strategies to help manage her depression in the future. This includes taking steps to prevent the depression re-occurring, but also adopting self-help strategies to deal with it, if and when it reappears.

Paula

Paula was 54 years old, works full-time and lives alone. The interview was very relaxed and informal and took place in Paula's home; it lasted approximately two hours. Paula was very open about her experiences.

Paula's first experience of depression was after the birth of her first child and she was subsequently diagnosed with post-natal depression. After the birth of her second child the depression returned and she was hospitalised for 'quite a long period', but did recover. She went on to experience post-natal depression after the birth of two further children. Initially she thought the depression experiences were linked to pregnancy and childbirth. However, seven years before the interview she experienced a severe depressive episode during which she made a serious attempt at suicide which resulted in her being in intensive care for over a week. She was consequentially hospitalised as a result of the depression, and received Electro Convulsive Therapy (ECT) along with

anti-depressants. She recovered from this episode and was well for a number of years. However, one year prior to the interview Paula once again experienced severe depression and was hospitalised for eight weeks and once again she received ECT in conjunction with anti-depressant medication.

Paula believes that her depression is largely bio-medical in origin, though acknowledges that it could also be a part of her 'self'. She has made several changes to her lifestyle, which includes taking regular exercise and taking up a new hobby, with the hope of preventing depression recurring. She accepts that depression will always be a part of her life and that at some point in the future she may well need medical intervention to help her get well.

David

David was 54 years old, married and works full-time. The interview took place at David's home and was relaxed and informal; the interview lasted approximately one hour.

David received his first diagnosis of depression twelve months prior to the interview and was off work at the time. He believes it is his first experience of depression which was brought on by the pressures of work stress and a related loss of self-esteem. While David sees his depression in terms of stress and outside pressures at the moment, he

did acknowledge that his personality may be an influence in his experience of depression.

Stephanie

Stephanie was 38 years old, works full-time and has a grown up child from a previous marriage; she lives with her current partner. The interview took place at my home as Stephanie did not want her partner to interrupt the interview and she was also depressed at the time of the interview, which lasted for just over two hours. It was the first interview I had carried out with someone who was currently deeply depressed and it was, in parts, harrowing to listen to so much sadness and despair in a person's life – and for so much of that life.

Stephanie had recognised something was 'wrong' in her early teens and had battled with eating disorders and low self-esteem over the years. Her first 'official' diagnosis was received around seven years prior to the interview and she had been on anti-depressants (different types and strengths) since then. She has seen a psychiatrist, though that was a few years ago; she now just picks up repeat prescriptions for antidepressants. Stephanie sees depression very much as part of who she is, and at the time of the interview could not imagine her 'self' without depression in the future.

Mark

Mark was 35 years old and works full-time. He is married with one child. The interview took place at Mark's home and lasted approximately one hour. While it felt a little awkward and stilted in the beginning, the atmosphere soon became relaxed and informal, as the barriers went down there was a gradual opening up that was quite apparent as the interview went on.

Mark's first diagnosis of depression a few years before the interview had given him a handle on previous experiences, which in hindsight he believes were periods of depression, beginning in his late teens, but have been characteristic of periods of his life since then. While counselling was offered, it was put forward as being too far down the line to be an option and Mark felt that the preferred route of the doctor was medication. He was subsequently prescribed antidepressants. Mark sees depression as an aspect of his self-identity, and although he does not like this aspect of his 'self' he acknowledges that his 'self' will always have the potential to experience depression.

Kerry

Kerry was 36 years old, works part-time and has two children; she lives with her partner. The interview, which lasted approximately one and a half hours took place at Kerry's home and was very relaxed and informal.

Kerry had her first experience of depression fourteen years prior to the interview and a further episode a year before the interview. She was advised to take antidepressants by her doctor, but had refused on both occasions. During her first experience of depression she was visited by a community psychiatric nurse who gave her a relaxation tape which she found useful at the time. When the depression returned several years later she tried hypnotherapy (which she self-funded) and also bought tapes to help her relax which she felt was useful. Kerry believes that depression is a part of her 'self' and self-identity and has made changes to her lifestyle to try and prevent depression from returning in the future.

Robert

Robert was 48 years old, works full-time and lives alone. He has a grown-up daughter from a previous marriage. The interview, which lasted approximately one hour, took place at Robert's home and was very relaxed and informal.

Robert received his first diagnosis of depression twenty years prior to the interview. After the diagnosis he was off work for eight weeks. While this is the only major experience Robert has had with depression he feels that he has suffered little bouts of depression since that time. In terms of identity, although he has not suffered major depression since the first episode, the experience has stayed with him. He recognises that self-identity wise he may always have the potential to experience

depression, and as such, he takes steps to distract himself if he does recognise the signs of depression creeping back.

Tracy

Tracy was 35 years old, works full-time and is married with one child. The interview took place at Tracy's home while her daughter was at school and her partner was at work. The interview lasted approximately one hour and was relaxed and informal.

Tracy had received a diagnosis of clinical depression two years before the interview, though she felt she had had 'problems' for a year before the diagnosis because of major life upheavals. Tracy experienced what she termed a 'breakdown', which resulted in her being sent up to the local hospital's mental health ward in the evening. She was not admitted but sent home with medication to be closely supervised by family members and friends. She believes that was her first experience of depression, though the experience has not left her. She has made several changes in her lifestyle, including changing her job, with the aim of preventing experiencing depression again. Although she feels she is over the depression at the moment she feels that the potential to experience it again will always be there, hence the changes in lifestyle to avoid this happening. While she may not have accommodated depression as part of her self-identity, she acknowledged that her 'self' may have the potential to experience depression in the future.

Kevin

Kevin was 55 years old, works full-time and is married, he lives with his partner. The interview, which lasted approximately one and a half hours, took place at my home.

Kevin had received a diagnosis of depression three years prior to the interview and was prescribed antidepressants by his doctor. He was referred to a psychiatrist though did not find this useful. He experienced bad side-effects from the anti-depressants so eventually stopped taking them. Three years after the original diagnosis he still experiences 'good days' and 'bad days'. In terms of impact on 'self', Kevin believes the experience will stay with him and that he would never be able to return to the 'self' that was, before depression. Although he has not experienced another episode of depression, the impacts of his experiences are still influencing his experiences of 'self' and self-identity.

Janet

Janet was 60 years old, works part-time and is married. She lives with her partner. The interview took place at Janet's home and lasted approximately one hour. The interview was relaxed and informal throughout.

Janet had received her initial diagnosis of depression six years prior to the interview, though recognised that she has always been what she described as 'nervy' and a 'worrier' from being a teenager and felt that

she could have probably been experiencing mild depression back then. She had been taking antidepressants for the past six years and had tried counselling which she found useful. She felt that depression was part of her identity and that her personality ('nervy', worrier') meant that she would always be susceptible to experience depression.

Liz

Liz was a 53 year old housewife who lives with her partner. The interview took place at Liz's home and was very relaxed and informal; Liz was very open about some deeply personal aspects of her life experience.

Liz's first experience with depression happened in her early 20's following a family tragedy for which she blamed herself. She was hospitalised at the time and received six sessions of ECT. Liz believes she has experienced between 30 and 50 episodes of depression during her adult life and has been hospitalised on numerous occasions. She recently began a course of injections which she believes has prevented the depression from returning for the past eighteen months. Liz's experiences of depression have had a major impact upon her life. She recognises that depression may be part of her self-identity, but sees the onset of her depression primarily in bio-medical terms since the injections she is receiving at the moment appear to be keeping the depression at bay.

Steve

Steve was 41 years old and currently unemployed. He is married with two children. The interview took place at Steve's home while the children were at school and lasted approximately one hour.

Steve had received his first diagnosis of depression around twenty years ago and has experienced several episodes of varying severity over the years. He was prescribed antidepressants at the time of the first diagnosis which he took for several years. He refused medication for future episodes and did not go to the doctors during his last experience. Steve sees depression as part of his identity and believes he will always have the potential to be depressed.

Neil

Neil was 40 years old, currently unemployed and single. The interview, which was informal and relaxed took place in a private office and lasted approximately an hour.

Neil has resisted a medical diagnosis of depression, though he did have what he described as a 'breakdown' earlier in his life which resulted in him being hospitalised. Neil resists the label of depression as he feels that accepting depression would mean relinquishing control over 'self', something he is not prepared to do. Although he does have experiences that he recognises are depression, it is an identity he does not want and so he actively resists accepting depression as an explanation for his

experiences. Friends have 'informally' diagnosed depression; for Neil, it is a 'way of being', a philosophy on life. This way he has control over his experiences. If he were to accept depression he feels he would lose control over his experiences of 'self'.

Helen

Helen was 34 years old, married with two children and works part-time. The interview took place at Helen's home and was conducted over two sessions as her youngest child woke up and it was not possible to continue the interview the first time. Overall, the interview lasted approximately two and a half hours, Helen was very open and frank and the interview was very relaxed and informal.

Helen received her first diagnosis of post-natal depression after the birth of her first child, four years before the interview. She was referred to a psychiatrist and prescribed antidepressants. She felt she had a bad experience with side-effects from the first antidepressants and stopped taking them after six months. However, she went downhill again and was put back on them by her doctor. Though she had a period of being relatively well, she was diagnosed with post-natal depression after the birth of her second child two years prior to the interview; although she was not taking antidepressants at the time of the interview and was not depressed.

Helen believes that depression has always been a part of her 'self', and self-identity, and was there, under the surface waiting to come out. She believes that once you have experienced depression, it will always have the potential to 'creep back up' on you. At the moment she feels that if she felt depression coming back she would try taking herbal remedies, but stressed that she would definitely get help from the doctor if she felt she needed support in the future.

Rose

Rose was 25 years old, works full-time and is currently single. The interview, which lasted approximately one and half hours took place at my home and was very informal and relaxed. Although Rose did not say she was depressed at the time of the interview she did get very emotional, several times during the interview.

Rose received her first diagnosis of depression a year or so before the interview, though recognised in hindsight that she had experienced depression, probably on more than one occasion before that. She was prescribed antidepressants though she chose not to take them. She had received some counselling which she found useful. Rose describes her 'self' as being quite sensitive and believes depression is a characteristic part of her 'self'.

Wendy

Wendy was 22 years old, and lives with her partner; she works full-time. The interview, which lasted approximately one hour, took place in a private office and was very relaxed and informal.

Wendy believes she has experienced depression to varying degrees since she was fourteen years old. She also had an eating disorder around that time which she received counselling for. She was diagnosed with depression at eighteen and has been on antidepressants since then. Her doctor recently tried to wean her off the antidepressants, but she slipped back into depression and is taking them again. Wendy openly accepts depression is part of her 'self' and self-identity and believes it will always be a part of her life.

Tara

Tara was 36 years old, works full-time and is married with two children. The interview took place in a private office and lasted approximately two hours. The interview was relaxed and informal and Tara was experiencing depression at the time of the interview.

Tara received an initial diagnosis of depression five years prior to the interview taking place. However, in hindsight she felt that she had experienced symptoms of depression before this that were undiagnosed. Over the past five years she had experienced three episodes of depression, all quite severe and had to take time off from work. She had

been taking antidepressants for the past six months and was still depressed. Tara accepted and acknowledges depression as a part of her self-identity and believed that she would always have the potential to experience depression, and that this was a part of her 'self'

The above short biographies provide a snapshot of the individual experiences of depression of those taking part in the study. As can be seen the experiences vary considerably, however, the consistent factor is the impact that depression has had on the lives of these individuals. The following chapters begin to tell their stories of depression and develop a theoretical standpoint to offer an insight into what it is like for individuals to experience the meaning of depression.

CHAPTER FOUR

The Dilemma of a 'Self': Negotiating Depression and Self - Identity

"I wouldn't be who I was if not for it [depression], that's for sure...it's part of who I am"

(Terry)

Introduction

Depression, as an illness experience, can directly affect individuals' sense of self-identity. Physical symptoms aside, depression is often characterized by a tangible shift in self-identity that can gradate between 'not feeling oneself', to experiencing a 'loss of self' (Karp, 1996; Charmaz, 1991). It is this perception of a 'loss of self' that is difficult for people experiencing depression to make sense of and is perhaps the most threatening aspect of their experiences. This is particularly the case during a first encounter with depression as experiences of 'self' on a day-to-day basis change from positive to negative, comfortable to threatening; with little or no subjective explanation available to make sense of what is experienced.

It is at this point during a depressive episode that crisis points arise, as feelings, thoughts and emotions become at odds with prior experiences and current expectations of 'self'. During a depressive episode the 'doing' of self-identity fails to elicit previous subjective experiences of

'being' that help anchor 'self' in the many facets of identity. At this stage, people's experiences of day-to-day life may feel threatening as their idea of 'normality' for their 'self' slips further away (Karp, 1996).

It is at this point that individuals may seek medical help for their distress and may find themselves receiving a diagnosis of depression. The subsequent medicalisation of their distress into a medical condition can offer individuals a brief respite period, in which they may seek to render comprehensible their experiences through the medical discourses available(*ibid*).

However, if and when individuals' experience subsequent episodes of depression they become increasingly aware that depression may not be entirely biochemical in nature and may well be a part of their self-identity. This may witness individuals' grieving for a 'self' that is lost, but also negotiating a 'new' identity that may make the depression experience less threatening and more affirming for self-identity (Karp, 1996; Charmaz, 1991). This crucial period may influence the subsequent path an individual chooses, in terms of self-identity, treatment and future management, as they navigate their way through the depression experience.

This chapter will explore the impact that depression has on individuals' self-identity and highlight the dilemma many people face when coming to terms with the fact that depression may well be a part of their self-

identity as opposed to purely biochemical in origin. By developing the work of Butler's, (1990) notion around 'performance', 'performativity' and the 'being and doing' of identity, the chapter will seek to highlight how the relational aspect of identity is central to understanding the experience of depression.

The chapter will also explore Jerkin's, (1996) theory of social identity and the relationship between self and society, highlighting how the relationship between 'being' and 'doing' identity, for the most part unproblematic and unconscious, is broken down during a depressive episode resulting in the experience of a 'loss of self' for individuals. The relationship between self-identity and social identity becomes increasingly less reciprocal as the 'doing' of identity – the social aspect of identity, fails to elicit the 'natural' previous experiences of self that 'make' self identity - that legitimize and 'naturalize' notions of an 'authentic self'. The 'naturalness' associated with 'being' an identity can be seen as having its formation in the early childhood socialization and experiences of the individuals and, following Jenkins, (1996) can be seen as the subjective aspect of the 'primary' self; the self that anchors all facets of identity and mediates the experiences associated within them. It is this 'self' that is experienced on an individual subjective level as the 'authentic self'.

To highlight the relational aspects of identity, the chapter will, through the narratives of the research participants, explore the stages individuals

travel through during the experience of depression and highlight how changes in the perception of depression are incorporated into their self-identity. The dilemma individuals face when accepting that depression may well be part of their self-identity and subsequent attempts to make sense of and take control over the depressive part of their identity can witness the emergence of a 'newly aware self', that is stronger, more resilient and in control, as opposed to the simple acceptance of a 'depression identity'.

Depression & Self Identity: Theoretical concerns?

There have been numerous studies which have sought to address discrepancies in the diagnosis rates of mental illness, particularly the over-representation of certain categories of individuals, to name a few; gender, age, social class and ethnicity (Busfield, 1996; Broverman *et al.* 1970; Brown & Harris, 1978; Kleinman & Good, 1985; Fernando, 1991; Littlewood & Lipsedge 1997). However, as discussed previously, these studies focus on sociological/psychological accounts such as 'gender role theory' as a plausible explanation of why certain individuals may be more susceptible to the onset of depression (gender role socialisation *as per* Busfield 1996, gender role construction *as per* Broverman *et. al* 1970). Other considerations include the impact of social roles combined with a combination of cultural insensitivity/discrimination in the diagnostic process (Ussher, 1991; Fernando, 1991). This culminates with the combined effect of rendering certain categories of identity, and as such,

individuals, more likely to experience or be diagnosed as experiencing, depression.

While these theories may offer an insight into the impact of social roles and the subsequent susceptibility to experience depression for certain individuals, it fails to address the complex nature of depression. It offers a relatively superficial account of depression as an illness, rather than addressing the complexities involved in relation to the impact that depression, as an experience of 'self', has on the subjective experience and perception of self-identity.

Depression as illness or experience?

It is fundamentally important to note that for many, depression is not necessarily experienced primarily as a medical condition or illness, it is an individual experience of 'self'; it affects moods, thoughts and emotions and as such, can directly influence experiences of 'self' (Karp, 1996; Hammond, 1991). Depression means many things to individuals, but its impact is not typically described in the theoretical literature in terms of the embodied nature of depression, and the very real physical symptoms that accompany changes in mood, thought and feeling (Hammond, 1991). For many individuals, the impact of depression is felt primarily on a subjective level and the change in day-to-day experiences of 'self'. Depression is experienced primarily in both physical and subjective

terms; this is evidenced by asking individuals what depression means to them, in their own words:

“... Just desperate, you, there’s no way out,... you can’t see a light at the end of the tunnel, you can’t, you just cry constantly and everything is too much effort, just anything, even making a cup of tea, you’d rather just sit here.....or go back to bed, because that way you can just pull the covers over and switch out the lights, and you don’t have to talk to anybody. Just loneliness as well, you feel so alone... and bleak and black, everything is black and horrible”

(Jane)

...” I just felt that I, well, I was around but I didn’t really exist.....I didn’t want to go out, I didn’t want to talk to anybody, I didn’t want anybody talking to me.....a dark cloud, just being enclosed and wanting to be enclosed, not wanting to do anything at all, just sleep”...

(Sue)

... “It’s such a desperately lonely illness, it’s all, it’s so lonely, you are totally in your mind, people are there to cuddle you and everything, people are worrying about you, but that, that doesn’t matter, in a way it’s a very selfish illness...you’re obsessed with yourself because it’s me,me,me; I can’t cope, I can’t do this, I can’t go there, I can’t do that, I want to, I don’t want to be here, I want to go to sleep....It’s all ‘I’, ‘me’ in the true sense of the word selfish, self, and that’s what’s so frightening

about it, because all the things that you love and care about, can't come in, they can't come in...."

(Paula)

"If I was trying to tell somebody, [what depression was like] I would say it was just like a feeling of, having no emotions, you, you don't have happy feelings.....I think, ultimately you know there's something wrong, but it takes a long time to discover what it is.....for me it was just a gradual wearing down of just feeling unhappy, and then from being unhappy to being just emotionless; not happy not sad, just nothing. Just empty, like an empty shell that's how I would describe it."

(Mandy)

"...It's like, you know, a form of black.....you can't see when you move forward, you don't really care whether you are going to move forward and everything is irrelevant".

(Mark)

".....It's like not wanting to get up in the morning, just wanting to curl up in bed all day, not wanting to talk to anybody, er, feel like you can cry at the slightest little thing....or snap someone's head off..... You're thinking all these horrible thoughts, your mind feels twisted.....you just want to shut down.....depression is just not seeing an end to, there's no end to it.....you just want to end it all, that's what depression is to me".

(Stephanie)

"....I think depression means to me, erm, losing some part of my personality, erm, I have done...to me it feels like I lose something that's part of me, and what causes that or whatever, you know, it doesn't really matter.....but it's that feeling of you know that you have lost something and then you have to start very hard to try and get it back again to get back to normality....whatever normal is for you, you know, you as a person".

(Gemma)

"When I'm feeling depressed I feel a lot heavier.....like I've got this huge burden on me...it's a fight, you've got to fight it...if you stop fighting it it'll take over and you will literally go to pieces".

(Wendy)

... "It's hard to get the mind-set across, just how, oh, how gloriously pointless everything is....every solution's just another source of problem...it's a bit like quicksand...sort of tremendous inertia...the idea that it's not about anything...that's the hardest bit of all to deal with...if there were some issues all about, you know, ...I mean, there are always issues, but they're not the cause of it, they just get wrapped into it"

(Terry)

"....I used to wish I could sleep forever, I hated waking up in the morning, first thing I thought about when I woke up was, 'have I still got it' [depression], and I knew I had...I wasn't suffering while I was asleep, I was suffering while I was awake so I used to hate waking up".

(Steve)

As these narratives highlight, the impact of depression is profound and can have a major impact on experiences of 'self' and self-identity; ultimately depression is first and foremost about an illness experience of 'self'. That is not to deny that there are very real physical symptoms that accompany depression; symptoms that in some cases are what initiate a medical consultation in the first instance. However, as noted through the experiences of individuals, the experience is one that is inextricably linked to experiences of 'self' and ideas of 'normality' for that 'self' that can be seen as ideas of an 'authentic self' that is constitutive of self-identity in the eyes of individuals.

Identity Issues

In terms of health and illness, issues of identity have been theorized in relation to the onset of physical illness and the effect that chronic illness and/or disability can have on an individual's sense of 'self'. Charmaz, (1991) examines the impact that the onset of chronic illness can have on an individual's sense of self-identity. According to Charmaz, (1991) the onset of chronic illness is often accompanied by a 'loss of self' experienced by individuals as they come to terms with the fact that their lives and their experience of life, both on a personal and a practical level are set to change, in some cases, dramatically. The 'self' before illness is lost to them as they seek to come to terms with (re)defining their 'self identity' with respect to their illness experience, and contemplate their future expectations for their self-identity in relation to the illness.

The onset of chronic physical illness requires that individuals 're-think' self-identity in terms of limitations imposed by the onset of illness, and also reflect on the prognosis for future health in relation to past experiences. This 'loss of self' is about definitions of self-identity in terms of what an individual can or can't do, restrictions and changes to a 'self before' and a 'self after' illness impacts. Coming to terms with illness in these terms can colour future perceptions for a prognosis of self (Charmaz, 1991). Self-identity is challenged because of it, or in response to it.

However, this theory fails to account for the fact that an 'illness identity' is not always something to which individuals necessarily can and do relate. It assumes that a (re)definition of 'self' will mark the future 'self' in terms of illness; that is, the illness will be the definitive aspect of their identity. If, following Jenkins, (1996) the 'illness identity' replaces the 'primary identity' established early in life, then subsequently all facets of identity will be mediated through this 'illness identity'. This fails to account for the fact that many people with chronic illness and disability do live fulfilling lives and further that they do not see themselves first and foremost in terms of an illness identity. The resistance by individuals to this assumption (that disability is in some way indicative of a 'damaged self') has highlighted that individuals want to be seen for 'who they are' rather than for their illness or disability (R. Butler & Parr ,1999; Galvin, 2005; Wendell, 1996; Michalko 2002:5). This is evident for example, in the term 'Diabetic' – what does that mean and can we assume that all

individuals with a diagnosis of diabetes have some common characteristics related to self-identity that they can identify with in such a way they see themselves first and foremost as diabetic?

Furthermore, in terms of depression, current theory fails to address the fact that individuals who experience depression, even the most serious and severe cases, do often have periods of their lives when they are not clinically depressed. This is in contrast to those who have a chronic illness or life limiting condition that may be managed effectively, but is a permanent day-to-day feature of their lives. As such, an 'illness identity' in terms of depression, even chronic depression cannot adequately address the complexities involved where there is a chance that a 'return to self ' may be possible at some point. This is especially the case in terms of treatment where the prognosis will be that there will be a point in the future where the depression will have lifted and as such, a 'self' without depression.

Contrary to theory then, in terms of depression or chronic illness and the subsequent emergence of an 'illness identity', or, 'depressive identity', the acceptance or rejection of depression as 'part of self- identity' is not as straightforward as previously suggested by Charmaz, (1991) and Karp, (1996), as will be discussed below. However, the narratives of individuals do reflect Karp's suggestion that during initial experiences of depression, individuals often experience 'inchoate feelings ' which bring with them an awareness that 'something is wrong' as their experiences

become increasingly worrying and any sense of control over their thoughts and feelings slips further away.

Initial Experiences of Depression – ‘What’s going on?’

While the nature of depression varies depending on the severity of the symptoms and the individual, there are a set of definable and identifiable ‘symptoms’ that amount to a medical diagnosis of depression (ICD-10, see Appendix 2). However, the individual experiencing ‘symptoms’ may not recognise their experiences as such; particularly in an initial experience or in the early stages of depression, the onset of symptoms is not necessarily experienced by the individual as illness. To gain an insight into the early experiences of depression, to begin the interview, all those taking part were asked about when they first realised that what they were experiencing/feeling was more than just feeling ‘down’, or ‘the blues’:

“...I just remember sitting in the bathroom, I’d gone up for a bath, and up until that point I’d just felt,...I suppose just low, I didn’t really know. I’d just got married and I should have been happy but I wasn’t and erm...I felt strange, but I don’t know how I felt, I just felt strange... it’s really strange, I don’t know, I just sort of thought then, ‘well, this isn’t normal’. You know, to feel nothing just emotionless really”....

(Mandy)

... “I definitely couldn’t tie it down to any, any one thing... More, more a sort of feeling or way of being that’s not, it’s not the standard version of me if you like...”

(Terry)

... “I felt really.., I mean, the change in my day-to-day sort of activity, because I used to go out a lot and do lots of activities and I just totally lost my appetite for that, I didn’t want to do anything except just come home. Just small things would set me off crying.....

(Anna)

Loss of Self

Without a doubt the resounding theme to emerge was the perceived ‘loss of self’ and the narratives of all those taking part recalled experiences that were threatening and frightening; incomprehensible and consuming. The general feeling associated with the depressive experience for individuals in retrospect, were changes primarily in their *experience* of ‘self’; experiences that were not ‘normal’ for them and often led to them articulating what was described in one way or another, as a ‘loss of self’.

An individual’s experience of ‘loss of self’ during depression is often the core of their discontent. The most threatening aspects of their experiences at this point is the perception of a ‘loss of self’; a loss they

have no control over. This suggests that individuals do harbour ideas and notions of an 'authentic self', or a 'core existence' (Parker, 1995):

"....When I'm poorly (depressed) I'm another person, it's not, I'm not the person he (partner) knows, somebody, nothing like the person I am when I'm fine....It's like you're not in charge of your, your own mind, your own body...my way of thinking doesn't vary much when I'm depressed to when I'm not depressed for a start, but only for a start, and then it does get out of control, I'm no longer me, I'm somebody totally different"...

(Liz)

"The person that I was has just totally gone, she hasn't come back, hardly, I just don't feel as if I'm anybody at the moment....just sort of floating....at the minute I'm just hanging in there...it's like somebody else has taken over your body and you've got no choice about it, you're not the person that you are, it's like the person in, inside a shell working it. I mean I just felt a totally different person when I had depression than what I do now".

(Helen)

"....I didn't know what was happening to me, I couldn't understand it, I was always bubbly, I was always outgoing at work, I was the one that would be the clown and make everybody laugh and at school I was as well and then all of a sudden.....I don't think it was me at all. It felt like it was somebody else, didn't feel like me".

(Jane)

“All these things were happening and this was why I was like getting, I wasn’t very organised, I wasn’t being me anymore”.....

(Sue)

“...I think the first step if you are really going down, where you are, are not yourself at all, you don’t feel for your partner and your children, you don’t feel anything. I’ve four lovely grandchildren; I didn’t feel a thing for them ...I haven’t, didn’t want to harm them but, ‘oh, go away’ you know... “it’s not me, oh no, it’s not me, no, everybody, my closest friends, my family... they know it’s not me, it’s just not me”...

(Paula)

.... “it [depression/anxiety] just got to me. I didn’t want to do anything, so it just wasn’t like me.....I wasn’t Kerry anymore”

(Kerry)

“...the really frightening part of it is just the feeling that you’re out of control and you don’t know what you can do to make it better really. Anything else, colds etc... you can sort of make it better, but with this, I don’t know what to do to make it better or go away...It is almost like your life is taking you along with it, in directions that you don’t want to go....feeling like being swept out to sea in a canoe without a paddle...”

(Anna)

'Doing' & 'Being' Identity

As the above quotes highlight, individuals attempt to carry on as usual, but their experiences on a day-to-day basis no longer elicit the 'naturalness' of their identity. On the contrary, the 'doing' of identity that was once unproblematic, un-thought of, becomes a task, a chore, a 'performance' (as *per* Butler, 1990), to be undertaken in order to promote an illusion of the 'self that was' before the onset of depression. Crucially, for these individuals the narratives suggest that the 'performance' of 'self' is no longer 'performative'; it is the breakdown of this relationship that is the core of their discontent.

Individuals utilize their previous experiences of 'self' as a reference point that is grounded in prior experiences of 'being' their 'self' which is for them, characteristic of an 'authentic self', to anchor their expectations of identity as they go about their lives, 'doing' identity. Their experiences across the differing identity categories they find themselves in will be mediated through their perceptions of this 'authentic self' during a depressive episode. It is this crucial relational aspect, of 'doing and being' identity that becomes problematic.

As discussed earlier, for Butler, (1990) the performance of gender is 'performative'. The largely unconscious routine ways of 'doing' gender through dress, speech, bodily acts etc... are the means through which gender identity is pre-scripted and sanctioned within society. It is through the 'doing' of gender, or gender 'performances' that individuals and

society read, categorise and legitimise gendered bodies as distinct and opposite corporeal realities, and assign the 'natural' embodied 'essence' that is identified as gendered identities: that is, the 'performance' of gender identity is 'performative'. For Butler, (1990), gender identity, the 'being' of gender, is an effect of, and not the cause of these performances. As such, there is no essential feminine or masculine 'self' that is driving such performances, no gendered interior that is manifesting itself through a set of repeated bodily acts and comportment: the 'being' of gender is an illusion, there is no interiority, no 'doer behind the deed' (Butler,1990:25).

During depression the breakdown between the 'doing' and 'being' of identity witnesses individuals becoming increasingly detached from their identity and the 'self' that is consciously undertaking the performance. The 'loss of self' that is experienced may well be a result of the breakdown of the dynamic relationship between the 'being and doing' of identity, where attempts to 'be', though the 'doing' of identity no longer elicits the subjective 'being' for the individual. This relationship is crucial and this a central aspect of the depressive experience that current theory fails to address – the complexities of the relationship between 'being and doing' identity and the impact that depression has on this relationship.

The breakdown of the relationship means that individuals have to consciously 'perform' their 'self' as they strive to create an illusion of

'self' that will enable them to carry on with their daily lives managing the numerous facets of their identity. The subsequent attempts by individuals at 'doing' identity reflect the crucial role that the social sphere has in the formation of 'self-identity' (Goffman, 1959, 1963; Jenkins, 1996; Eriksen, 1993). For example, in his work on social and personal identity and the impact of social stigma upon self-identity, Goffman (1963:14) distinguishes between the 'discredited' and the 'discreditable' in social interactions. The 'discredited' are individuals who have a visible disability, or some form of 'visual difference' (stigma), and who can assume that this 'stigma' is apparent in social interactions with 'normals' (*ibid*: 57-127). The physical difference results in individuals being stigmatised by 'normal's' during everyday social interactions. However, the 'discreditable', those individuals who may have an 'invisible' disability or 'stigma' (for example, depression) can manage their social identity through the amount of information that is given out to 'normal's' in social interactions. Goffman refers to this process of managing identity on a social level to avoid stigmatisation as 'passing'²¹.

This may appear similar to Butler's (1990) notion of 'doing' identity on a social level. However, there are distinctions to be made. Initially, Butler distances herself from Goffman's work because of the implication therein that there is in fact, a 'doer' behind the 'deed'; an 'essential self' guiding social interactions (*ibid*: 25). This is in contrast to Butler's assertion that the 'being and doing' of 'self' on a social level is in fact a façade that

creates a semblance of interiority, of an 'essential inner self' guiding and managing social interactions.

During the depression experience there is a conscious awareness on the part of the individual that they are creating an 'appearance of self' to avoid social stigma and the ascription of an identity that they do not wish to be defined by (in this instance, a 'depressive identity'). The findings presented within this thesis suggest that during depression there is no experience of an inner 'self' guiding the 'performance' as suggested by Goffman. On the contrary, the 'self' may actually be experienced as lost at this point in time.

This highlights the fact that the social 'performance' does not necessarily succeed in legitimizing self-identity on a subjective level as theorized (Jenkins, 1996). On the contrary, during depression individuals' 'self' may consciously 'perform' identity but they feel detached not only from their performances, but also from the 'self' that is 'doing', or performing identity. The 'performance' is no longer 'performative' on a subjective level.

This may well create a dilemma wherein at once it highlights the very 'unessential' nature of identity and the fact that, following Butler, (1990) the 'doing' of identity on a social level is taken as evidence of some 'interiority', of 'being' identity. However, on a subjective level the experience of 'losing oneself' (as the 'doing of identity' fails to elicit the

'being' previously associated with it), simultaneously reinforces the idea of an 'essential self' to individuals, (by evidence of the fact that they are experiencing this 'self' as lost during a depressive experience), and the very un-essential nature of identity, given that they are actively 'performing' 'self' socially. At once, the experience of depression subverts the idea of stable and 'essential' identity categories through the individual, subjective experiences of 'self' during depression and the conscious awareness of the ability to 'perform' 'self' socially.

Individuals' experiences of depression, and the perceived necessity to 'perform' identity may create the illusion of 'self-identity' within the social sphere, but the effort required on the part of the individual to accomplish this highlights that this relationship – the subjective experiential 'self' and the social 'self', has to be legitimated on an individual and subjective level. It is this crucial breakdown of relationship between the 'being and doing' of identity that characterises early experiences of depression. When the 'doing' of identity is experienced as a 'performance' it calls into question the definitive role of the social in identity formation on an individual subjective level.

Early experiences of Depression

As discussed above, early experiences of depression (typically before medical diagnosis) are often characterised by "inchoate feelings" (Karp, 1996: 57), or a perceived 'loss of self'. Individuals attempt to make sense of experiences that are not, as yet, medically defined nor

experienced as illness. One of the key features to emerge from the findings of this study is the extent to which individuals judge their distress in relation to ideas of an 'authentic self'; a way of 'being' that for them is 'normal' but that they believe to be slipping away. This often involves individuals' struggling to render comprehensible experiences that are, at that moment in time, incomprehensible to them in relation to previous experiences and characteristics of 'self':

.. "I couldn't hack people, I couldn't hack going out, erm, couldn't hack pressure at all...and I started to feel something's not quite right... I'd suddenly gone really quiet and it's just not me (laughs)...all these things were happening... I wasn't being me anymore"...

(Sue)

"...I didn't think of depression because...I've always been bubbly and just got on with whatever. But I went to the doctors and said I can't stop crying and I don't know why. Just anything, I just burst into tears..."

(Jane)

"I was just 22 at the time; I'd never experienced it so I didn't know what was happening to me...I just had no interest in anything".

(Paula)

In these early stages, questions surrounding the experience of self-identity are not necessarily perceived as a result of illness. The turmoil

being experienced on an identity level is bound up with trying to make sense of feelings, emotions and patterns of thought (Karp, 1996). It can be difficult to attempt to render these experiences comprehensible with a medical model diagnosis, since mental distress is not (usually) visible in the physical sense²². At this stage, depression may not have been diagnosed either individually or medically and questions of self-identity and depression may or may not be an issue.

In this first instance, 'depression' is not typically experienced as part of self-identity; rather, experiences of 'self' may be perceived as a subjective 'loss of self'. This is different to coming to terms with a perceived 'loss of self' in the face of the onset of serious physical or chronic physical illness. Recognition of the limitations imposed by the onset of physical illness may involve re-defining self-identity and the 'self's' relation to others (Charmaz, 1991).

However, while there may be similarities in the illness experience, especially for individuals who experience chronic depression, the impact of chronic physical illness may not be as precarious as the experience of mental illness. With depression, particularly an individual's first experience of the symptoms of depression, there may be nothing tangible to which the changes in experience of 'self' can be related. What then, is the impact of a medical model diagnosis of depression that

²² This is not to detract from the embodied nature of depression, and often individuals initially find themselves approaching their G.P. for help with physical symptoms, such as insomnia, panic attacks (not defined as such at that stage), or general aches and pains.

takes the individual's complex subjective experiences and transforms them into a medical condition?

The Impact of a Diagnosis

For Karp, (1996) the impact of a diagnosis by the medical profession is a key turning point for individuals in terms of depression as identity. This moment, according to Karp, marks a significant 'career path' for individuals as they come to terms with depression as an identity. The 'career path' marks points of distinct, yet often subtle changes in individuals' perception of their relationship to their depressive experiences, which ultimately ends with the acceptance on the part of individuals of a 'depression identity' culminating with a transformation of self-identity²³.

Karp, (1996) offers a thoughtful account of the impact of depression on self-identity and a detailed insight into how a depressive identity may emerge as individuals' struggle to make sense of their experience of depression. However, asserting the 'depression identity' as something all those who have experienced depression can relate to, recognise, and ultimately 'share in', fails to account for the complexities involved in the relationship between the experience of depression, 'self' and self-

²³ In his analysis of depression Karp (1996) adopts a 'symbolic interaction' approach and sets out the following stages which he states characterises the 'career path' in the development of a depressive identity. These stages are as follows: 1. "A period of incoherent feelings"..., 2. Reaching the conclusion that 'something is really wrong with me', 3. 'A crisis stage' – resulting in contact with medical experts, 4. "A stage of coming to grips with an illness identity during which individuals theorise about the 'cause (s)' for their difficulty and evaluate the prospects for getting beyond depression". For Karp, "Each of these career moments assumes and requires redefinitions of self" (1996:57)

identity; and where depression is ultimately placed in relation to self-identity. It also fails to address the issue of the role of the social sphere in the negotiation of depression as identity on an individual level (this will be discussed in detail in the following chapter).

The 'loss of self' articulated during depression may be felt on a more subjective, experiential manner and more importantly, the aim of medical intervention and the driver for individuals, certainly in the early experiences of depression, is a desire to 'return to self' that was before the onset of depression. The aim of medical intervention at this point is to 'cure' depression.

A medical diagnosis of depression may render comprehensible what was previously incomprehensible to individuals as subjective experiences are transformed into mental (medical) illness. This may initially place the depressive experiences outside of self-identity, into the medical realms of chemical imbalances within the brain; an illness that can be 'cured' by medical interventions. As such, rather than affirming a depressive identity, the initial diagnosis of depression for some individuals may be seen as rendering the depression experience outside of self-identity and reaffirming notions of an 'authentic self', albeit a 'self' that is lost through illness to depression. Furthermore, as the narratives of this research will highlight, incorporating a 'depressive identity' is by no means as clear cut as recognising and accepting depression as self-identity.

Karp, (1996) also fails to address the relational aspect of depression; that is, the experience between 'being' and doing' of identity, as *per* Butler, (1990), where, as discussed earlier, the 'doing' of identity, which has been, up to that point, relatively unproblematic, becomes something that has to be thought about and consciously 'performed' with the aim of creating the 'illusion' of 'self'. Importantly however, undertaking the 'performance of 'self' no longer elicits the experience of 'being' 'oneself' as evidenced by the experience of a 'loss of self'. Performance of 'self' is no longer performative on a subjective level.

While for some people, the medicalisation of their distress through a diagnosis of depression may result in the acceptance of a depressive identity; this is not always the case. As shall be seen below, certainly not everyone who experiences depression ultimately perceives depression as defining their self-identity. The individual, at this early stage may well be looking to have sense made of emotional or psychological distress; they are not necessarily looking to have their experiences made sense of in terms of identity. At this point, a medical diagnosis may, albeit temporarily, offer relief and an explanation for their distress.

Initial Diagnosis

All those taking part were asked how they felt when they were diagnosed with depression:

“Relief I think, that there is something wrong with me... it's quite a relief to think, well, it is something that's causing it”

(Mandy)

“It felt positive to be getting some help from somebody”

(Terry)

“I felt pleased that he'd [Doctor] recognised the fact...it was like a comfort thing”

(David)

“I thought, right, ok, now I have to deal with it...I came home and I cried a lot...”

(Sue)

“Just really sort of shell shocked really...I couldn't understand why it was happening at the time...I was just really confused I think”

(Anna)

“Erm, relieved in a way 'cause I thought I was going mad, so I was relieved that someone knew what was, what was wrong and that 'cause he told me it wasn't something I could get rid of on my own, 'cause I felt like a failure, he said it's nothing to do with that at all...”

(Helen)

For many then, the initial diagnosis can afford individuals an opportunity to make sense of incoherent experiences and relocate 'blame'. A medical diagnosis can help to mediate a shift in individuals' perceptions of their experiences. What may have been subjectively experienced as a lack of control over 'self', can subsequently be perceived as a medical condition that restricts their ability to govern and control their subjective experiences.

However, not all individuals willingly accept a medical diagnosis of their problems, and may actively resist a purely medical account for their distress:

"...One day they said they wasn't going to do anymore tests...and I had to see a psychiatrist, so I went to see a psychiatrist and [the psychiatrist] put me on tablets...I would never accept the symptoms were coming from depression erm, so, no, there's got to be something else"

(Stephanie)

"Erm, I suppose part of me, only part of me acknowledged it, the other part says well, yes, ok then, as long as this stops...and it wasn't really an acknowledgement of this is...it's a separation of you...saying like, ok, just give me medication..."

(Mark)

"I was surprised, I was very surprised, I thought it could be many things possibly, but depressed...If you're depressed you're miserable, you know sort of in a black mood...it wasn't like that, it was, erm, just not wanting to be part of anything, you know...can't be bothered..."

(Robert)

"I was shocked, really really shocked"

(Kevin)

The initial diagnosis is by no means straightforward in terms of the impact it has on the individual's self-identity. However, as the narratives highlight, the initial diagnosis of depression, whether it is embraced or resisted, does not necessarily involve a shift in an individual's self-identity at this point, nor does it ultimately result in the acceptance of depression as a defining aspect of their 'self'. On the contrary, individuals may, at this point be focused on a 'return to self' that existed before the onset of the depression that marked their experience of a 'loss of self'; indeed the aim of treatment will be just that, to secure a return of 'self': a 'self' that is free from depression.

However, the hope of a 'return to self' may be over-shadowed by recognition that the depression may return, and if and when individuals go on to experience further episodes of depression they may have to consider the possibility that depression may indeed be part of their self-identity. How do individuals seek to negotiate depression as an aspect of their identity in the face of an increasing awareness that their 'self' may

be inherently 'depressive'; and does this necessarily entail a re-definition of 'self' in relation to depression; that is, the incorporation of a 'depressive identity'?

Depressive Self-Awareness

The research findings presented here suggest that the awareness of depression as part and parcel of self-identity can be recognised as occurring during the depression experience and consisting of three stages:

- Subjective experience of a perceived 'loss of self' and expressed desire to 'return to self'
- Depressive-self awareness
- (re) negotiation of 'self'.

The conscious recognition of a 'loss of self' as a result of depression may highlight the un-stable, non-essential nature of self-identity, ironically through an individual's need to make sense of their experiences by reference to a 'self' they do believe to be 'authentic'. It can also be the point where individuals seek to take action in order to return to their idea of their 'authentic self'.

The subjective experience of a perceived 'loss of self' and an expressed desire to 'return to self' can be largely witnessed where individuals have their first experience of depression made sense of, often, through medical discourse. This 'medicalisation' of their experiences of 'self',

often brings the hope of a 'cure'; medical intervention with the aim of a 'return to self'. However, all those taking part stressed the fact that the 'self' before depression, was not easy to return to. Many articulated the major impact that the experience had on their lives, and ultimately the impact it had on self-identity, as will be discussed below. This was the case even for those who had only ever experienced one episode of depression, through to those who had experienced recurring depression throughout their lives. The impact that depression has on an individual's subjective sense of 'self' should not be understated; those who only ever experienced depression once marked the experience as one which has stayed with them throughout their lives:

"...having been through it [depression] ...I say you recognise the symptoms now of what's happening and stop it dragging you too far back...I'm determined I won't get sucked back into it [depression] ...I'm sure it's just bubbling under the surface somewhere, I'm sure of that..."

(Robert)

Those individuals who only ever experience depression as a one-off illness may not have to deal with the identity issues of 'self' that those who experience depression throughout their lives do. However, it is clear that an awareness of the impact that depression has on 'self' can and does have a profound effect on self-identity. The individual experience of the crisis of 'self' brought about by the breakdown between the 'being and doing' of identity never fully leaves them:

"I wouldn't say I'm a hundred per cent, I would say I'm ninety six [per cent] ... I don't think I shall ever be a hundred per cent again. No,"

(Kevin)

"...I feel a lot calmer almost now...I feel I've really slowed myself down and slowed my life down and stopped trying to please everyone...So I definitely feel more in control than I was...I do feel my outlook has changed on life really..."

(Anna)

The Dilemma of a 'Self'

All those taking part generally articulated a desire to 'return to self' once the depression had lifted. This was regardless of whether the awareness of depression had been acknowledged and accepted as part of self-identity, or conceptualized as a one-off illness. However, when accepted as part of self-identity, the desire to return to the idea of an 'authentic self' is problematic for a number of reasons.

First and foremost, if depression is accepted as part of self-identity, how 'authentic' is this 'self' if it has been 'lost' to a 'depressive self', which is, and always has been, after all, a part of the 'authentic self'. Can there be a return to a 'self' that was 'pre-depression, if the potential to be depressed has always been a facet of the 'authentic' self, and

subsequently now poses a possible threat for future depression and further 'loss of self'? Furthermore, the very act of 'performing' a 'self' while feeling detached from the 'self' doing the performing highlights to individuals the constructed and non-essential nature of identity, subverting their idea of an 'authentic self'.

A dilemma arises as individuals, armed with an awareness of the impact that depression can have on their experiences of 'self', may go on to accept depression as potentially part of who they feel or believe they are, identity wise, but do not want to fully embrace it as it does not reflect the 'self' they want or wish to be. This may, at first glance, appear to support the idea of a 'reflexive self' as theorized by Giddens, (1991), with individuals actively seeking to fashion a 'self' of their choosing, in this case, a 'self' that is not depressed. However, the crucial difference is that they may well choose to acknowledge depression *as part* of their self-identity, that is, a further facet of a 'self', but the depressive aspect of their identity is not considered by them to be definitive. By seeking to take a measure of control, they are asserting that they will not be ultimately *defined* by their depression, while simultaneously acknowledging that self-identity is multi-faceted and changing.

This recognition highlights a conscious awareness that the 'self' can be many things at one time, as in post-structural theorizing (Foucault, 1984; Rose & Seymour; 2000; Hall 1996) and not solely defined by any of these. It is not simply about a 'self' of their own choosing, but rather,

about recognising the complexities of 'self', and the impact that the facets of 'self' may have on experiences of 'self' and self-identity. Surely then, the acceptance of depression as part of self-identity is by no means straight forward, but does highlight the unstable and fragmented nature of self-identity and furthermore the fact that identity is relational (Butler, 1990; Hall, 1996; Roseneil & Seymour 2000; Jenkins 1996).

'Being' and 'Doing' Self-Identity during Depression

As discussed previously, the relational aspect between the 'being' of 'self-identity' and the 'doing' of self-identity serves to reinforce on an individual level the 'reality of authentic self', yet simultaneously highlight the non-essential nature of self-identity evidenced by the fact that the 'doing' of identity and the experience of 'being ones-self' become problematic during depression. While for Butler, (1990:25), 'the deed is everything', the theory fails to address the experience of 'doing' and its crucial relationship to the 'being' of identity'.

It is one thing to assert that the 'doing' creates the illusion of 'being', but this fails to address the fact that the 'being' of identity is subjectively experienced and individuals have clear ideas about what they expect from the identity categories they occupy at any time, and in differing circumstances. The crucial aspect here is that experiences of 'being' are the foundation for individuals to measure the authenticity of their self-identity. It is one thing to 'perform identity', and identity to be accepted/rejected on a social level, however, subjectively, if the

experience fails to elicit previous comfortable feelings of 'being oneself' through the breakdown of this reciprocal relationship – confirming and re-affirming of self-identity fails to happen.

".....you're used to going out and everyone's 'oh, Kerry's here, she'll be talking, she'll give us a laugh.....that's what's frightening you because people are going to think, 'what are we going to do if she doesn't talk?... I used to hate going into the school playground, I'm not kidding you..It was so hard work. You take it for granted, 'oh, I'm walking to school today, but it was horrible....I was frightened of the day-to-day things that people take naturally".

(Kerry)

... " a lot of the time I don't let people see, I don't like to let people know how I feel....everybody thinks I'm like that [bubbly personality], everybody....But I'm not, they don't know me inside....."

(Rose)

.... " it was a conscious effort, it wasn't to be cheerful, it was just to be sociable, you know, you don't want to sit there in the corner looking...miserable...not responding to people.....generally speaking people came round and I made an effort to be at least pleasant...but as soon as they went out the door, it, the tiredness, sit down, flop down....it was 'oh, I'm glad they've gone".

(Robert)

...it would have been so easy just to give in and not go out and not see people and not to talk to people; that would have been so easy to do that....But I made myself try and carry on with my life as it had always been, you know...because I was very out going and liked... that aspect of my life, I didn't want it taken away from me [by depression] and I felt it was being taken away and I was trying to cling on for dear life....I can remember sitting in pubs and them all looking at me and me sat in tears. When we're all out having a laugh for a meal and I'm in tears...I couldn't cope with the situation I was in but trying to make myself cope with it".

(Mandy)

... " I sometimes go out....and I've done that...actually managed to get myself there and thought, 'I really am not enjoying this, I do not want to be in this place'...I think you have to be with really close friends to be able to do that, to be able to say, you know, 'this isn't where I want to be right now....this isn't doing me any good'.

(Gemma)

... "everything was so hard [when depressed] ...where before everything was so simple".

(Kevin)

Once an individual has experienced the breakdown of the relationship between 'being and doing' of identity there is a conscious recognition

that the 'performance' of 'self' – the 'doing' of identity, can be just that, a 'performance'. The 'loss of self' that is experienced during depression is characterised by the fracturing of the relationship between 'self' and 'performance' which in turn renders identity problematic.

Having experienced the crisis of 'self' and self-identity brought about during depression through the rupture of the relationship between 'being and doing' 'self' and identity, individuals acquire an awareness that the cohesion of 'self' they experienced prior to depression (through the performative aspect of 'being and doing') may never be able to fully re-establish the coherence between 'being and doing'. Consequently, it will be difficult to restore the cohesion to the 'self' that was, post-depression. Rather there is awareness that the post-depression 'self' will be fundamentally 'scarred' as a result of the fracture that occurred in the relationship between the 'being and doing' of 'self' and identity. The resultant awareness of the tenuous nature of the relationship between the 'being and doing' of identity may never leave individuals who have experienced depression. It is this awareness of 'self' and self-identity that makes a 'return to self' problematic. The performative aspect of identity which is crucial to establishing coherence between 'being and doing' 'self' and identity, and is central to the subjective sense of a cohesive 'self' behind the everyday life experiences of individuals can be extremely difficult to re-establish.

Performance is no longer performative on an individual level, it is the lack of cohesion between 'self' as experienced subjectively and the 'self' 'doing', or performing that can be seen as fracturing 'self' from the 'authentic self'. It is a return to this 'cohesive self', experienced as the 'authentic self', that individuals' desire; a desire for performance to be performative on a subjective level once again.

(Re) Negotiating 'self'

Accepting that depression may well be part and parcel of self-identity occurs when individuals go on to experience further episodes of depression. The initial hope of a 'return to self' and return to a 'normality' that is free from depression is overshadowed by increasing awareness that a medical approach does not produce the 'cure' individuals may have hoped for in the early days. Along with this awareness comes a recognition that depression may be endemic, a part of self-identity and this in turn may lead to a rejection of a purely medical model approach to depression:

..."It could be part of my make-up, where it rears up every so often; it could be, yes, it could be".

(Paula)

....." It's definitely there as you, as a person, it's ready to pop up at any time, it's in you all the time, never going to go away.....as soon as you get a threshold situation or anything like that, it's going to pop up all your

life.....I think there's something in you, why do some people sort of, able to cope with things and you just can't?".

(Stephanie)

...I had to go see a psychiatric nurse at my own GP.....He just wanted to know what the problem was, but there wasn't no problem. It just comes on me. It just comes on me. If I know the problem I wouldn't have done it the second time" [laughs] ... "it sneaks up on you"...

(Kerry)

"Its part of me....it's part of who I am I think, part of my make-up or whatever".... [There are].... so many triggers that go towards me being depressed....sometimes it can be two or three pressures and others it can be twenty or thirty pressures, it doesn't necessarily, you know, correlate".

(Gemma)

"....I suppose your make-up of your body, your personality, maybe hereditary...I would say it was there waiting to come out, 'cause things upset me, I never got depressed, I got upset about things, but there's a difference between upset and depression.....I think it's in you and certain things that take you over the edge pull it out of you..."

(Helen)

..."I've read all the bits and pieces about the serotonin and when the doctor explains that you kind of think, 'oh, there's a relief, it's not my fault....But deep down I feel that it is without a doubt....it's much easier

to give you tablets to sort out serotonin levels...there's very little regard for the real reason why it's happening. I feel it's more....personality and circumstances, that there must be a reason why different, different chemicals are actually put into the, the work... self-preservation...there's always a why....you're never given a why"

(Mark)

..."The medical professions all desperately keen on chemicals whizzing around in your brain.....it's not a theory that does a lot for me really. Some of it's hereditary I suppose....I don't know where it comes from to be honest. I just know it does".

(Terry)

Medicalised 'Self'

In terms of identity issues, a key theme to emerge from the study was the rejection of a medical model approach to depression in terms of both diagnosis and treatment strategies once individuals experience recurrent episodes of depression and face the possibility that depression may be part of their self-identity. This is not only in terms of medical definitions and treatments, but also the impact these strategies may have on their elusive 'search for the authentic self'. At this point, many individuals reconsider their treatment options, or reject medication completely; often justifying this by reference to the impact medication has on their experiences of 'self'. Furthermore, in some cases, individuals face a further dilemma of being unsure of whether they will be able to identify

the return to the 'authentic self' that was, pre-depression, while taking medication:

"...If I took the tablets then how would I know if I was getting better 'cause of me, or the tablets?"

(Sue)

"...I think, that's why I don't want to go [on anti-depressants], I don't want to get addicted to anything. I don't want to be a false [person], false in that way, 'cause that'd be making you up all the time wouldn't it?.....'cause it does make you, I think if people are on anti-depressants, they're being a totally different...on a high, and I don't want to be like that just because they're [anti-depressants] making me like that ... It's not making me the person that you want to be, it is, but under false pretences".

(Rose)

... "The Prozac....was okay [no side-effects], I stopped taking that because I felt like it was too extreme.. .I'd gone from having virtually no personality, no confidence, not being able to do anything, to suddenly being, you know, practically bouncing off the walls. And I just thought. 'that's not me'.....because it's the drugs that are doing it, it's not me feeling, making myself feel like that, so I stopped taking them".

(Wendy)

[The anti-depressants]... "Didn't seem to particularly either help or hinder, I sort of diligently took them in the sort of spirit of, you know, 'Doctor knows best, I suppose I'd better eat these things', but I was never very convinced that they did anything much at all...it was better than being depressed, but it wasn't normal life...everything was kind of 'flat' almost...bad things didn't really get to me, but neither did good ones either".

(Terry)

"...When I went outside I would get panic attacks and have to come back in, but, you know it's all irrational fear and I knew that at the time. It was like, 'well, no, I'm going to have to go out, I have to get out of this house'. But you know, I still had that strength of character that was obviously in me to do that. You know, if I'd been on medication that slowed me down maybe I wouldn't have had that. You know, I think because I still had my wits about me, in the respect that I wouldn't take the tablets. I kind of knew that at the end of the day the only thing that would get me better was me."

(Mandy)

"....He [Doctor] started me on anti-depressants....which did help me, I mean they must have done, I got better...but you know, it's not just the anti-depressants, it was the help and support from somebody who knew what I was going through to talk to....I didn't like being on them (anti-depressants), I felt like a failure,....I think, you know, the 'up's and

downs' are really part of me and I think when I'm taking the anti-depressants...one of the things I don't like about it is that you're.....you don't have any 'ups' either...I don't think 'ups and downs' are a bad thing and you know, it's....again, what makes me, me, you know...."

(Gemma)

A move away from medical treatments is also often accompanied by a shift in the locus of control concerning the diagnosis and management of their depressive experiences. This can be evidenced by individuals challenging the ethos that 'doctor knows best' and a recognition that *they* (the individual) are the *expert* on their depression experience, and their experiences of 'self' during depression. Depression is acknowledged as influencing individuals' experiences of 'self', but importantly the control over their experiences of 'self' is re-gained by individuals as the depression experiences become more familiar and as such, less frightening.

Marginal self

It is around this time that depression as part and parcel of self-identity is negotiated. However, as the individual narratives highlight, depression is not simply accepted and fully accommodated as self-identity without negotiation on the part of the individual. The process of accepting that depression is 'part' of self-identity involves rendering the depressive part of their identity to the 'margins' of self-identity. There is at once recognition and a stand-off. This is characterised by individuals

accepting depression may be part of their identity – but it is just that, a part, rendered to the margins of their self-identity – unwilling to allow it to define who they are and exercise control over their definition of ‘self’. The potential of the ‘marginal depressive’ aspect of their identity to overshadow their ‘authentic self’ is recognised and noted, and control over the future is reinstated with ‘self’ for the present time²⁴.

As previously stated, reasserting control over their experiences can witness individuals beginning to challenge the mandate that ‘doctor knows best’ when it comes to their experiences of ‘self’ and depression. This is a particularly empowering step for individuals as they navigate their way through the depression experience. Individuals witness a progression from little or no control over their experiences and acquiescence to the medical profession’s management of their experiences, through to becoming an informed individual, reflecting on their experiences and confident to challenge the authority of the medical profession.

[the doctor] ... *“put me on twenty milligram [dose of anti-depressant] and after a month put me up to thirty, three months, then forty and then fifty milligram which was the maximum I had and I stood that for another five or six months and nothing was happening...all the the they [tablets] do*

²⁴ This is the case for individuals who are not overwhelmed by depression to such an extent that they are hospitalised during a depressive episode. Many of those interviewed who had experienced severe depression and had been hospitalised in the past adopted what might be termed a ‘only go so low’ strategy where they recognised that their depression may pose the potential to overwhelm them in the future, but importantly, they would decide when to seek medical assistance with their depression.

actually was slowing me down, slowing my energy down, that's all they appeared to do to me. So I thought, 'Why am I pumping these inside me?...so I decided to cut them down myself and I went to see the doctor and told him what I was doing...I just stopped it'.

(Kevin)

"I got no help from my parents or doctor or anything. I can't remember a doctor helping me, just give me tablets and make me go away. I think, I don't think doctors understand it [depression] either".

(Steve)

... "I think he should have offered me that (Counselling/anti-depressants) straight away. The first time I went, 'oh I'm getting divorced' – 'oh well', you know 'get on with it, you'll be alright'. But I wasn't alright, I was falling apart"...

(Jane)

"....I went up to the hospital to see a psychiatrist, he said that I had to take anti-depressants and I said I don't want to... So I had to go back and see him in six weeks....So he turned round to [daughter] and said, 'make sure your mum takes these tablets'.....when I went back to see him again he discharged me, didn't want to see me anymore....[because] I wouldn't take the treatment"....

(Kerry)

“...The worst bit of dealing with doctors and consultants in particular is that it’s so disempowering....they’re not really concerned with what you think or say...that kind of experience is not the kind of thing you need at that point in time really... in one sense it’s sort of scary to think, ‘oh these guy’s can’t work it out, what hope have I got’ sort of thing....But then, on other occasions they [professionals] seem so entirely clueless that I think. ‘christ’.....’I’m probably better qualified than you’.

(Terry)

... “You’d just go in, [psychiatrist would ask] ‘How are you feeling?’ [I’d reply], ‘oh, good days, bad days, some worse than others’. [Psychiatrist] ‘Right, but you’re no worse’? (Kevin) ‘No, no’. I just stood it for so long and then said ‘yeah, I’m getting a lot better’. I wasn’t, that was a lie but I was fed up with what was happening, nothing was changing, I were feeling no better....taking a drug I didn’t like taking...they [psychiatrist/GP] would never agree with me [that the depression stemmed from work/fear]...they wanted to find something else.....Nothing suited what they wanted to find and I knew it wouldn’t work....so I stopped going....with their permission like, I did ask to discharge myself”

(Kevin)

As can be seen, a recognition that depression is part and parcel of self-identity, albeit, a marginal part, can prove empowering for individuals as they come to terms with the fact that there is no sure way to ‘cure’ their depression and that they are ultimately the experts on their experiences.

Taking back control of their experiences is in contrast to early experiences where the medical diagnosis can be seen as rendering depression outside of identity and as such, outside of the control of the individual.

The rejection of a purely medical approach and the reclaiming of control follow the acceptance of depression as a 'marginal self', with the 'authentic self' now aiming to control the impact that depression has on the experiences of 'self': as opposed to depression controlling their experiences. This is particularly the case when making individual choices about the management of future 'selves'.

'Self' Monitoring

The accompanying increased awareness of 'self' that follows individuals' subjective experiences during depression may actually facilitate the resolution of the identity dilemma faced by individuals. There is recognition that depression may be an aspect of their self-identity which will always have the potential to overshadow their experiences, but also awareness that it does not have to be definitive of self; nor necessarily completely control their experiences.

However, individuals may recognise that, even on the margins of identity, depression will always have the potential to influence their life experiences, and an awareness of the tenuous relationship that exists between the 'being and doing' of identity. The recognition that the breakdown of this relationship (as a result of depression) will always

have the potential to fracture the cohesion of 'self' (that is experienced as the 'authentic self') may lead individuals to actively 'monitor' their experiences of 'self' in an effort to protect from the 'depressive self' at the margins of identity encroaching on the newly aware 'authentic self':

..."I was quite down when I got back [from holiday], like you usually are when you come off holiday, but 'cause I've been depressed you're more susceptible to it [depression], I was like 'oh God', you know 'don't let yourself slip back that way, just try to look forward'"

(Jane)

"I know I am continually depressed, it's always there, you can feel it, somewhere, but it's whether I allow my brain, that side of my brain to take over and let the depression get a hold...I don't want depression, have to fit my life around depression, the depression has got to fit in with my life...it's constantly there...don't let it control you"

(Sue)

"I try to avoid it [depression] but it's something I do get stuck with, you know, sleepless nights...at some point I just say, 'whoa – stop' and every time it comes into my head I physically, not mentally, stop thinking about it and desperately think about something else and gradually you will and it stops, puts the brakes on otherwise it will just drag you down"

(Robert)

As the above narratives highlight, an acceptance of depression as part and parcel of self-identity can have a positive impact on the experiences of individuals in that it empowers them to actively seek control over their future experiences. This empowering process allows individuals the opportunity to exercise their 'expertise' on their 'self'; monitoring their experiences in relation to how far the depressive part of their 'self' has encroached into the realms of 'authentic self', and taking action when they feel it is appropriate.

'New Self', or 'Newly Aware Self'?

The narratives of those who have experienced depression evidence the fact that experiences differ and the impact that depression has on identity is not uniform – this itself highlights the fact the 'depressive identity' is unlikely to be a concept to which individuals can and do recognise and/or relate to. On the contrary, the complex and multi-faceted nature of identity is evident, depression may have similarities in terms of experiences, but the impact of these is mediated through individuals' ideas of an 'authentic self' that influences and shapes their experiences of self-identity.

While individuals who experience depression may not identify with a 'depression identity' the acceptance and marginalization of depression as part of self-identity may give rise to the emergence of a 'new self'. Importantly though, this is not ultimately a 'new' identity as such, but is characterised by the synergy that results from accepting depression as a

part and parcel of 'self', coupled with an awareness that the cohesiveness and coherence of 'self' is tenuous in the light of the depressive aspect of 'self'.

The 'new self' to emerge might best be described as a 'newly aware self'; it is not defined by the depressive part of identity and individuals do not emerge with a 'depressive identity', nor is it possible to go back to the 'pre-depression' 'self'. The 'newly aware self' continues to recognise the pre-depression, cohesive and coherent 'self' they experienced as their 'authentic self'. However, the knowledge that identity and performances can be illusory and detached from 'self' also reaffirms the fragile non-essential nature of the relationship between the 'self' (being) and the performance (doing). The 'newly aware 'self's' focus on a 'return to self' that was, pre-depression, is unattainable since the experience of 'self' as cohesive and coherent, which served to affirm the 'naturalness' of 'self' and self-identity is already revealed as a myth.

The aim then becomes to negotiate the extent to which a 'self' can be fashioned that is coherent and 'natural' to the individual, on a daily basis, that is characterised by a cohesive sense of 'being' and 'doing' that is reminiscent of the 'authentic self'. The newly aware self is a result of the synergy created from the acceptance of depression as part of 'self', the recognition of the illusory aspects of identity and the desire for a unified, coherent and cohesive experience of 'self' and identity.

The Impact of Depression on 'self' and experiences of 'self'

While individuals have differing experiences of depression, all those taking part noted that depression had had a major impact on their 'self', their life experiences and their perceptions of life:

...If I had my life over again...yes there are times when I could have done without it [depression], you know it really did stand in the way...it broke one relationship up that was really strong...that was heartbreaking...I thought that was it, the end of my world at the time...but, if I got my life to live over again, there isn't such a lot I would have done differently...in fact it [depression] makes you more grateful...it makes you appreciate life more"

(Liz)

" I think that having gone through that [depression]...in some ways, it makes you a better person"

(David)

"...I think I am more concerned with who I am now and about what I can do and what my limitations are"

(Gemma)

..."I think I'm still the same person, I don't see myself as less of a person, I would think I'm more tolerant now"

(Tracy)

"I'm learning to slow down a bit, which I never did...now I just take things as they come basically...it's [depression] made me appreciate life more...I know I'm not a hundred per cent, I don't think I ever will be now, but it doesn't matter anymore, I can control it"

(Kevin)

However, not all individuals felt their experiences had allowed changes in self that could be seen in a positive light:

"I think it's [depression] changed the direction of my life...it's prevented me from doing what I wanted to do in life, and that, I mean that in itself does upset me...I do actually hate what it has done to me"

(Wendy)

"...Even when you come out of depression it leaves you feeling bad about yourself because you've been so weak to allow [depression]...I think depression's a symptom of who I am, rather than who I am being part of depression"

(Mark)

The impact of depression on individuals should not be understated. Depression means many things to many people, as is witnessed by listening to those who experience depression. However, by negotiating depression to the margins of identity, individuals become empowered to take the control over their experiences. They become experts on their

experiences and in the identification of depression in the future. This can include deciding if and when they seek medical assistance in the future, and also allows agency and control over the management of their depression through alternative strategies and can include getting involved in the development of future services for mental health service users (Parr, 1999). There is also a wealth of 'self-help' books emerging that are aimed at putting the individual in control of their experiences of mental ill-health and promoting individual control and management of future mental well-being, to name a few: Corry & Tubridy (2005); Dryden, (1999); Butler, G & Hope (2005).

This approach can reflect their awareness that depression is something that is part and parcel of who they are; and that treatment strategies may need to be tailored to suit their 'self'. Importantly for individuals, it is a point where they can assert that they are not simply allowing depression to happen 'to them' with little or no control.

Future Selves - Managing 'self' in the future

The 'newly aware self' to emerge with the acceptance of depression as part of self-identity is not, as noted above, seen as being defined by depression; there is no 'depressive identity'. The 'new' identity to emerge can be seen as stronger, resilient and more in control, a result of the synergism that arises from the pre-depression 'authentic self' and the impact of the depressive experiences on their self-identity. This 'newly aware self' brings with it the hope of a future where depressive

influences are mediated through knowledge of 'self' that can render future experiences less threatening and more affirming for 'self'. This may influence the subsequent path an individual takes in terms of future treatment and management of the depression.

Self help strategies aimed at re-establishing the coherence of 'self' and self-identity by re-locating depression to the margins of identity may be adopted, empowering the individual through the knowledge that they have a measure of control over their 'self' and ultimately their experiences of 'self'. The actions individuals take may involve strategies which include lifestyle changes in many aspects. These may include trying various alternative remedies: exercise, relaxation, and aromatherapy, herbal remedies, changing priorities and attempting to adopt a different perspective on life in general.

All individuals were asked how they saw themselves managing their 'self' in the future.

"If it's there now, I'll recognise it...there's the anticipation that at some point in the future it's going to come back. That's something that took quite a long time to get used to...I can't see myself leaping back into the arms of the medical profession at the moment...I would be much more inclined to manage it myself, if at all possible"

(Terry)

"...It [depression] doesn't scare me...'cause I think there's so many things you can do as well now, St Johns Wort and exercise...whereas before I was always scared because there was nothing I could do...[now] I feel in control of it, like I could do something if it was there"

(Steve)

"I can't say other than I've just got to try one way or another...you can never tell what level it is going to be at, I've just got to be aware it's going to be there"

(Sue)

"I try and fight it, yeah, try and fight it...if you don't grab it before you go too far...then you are in the pit, you have to grab it early...I've changed my lifestyle quite a bit since I got well last year...I go to the gym four times a week and swim every day...so I've changed quite a lot of my lifestyle...and I'm hoping that that, you know, will deter onset in the future"

(Paula)

"I can see peaks and troughs...there are times when everything's just great and others when it becomes a real slog, I'm sure everyone gets like that...there are times when the slog becomes a real slog...even the slog looks good...and then it's a case of battling through it...I usually try and change something I'm doing, something that will break the

cycle...it's like putting a barrier across it and then you can buy a bit more time and get yourself sorted out...

(Robert)

"I've always got somewhere to go...I'm always days ahead of myself...'cause I've got to have something else in life to look forward to...[if depression returned] I'd maybe put myself on St Johns Wort to see if I could overcome it before it stuck"

(Helen)

"I'm probably a different person through experiencing the depression and hopefully I come out of it stronger, but scarred, as I'm learning more about it I'm able to deal with it better...I do think depression is part of who I am...no matter how much I work at it in setting boundaries...it'll always be part of me"... "I do try very much...to look after myself [more] than I used to and that includes, you know, making sure I get some fresh air and...I relax and I do Yoga...have massages [these] are part of my coping strategy and yet before I would have considered them as luxuries I couldn't afford...now I see them as necessities in my life"

(Gemma)

"The depression's a part of me...I know it's in me, nothing to do with some one particular situation...it's something I know I am going to have for the rest of my life and it's how I chose to deal with it and how I let it manifest itself and if it manifests itself is up to me"

(Sue)

Conclusion

Depression, as an illness experience, can have a profound impact on individuals' self-identity and their life experiences. In the early stages, before a medical diagnosis is available, individuals often experience 'inchoate' feelings and struggle to make sense of what they are experiencing. At this point a medical diagnosis of depression may render comprehensible experiences that have been incomprehensible, overwhelming and frightening as individual ideas of 'normality' slip further away. Contrary to theory that suggests that individuals adopt an 'illness' or a 'depressive' identity at this point, it can be seen that a medical diagnosis of depression has the effect of rendering depression outside of identity and outside the control of the individual. A medical diagnosis at this point may prove disempowering for individuals as the medical profession assumes control and seeks to 'cure' depression. Within the realms of medical discourse depression is perceived as something that is *happening to* the individual, with little opportunity for control; any 'return to self' is to be secured through a medical model intervention with little room for agency on the part of individuals.

However, recurring episodes of depression may see individuals coming to terms with the fact that depression may be endemic, and as such a likely feature of their future lives. This in effect forces individuals to address the possibility that their 'self' may be inherently susceptible to depression, or rather, that depression may be a part of their identity, rather than purely a biomedical illness.

This chapter has explored the impact that depression has on individual experiences of 'self' and self-identity and further highlighted how 'performativity' and 'performance', the 'being and doing' of identity, is a central issue in the experience of depression. By developing the work of Butler, (1990), it is possible to recognise that the core of discontent for individuals during a depressive episode can be traced to the breakdown of the relationship between the 'being' and 'doing' of identity. Self-identity, once un-problematic and 'natural', becomes something that is to be 'produced' and 'performed' by individuals as they attempt to create an illusion of the 'self' that was, before the onset of depression. The research findings suggest that the social aspect of identity, - the 'doing' of self-identity is not enough to subjectively legitimise 'self' (being) and self-identity to individuals. The narratives of individuals highlight that during depression, even though they may succeed in 'performing' the differing aspects of 'self' and identity on a day-to-day basis, the 'doing' of identity remains detached from the 'self' undertaking the performance. As such, the performance is no longer 'performative' on a subjective, ontological level.

When the 'doing' (performance) of identity fails to elicit previous thoughts, experiences and emotions that were associated with 'being' (i.e. is no longer 'performative'), then 'self' is experienced as 'lost'. The subjective 'loss of self' creates a paradox by simultaneously reinforcing the notion that there is an 'authentic self' which shapes individual

experiences and expectations of 'self' and self-identity, whilst concurrently subverting the notion of essential, unified identity categories by highlighting their constructed and non-essential nature. The dilemma that people face in coming to terms with the notion that depression may be part and parcel of their self-identity involves a recognition that a predisposition to depression may have always been part of their 'authentic self', coupled with the newly acquired awareness that the relationship between 'being and doing 'self' is tenuous and a potential threat to the experience of 'self' as cohesive and coherent.

The hope of a 'return to self' that was, pre-depression may be resolved by accepting that depression may well be part and parcel of self-identity. However, this does not, as previous theory has suggested, involve the emergence of a new 'depressive' or 'illness' identity (Karp, 1996; Charmaz, 1991). Individuals may accept that depression is a part of their identity, but do not allow it to define their 'self'. As such, the depressive aspect of their identity can be seen as being placed at the 'margins' of identity. This allows the recognition that depression is but one aspect of their identity; it does not define who they are and they will fight to ensure it no longer dictates their experiences. In accepting depression as *a part* of self-identity, the individual is independently attempting to control the experience by rendering it more comprehensible to their self.

If an individual accepts that depression may be 'a part of their self-identity'; the synergy this creates enables them to regain a measure of

control over the experience, this influences the subsequent path they may take in terms of treatments and management of depression in the future. The knowledge that identity can be an illusion, performed socially while experienced as detached from 'self' simultaneously can empower individuals to assert changes within identity and fashion a 'self' of their choosing. However, individuals do search for a 'return to 'self'; a 'self' that was experienced as coherent and cohesive affording the stability that allowed individuals to go about their daily lives without consciously thinking about the performances that are necessary to undertake 'self' successfully on a social and subjective level.

The research findings suggest that for many, facing the future in the shadow of depression is no longer as threatening once they have acknowledged the fact that depression is likely to be part of their future lives, but refuse to be defined by it. Management strategies and lifestyle changes take on increasing importance. Importantly, these treatment and management strategies are based on their 'expertise' of their 'newly aware self': that is, a 'self' that recognises depression as an aspect of their identity. This 'newly aware self' is not a 'depressive identity' or an 'illness identity', rather it is characterised by the synergy created by acknowledging depression as part of self-identity in the quest to refashion a 'self' that is experienced as coherent and cohesive. The experience of depression and the crisis of identity experienced during the rupture of the relationship between 'being and doing' never leaves individuals.

The account of identity and the subjective experience of the relationship between the 'being and doing' of 'self' during depression that has been developed throughout this chapter could be further utilised in other academic fields concerned with the nature and experience of identity. This could include areas such as disability studies, ethnicity studies and identity studies. The approach could facilitate a deeper understanding of the 'being' and 'doing' of disabled identities, ethnic identities and more generally in the experiences of 'self- and self-identity across other disciplines. Perhaps more importantly, it can highlight areas of potential for agency to resist the social ascription of the totalising nature of the identity categories.

The following chapter further explores the role of the social sphere in individual experiences of depression.

CHAPTER FIVE

The Social Nature of the Depression Experience

The previous chapter explored several issues relating to 'self' and the depression experience, highlighting the crucial relationship that can be seen to exist on a subjective level between the 'being and 'doing' of identity. It was noted that although the social sphere can be seen as instrumental in the manner in which identities are created, performed and granted (or denied) legitimacy, the social sanctioning of identity is not enough to consolidate the subjective experience of identity during depression: the 'performance' alone is not enough to ensure the acceptance and experience of identity on a subjective level. On the contrary, the need to 'perform' a 'socially authentic' self that is validated on a daily basis only serves to reinforce the experience of a 'loss of self' for individuals.

The 'loss of self' experienced during depression can be recognised as the subjective experience of the breakdown of the relationship between 'being and doing' identity. The breakdown of this relationship creates a paradox since it at once reinforces to the individual the notion of an 'authentic self' that is lost, while simultaneously highlighting the un-essential nature of identity: since the performance is consciously performed by a 'self' that is, in fact, detached from the performance. Performance may no longer be performative subjectively, but the aim of

the individual undertaking the performance is to (re)create an illusion of the 'self', that is, the 'normal self' that was, prior to depression, on a social level.

The following chapter will explore these issues further, focusing on the impact that the social sphere has on individuals' 'willingness' to embrace depression as part of their self-identity. It will begin by highlighting general perceptions of the legitimacy of depression as an illness within society and explore the impact this has on individuals who experience depression. Key issues around the perceptions, social legitimisation and experiences of 'self' on a social level will be examined. Further developing the work of Butler (1990) and Jenkins (1996), the narratives of individuals who have experienced depression will highlight how the social censure of depression as an identity or an illness category within wider society can restrict individuals' willingness to embrace depression as part of their identity on a subjective level. While it is possible to recognise the crucial role that society has in the legitimization and policing of identity categories on a social level, it also highlights the fact that individuals can and do actively resist being defined by identity categories. Moreover, the influence of the social arena is not always the key factor that determines whether individuals are subjectively defined by identity categories.

The research findings suggest that individuals can and do actively resist being defined by identity categories within society and that the social

sanctioning of identity is not always sufficient to ensure the concomitant incorporation of identity categories as definitive aspects of 'self' and self-identity.

The Social 'Dilemma of a Self':

As the previous chapter highlighted, depression, as an experience of 'self' can have a profound impact on individual's lives, both on a subjective and social level. The acceptance of depression as a *marginal part* of self-identity may resolve the dilemma faced when accepting that depression is a part of self-identity and ultimately empower individuals to take control over their experiences in the future. However, while this may render depression less threatening and more affirming for self-identity on a subjective, ontological level, the same cannot be said on a social level. This is especially the case with depression, as noted earlier, since not all identities are equally valued, and some are subject to social censure (Roseneil & Seymour, 1999). The willingness of individuals to invest in identities is central to their maintenance and legitimacy. Depression, as an illness identity presents a dilemma to individuals as they recognise and can identify with depression as an experience of 'self', but do not wish to be defined by it in terms of 'self' and self-identity on a social level.

During depression, the 'authentic self' that is experienced as 'lost' is not simply replaced by a 'depression identity'. The fracturing of the relationship between 'being and doing' 'self' during depression, and the

conscious awareness of individuals that they can perform an illusion of 'self' socially, serves to subvert the idea of a pre-depression 'authentic self' to individuals. As the narratives of individuals highlight, once depression is acknowledged and accepted as part and parcel of 'self' and self-identity the synergy created witnesses the subsequent emergence of a 'newly aware self'. The 'newly aware self' recognises and acknowledges depression may be a 'marginal' part of 'self' and that this aspect of their identity has the potential to disrupt the already tenuous relationship between the 'being and doing' of 'self' and self-identity.

This 'newly aware self' does not, contrary to Jenkins (1996) need to be legitimised on a social level, nor is it given meaning and substance through the 'doing' of the identity socially as *per* Butler (1990). On the contrary, the knowledge that depression as an illness and an identity category is stigmatised on a social level renders it a facet of identity that individuals may well experience in terms of 'being', but go to great lengths to avoid 'doing' depression on a social level.

This can be seen as a key focal point of resistance on the part of individuals. By refusing to let the 'being' of depression translate into the 'doing' of their 'self', at least on a social level (through, for example, the continued efforts to 'perform' their idea of a 'normal self' as they go through typical daily routines), they have control over the 'self' they present and perform: a 'self' they perceive to be 'normal' for them

socially. This allows for the acknowledgement of depression as an aspect of their self-identity, but agency to refuse to be defined by it, both subjectively and socially.

This can be an empowering experience for individuals even though the effort to undertake the 'doing' of their socially 'normal self' can be tremendous. The effort that individuals put in to 'performing self' socially, to avoid being defined primarily in terms of their depression, is perhaps not surprising given the remarkable tenacity of the stigma that surrounds mental illness in society. To gain a deeper understanding of the social sphere and its impact on the reluctance of individuals to adopt a 'depression' identity' (both subjectively and socially), it is important to have an understanding of how individuals feel depression as an illness identity is perceived by society in general. This allows an insight into how individuals feel they will be judged if they were to allow the 'being' of depression to translate into 'doing' and consolidate a 'depression identity' on a social level. All those taking part were asked how they thought depression is seen in society:

"I think the term [depression] is used way too often, way too lightly...I think people view it as 'oh, you've gone bonkers and they'd probably avoid you"...I think other people would see it as an excuse to have a week off work...."

(Jane)

"I still think it's really under-estimated. Misunderstood really, there's a lot of people who've never experienced it that think you're just, you know, in a bad mood, and you just get, 'snap yourself out of it'. And I find that quite difficult. I haven't told many people at all to be honest. Only people I had to tell"

(Anna)

"Stigma definitely.....if you do find any people who don't understand or know it, they'll treat you differently, and you're aware that they're treating you differently".

(Sue)

"I still think there is a lot (of stigma) because it's one of those things that cannot be seen..."

(Paula)

"...Some people ridicule it, they don't understand it, a mental illness, yet a lot of the time a mental illness is something that we can't control and they don't realise that we're suffering, you know a bit of kindness shown would go a long way at that particular time, instead of being ignored or laughed at or whatever..."

(Liz)

"...I think they just think you're silly. I mean, I've been told, you know, 'pull your self together'. People don't believe it that's never had it".

(Kerry)

"There is a big stigma about it, 'cause they just think that if you're depressed, mental illness, you're a bit schizophrenic and you're going to kill somebody"...

(Helen)

"I still think it's a taboo, people still say, 'pull your socks up', 'get your act together', that type of thing...unless you've had it, you can't understand it...you can read up on it, you can imagine how someone feels...but until you've actually been there, you know, and I wouldn't wish it on anybody"

(Wendy)

... "I think really, unless you've had it yourself, or someone close to you has had it, people tend to think of it as a, you know, 'oh, I'm feeling a bit depressed today', you know, 'I'm a bit glum'. And it's not, you know, it's not really like that, it's a separate animal...people are better these days than they were, but...the important ignorance in it is the ignorance of what it's actually like".

(Terry)

The narratives above reflect the general feeling of all those taking part, that society in general lacked understanding and empathy surrounding depression, with several suggesting that depression continued to be regarded as a personal 'weakness'. The lack of understanding around depression, *as an illness* was one of the key issues for individuals. The

main problem identified by individuals taking part in the study was that in lay discourse depression is used daily by individuals who have no experience of clinical depression, and who use the term lightly and out of context. The participants believed that the lay discourse that constructs depression as either a weakness of 'self', indulgent self-pity or an excuse to take time off work means that depression is not recognised as a legitimate illness within society (Pilgrim & Rogers, 1993). If depression is not perceived as a legitimate illness then it is not surprising that a 'depression identity' will be regarded in much the same way. If a 'depression identity' was to be validated within society it would likely be constructed within the lay discourses that surround depression as an illegitimate illness, that is, it would be definitive of an individual with a personal weakness masquerading behind an un-legitimised illness.

Given this knowledge, it is perhaps not surprising that individuals do not wish to adopt a 'depression' identity as a core definitive part of 'self'. The previous chapter highlighted the personal sacrifices and battles that individuals have fought during depression. In this case depression as an illness and identity category that has distinct characteristics defined within society is at odds with the experiences and perhaps more importantly, the personal characteristics of individuals who have experienced depression.

The fact that several of those involved in the research suggested that only those that had been through depression could understand what it

felt like, highlights that in this instance, it is the 'being' of depression that legitimises it as both an experience of 'self' and an identity. The continued social censure and stigma associated with depression means that individuals go to great lengths to avoid 'doing' the depressed aspect of their self-identity 'socially', and may, be very reluctant to share this 'marginal' part of their self-identity with others.

The reluctance to share the depression aspect of self-identity with others related to the fact that the vast majority of individuals were of the opinion that if people knew they had or were experiencing depression, their perception towards them would change. This was seen as reflecting the social stigma and the general misconception (as will be discussed later re: gender) that one aspect of your self-identity defines who you are, and as such, your experiences and opportunities for your 'self' – both socially and subjectively. All those taking part were asked whether they believed that people's perception of them would change/has changed if they knew the individual experienced depression:

“ Yeah, they're a little bit, you know, wary I think, they think 'ohh', you know, 'don't want her to get all upset and start crying in the middle of work' or something like that...I definitely sense that, especially with my manager. He's very like, 'oh, only if you, if you feel ready, only if you want to', you know? So then I get a bit embarrassed to be honest...”

(Anna)

“ ...If you do find any people who don’t understand or know it [depression] they’ll treat you differently and you’re aware that they are treating you differently”...

(Sue)

“I do think it probably does affect how other people look at me.....if they’re going to judge me, let them judge me, erm. Because this is me, this is who I am...”

(Gemma)

“I think they laugh at it.....’cause I did, I was of the same opinion as a lot, well, the majority of people.....the only people I believe understand it is them that’s had it and until you’ve had it you can’t understand it”.

(Kevin)

In the case of depression and self-identity, the acceptance of a ‘depression identity’ is not as straightforward as previously theorised. It was noted earlier that current theories that seek to address the impact of chronic illness and depression on self- identity (Charmaz, 1991; Karp, 1996) lack the sophistication to address the complexities that surround depression and self-identity. These theories also fail to address the fact that social censure and stigma may render the depression identity an aspect of self-identity that individuals do not wish to embrace socially.

As such, individuals actively seek to 'perform' their idea of a 'normal self' socially rather than share the depression aspect of their self-identity. As the research findings highlight, in many cases individuals go to great lengths to 'perform' as their perceived 'normal self' socially, in a range of different situations, for example, at work and during social gatherings. In these instances, the 'loss of self' renders the 'performance' of self-identity problematic; the 'doing' of identity is experienced as a conscious effort, requiring great effort, but necessary to (re)create the 'illusion of self' on a social level.

These issues also highlight the inherent problems of adopting theories that privilege the social arena in the legitimization of identity categories and identity formation on both a social and a subjective level as per Jenkins, (1996) and Butler, (1990). As the individual narratives highlight, in the case of depression, it is the 'being' of the depression experience that subjectively legitimises the 'depression' aspect of self-identity and ultimately leads to the incorporation of depression as a marginal part of 'self'. The perceived lack of understanding and empathy for depression as an illness by society in general negates its ability to legitimately validate and legitimise depression as an identity, in the opinion of those who have experienced the 'being' of depression. As such, this may restrict the possibilities for the depressed part of 'self' socially, but simultaneously empower the individual to resist being defined by a socially constructed and sanctioned identity category that they do not identify with, nor wish to be defined by.

Being & Doing: Performing 'Self' during Depression

As noted above, the acceptance of depression as part and parcel of self-identity may take place on a subjective level. At this level the depression aspect of their identity may well be experienced as less threatening and more affirming for self identity, it can also leave individuals feeling empowered to take control over their experiences. However, on a social level, individuals recognise and perceive that the social stigma associated with depression leads to social censure, which, in effect, restricts the acknowledgement of this 'marginal' part of their self-identity on a social level.

Many try to fulfil the roles they occupy on a daily basis, as was discussed in the previous chapter, often describing it as 'going through the motions', performing the identity, but not 'being' it. However, the narratives of those taking part highlight the effort, both physical and mental required to 'keep up appearances' of 'self' during depression. The key driver for individuals here is the avoidance of being defined by depression and hence being seen by others first and foremost as a 'depression identity' rather than who they feel they are, their 'authentic self', even if it is 'lost'.

All those taking part were asked about how they got through the days when depressed:

"Well, sometimes, I just feel, 'Oooohhhh' (exasperated), you know, 'I don't want to do this', but it's a lot easier than it was last October. Now I feel sort of like I'm doing, sometimes at work, I do get the odd hour where I think, 'ohh', I feel it sort of coming on again, if I've had a bad day or something. I just try to go away, just for half an hour, go for a walk, get some fresh air and just, you know, calm myself down".

(Anna)

"Every morning's a struggle to get out of bed, just to go... just to get to work, every morning...I'm depressed today, but I've got to be Sue at work...."

(Sue)

The 'newly aware self' to emerge as a result of the synergy produced from acknowledging and accepting depression as a facet of identity on a subjective, ontological level is consciously aware that performances of 'self' can be detached from the 'self' undertaking them. During depression, the rupture of the 'being and doing' relationship results in a lack of cohesion and coherence between 'being and doing' of 'self' and self-identity. It is this breakdown that sees individuals consciously striving to (re) create the 'normal' social 'doing' of identity. The ultimate aim of 'doing' 'self' socially is to (re) create the illusion of a 'normal self'

socially. This project is undertaken in order to facilitate the continued legitimacy afforded to the individual as just that, an 'individual' with a multi-faceted individual identity, who is not pre-judged and primarily defined by reference to a 'depression identity'; an identity that they do not relate to as defining their 'self'.

However, in some cases, especially during severe depression, it is not always possible to 'carry on as 'normal'', and for some individuals there were times when they could not find the energy to 'do' their 'self' on a day-to-day basis:

"... [I]... didn't actually come into work, just didn't turn up for work....I just wanted to sleep and not wake up....it's a struggle to get out of bed every morning....I make the effort, but...it's exhausting"

(Wendy)

"I went back to bed, all the time. All day."

(Jane)

It is interesting to note that social withdrawal is a key symptom associated with depression (Hammen, 1997). It is plausible that this characteristic is associated with 'self' aiming to protect the 'authentic self' from further distress through having to perform self-identity socially during depression. If the breakdown in the relationship between 'being and doing' 'self' on a subjective level (discussed in the previous

chapter), is further stressed through the social sphere, through, for example, people insisting individuals are 'not themselves', and so on, this could exacerbate the situation for 'self'. In this instance individuals would be aware that their attempts to 'perform' their 'authentic self' had not been successful socially. Not surprisingly, for many sleep offers the greatest escape from the depression experience and a respite period for 'self', as well as offering relief from the fatigue that plagues many individuals.

'Doing' Self at Work

The need to 'preserve' the social appearance of the 'normal self' was evident in many of the key areas of their lives, including, for example, work. During a depression experience, the general consensus from individuals was that getting through the day was something that required an enormous effort. Physical symptoms aside, managing and performing the numerous roles that make up their self-identity on a day-to-day basis was consciously undertaken in an effort to ensure that the outside world, the social arena, did not become aware of the inner turmoil that characterised their current experiences. Individuals were asked whether they would/did tell their work colleagues/managers that they experienced depression:

"No, because.....to me they might have looked at me differently, they were my friends, they'd accepted me as I was, why change it? If I mentioned depression maybe they would have looked at me differently

or not got involved and I was ok at the time, I was working, I was fine, why bring it up?

(Liz)

"...I wouldn't talk about it at work....you don't tell them, [if you did] maybe you will not be given that bit of work that could help in your career".

(Mark)

... "Not many employers are happy to sort of take on a self-confessed depressive"...

(Terry)

[If she were to go off on sick with depression] ... "It would be just 'oh God, she's gone off, she can't handle it'....probably 'don't want her back...it'd be seen as a nuisance value....it'd be, you've done it deliberately kind of thing...to get out of work...you'd be putting more pressure on them, so they wouldn't look very kindly on it"

(Mandy)

[After three months off work with depression...going back to work...]

"I fought it that first week I went back. I did. It was the hardest thing I've ever done in my life".

(Kerry)

Several of those who did share the fact that they had experienced, or were experiencing depression within the workplace noted that some of their colleagues were reluctant to allow them to share their openness, particularly when thinking about future promotion opportunities:

“... Some people think I’m a bit open....and shouldn’t be telling that many people that you suffer from depression, it won’t do you any good promotion wise and stuff like that...[but]...even on a ‘bad day’, I’m getting on....I’m quite a productive person...I know my boss suggested I didn’t put depression on my sick note...”

(Gemma)

“...When my Human Resources manager came to see me....she said, ‘oh I’ve not told him [Manager] what you’re off with, I’ve told him you’ve got glandular fever...I’m not bothered, I’m still me at the end of the day, I’m still capable of doing my job. I don’t think even to this day I let half of them know what I was off for...”

(Tracy)

However, not everyone felt that being open about their depression at work was necessarily a bad thing, and some had positive experiences:

“...Everyone at works been fine, I’d never not tell anyone, to me it’s just matter of fact”

(Helen)

However, there was a general feeling on an individual level that depression appeared to lack the legitimacy as an illness that warranted taking time off from work:

"I still think, even in our work place, people go off with depression and it's 'oh God, not another one', you know, just an excuse, because it's something you can't see... in the long term I think depression is seen probably as just a scapegoat for other things. Do you know what I mean? Like 'oh, we can all use that one', you know, 'I can say I'm depressed'. I don't think it's taken seriously. I think people tend to see it as making excuses".

(Mandy)

"...The biggest problem was convincing work...I was sending sick notes in saying I was off with depression.....and they would say, 'well you can still come in and work can't you?'."

(Robert)

.... "I don't know whether it's [depression] even recognised, you know, sickness in the sense that, like a broken leg, or you've got to go and have some treatment at hospital. You know, [with depression] people probably think you're just...couldn't be bothered to come in".

(Wendy)

Depression, the Body & Illness in Society

The lack of legitimacy afforded to depression as an illness that warranted the same, if not more, social sanctioning as other 'physical' illness was a common theme to emerge. Many noted that the lack of 'visible 'markers' failed to legitimise depression as an illness, largely on a social level, but also on individual level.

This highlights another key point that has emerged in social theory over recent years; the impact that the body has in society. Butler (1990) noted that in a real sense, one 'does' one's body, in line with pre-scripted social 'norms' that ensure the continuation of the sexes as distinct, opposite, but complementary. Recent years have also witnessed the publication of a wealth of research that has also highlighted the extent to which the body is also a key symbol of 'self' in society (Shilling, 1993; Synott, 1993). This is reflected in the work of Butler (1990), where the body takes centre stage in the performance of identity, and also in the work of Jenkins (1996) where social identity can be seen as being legitimated on the basis of an individuals' ability to pass-off an identity through the enactment of various characteristics of an identity, but read primarily through the body – be it through speech, accent, mannerisms. All identities can be seen as being embodied in the sense that the body becomes the canvas through which identity is read and legitimised within society. This is particularly the case with illness, where physical markers, such as physical disability that serve to legitimise illness socially (Galvin, 2005; Michalko, 2002; Wendell, 1996).

Depression is without doubt an embodied illness, perhaps more so with its typical combination of both physical and mental symptoms. However, it became evident during the research that the lack of physical 'markers' to legitimise their depression experiences as an illness, both socially and at times subjectively, was perceived to be problematic to varying degrees:

"Usually when you go to the doctors and they prescribe things for a physical illness or something, you can go home and think 'oh good I've got my anti-biotic' or whatever, I'll be, feel better in five days time or whatever...I mean the tablets he'd given me, he did say that they'd take a couple of weeks really to get into your system. So there was no going home and sort of tucking myself up in bed with, you know, Lemsip or whatever ...If you break a leg or something it's easy for people to say 'oh I hope you get better soon' and relate to that. But this was just so much different because I could talk to people, all right, you know, I wasn't sounding all bunged up, or really under the weather or anything and it's difficult to get across how you feel"...

(Anna)

"It's one of those things that cannot be seen, if you've got a plaster on, or a, you know, if you're bandaged up, you know what's the matter. But it cannot be seen and it's very difficult to explain it..."

(Paula)

"You can't see it and if you see somebody down the street with a broken arm you'd open the door for them, but mental illness, you can't see it, people are not aware of it"....

(Liz)

"... It's another invisible disability isn't it? Very easy to dismiss".

(Mark)

"... They [society] treat you as being fine....even when you say you're depressed.... They'll sympathise for a few minutes and then carry on as normal, 'cause you don't look physically ill. If you had a broken leg or something then, you know, you've got something to prove it... you don't see anything, there's nothing physical, there's no spots and boils or cuts for people to look at and say, 'oh, you're ill', so they think you're fine".

(Robert)

"....It's sad if you see somebody with a disability, can't walk properly, they're blind or in a wheelchair because you're sympathising, but with mental problems you can't see it and these people need help and need to be sympathised with"

(Helen)

For many of those taking part, the lack of physical 'evidence' to legitimise their depression as an illness socially was one of the key issues associated with the perceived lack of empathy afforded towards

those who experience depression by society in general. The lack of understanding of depression as an illness, as opposed to depression as a state of mind that most people experience at some point in their lives, as noted earlier, only further serves to perpetuate the reluctance of individuals to allow the depression aspect of their identity to define their 'self'.

Legitimising Depression as an Illness of 'Self'?

This search for legitimacy for depression as an illness within society through the 'marking' of the body highlights a further dilemma for individuals. The very fact that they can create an illusion of 'self' through the social performance of a 'normal self' is dependent upon the extent to which this 'normal self' is sanctioned socially. The aim of the performance or 'doing' of the 'normal self' socially is to avoid being identified with the depression aspect of their self-identity. The crucial aspect of the performance or the 'doing' of 'self' is the extent to which this is performative socially. That is, the 'doing' of a 'normal self' is dependent upon the enactment of a 'self' that is not depressed, which in turn leads society to recognise the 'doer' of the performance as the 'essential, normal self' behind the performance.

The ascription of 'markers' may help to legitimise their depression experiences on a subjective level. However, individuals have already acknowledged and accepted depression as part of their 'self'. If individuals could ascribe markers to legitimise their depression as an

illness, it would deny them the opportunity to resist depression as an identity socially and it is the social aspect of the depression identity that they do not identify with subjectively, nor wish be identified with socially.

The Impact of Social Stigma on Identity

The impact of the social stigma surrounding depression is similar to that surrounding individuals with a physical disability, not least the fact that individuals with a physical disability also wish to be seen as the person they are rather than the disability they live with (Wendell, 1996; Michalko, 2002:5). However, as noted earlier, the body is the key means through which society 'reads' individual performances. As such, it is increasingly difficult for individuals with a physical disability or chronic illness to 'perform' as the 'self' before the onset of illness/disability and have that performance sanctioned by society (Goffman, 1963). The performative aspect of 'doing' a 'self' with a disability means that individuals may internalise the stigma associated with their disability in the early days (Galvin, 2005: 398-399). The crisis of identity at this time can also be seen as a breakdown of the relationship between 'being and doing' 'self' socially with a disability.

The dissonance created on an individual level can be recognised as the struggle to (re)define 'self' and self-identity following the onset of illness/disability. The subjective 'self' may not experience the disability or illness as a definitive aspect of 'self' at this time. However, there is a recognition on the part of the individual that the social sphere, and the

concomitant social stigma surrounding physical disability, can and does place limitations on the possibilities for 'self' in the light of their illness/disability (Goffman, 1963). This is due to the social inscription of a 'disability identity' upon the individual, which then becomes perceived as the definitive aspect of the individual's 'self', socially. The encroachment of the social sphere into definitions of 'self' and self-identity places limitations on the options of 'doing' a positive identity legitimately in the face of the social censure.

It is important to note that people experience illness within society and that the culture and belief system of that society can have an influence on individual experiences of illness, and what is seen as legitimate illness (Radley, 1994; Thomas, 2002; Turner, 1995; James & Hockey, 2007). Culture also influences individual perceptions of what is acceptable in terms of seeking help (Radley, 1994). Clearly the impact of social stigma and restrictions upon individuals who experience a disability means that the identity of a 'disabled person' is not something to which many people aspire to (Wendell, 1996:25). The typical stereotype of a disabled person as someone totally dependent and defined by their disability is not the lived experience of 'self', the 'being' of 'disabled', for many individuals living with a disability (Wendell, 1996:27; Michalko, 2002). This is similar to the experience of depression, where, as discussed earlier, the individuals who experience depression do not relate to the social stereotype of a 'depressed person' and do not wish to be defined by that aspect of their self-identity on a

social level, even when they have acknowledged that depression is a facet of their self-identity.

However, living with a physical disability does have practical issues associated with it and many individuals do appear to undergo a shift in self-identity following the onset of chronic illness or a change in physical ability (Galvin, 2005; Charmaz, 1991; Wendell, 1996):

“Recognising myself as disabled required that I change my self-identity and adopt a radically new way of thinking about myself. This included accepting the reality of the stigma of being chronically ill”...

(Wendell, 1996:26)

The impact of social stigma associated with certain identity categories (for example, the ‘disabled individual’ and the ‘depressed individual’) can have influence the extent to which individuals re-define their ‘self’. This is evident in research studies into disability that have highlighted the fact that social stigma can be as influential as the material social world in the re-formulation of self-identity in the face of the onset of chronic illness and/or disability (Galvin, 2005). While a thorough review of the area of disability studies is beyond the scope of this thesis, it is worth highlighting briefly the ‘social model’ of disability and its relation to social stigma and identity formation.

Social theory of Disability

In brief, the social model sees the attitudes and reactions of wider society, and the physical environment (designed by 'able-bodied' for 'able bodied') as effectively 'dis- abling' for individuals with a physical impairment/disability. As such, it is living within a society designed to meet the needs of the 'non-disabled' that creates barriers and difficulties for individuals living with a disability, not the individual bodies of the 'disabled' *per se*. This is in contrast to dominant medical definitions and 'treatments/ rehabilitation of disability (where the individual is encouraged to learn to cope with a physical environment designed for able-bodied), which in effect renders the 'problem' of disability an individual 'disabled person' one, as opposed to a social one. As such, it is the individual identity that is sanctioned as a 'disabled identity' and subsequently marginalised (Butler, R & Bowlby, 1997; Parr & Butler, R 1999; Galvin, 2005; Thomas, 2002).

While the social model of disability represented a challenge to the dominance of the medical model approach to disability, it has been criticised for losing sight of the very real impact of living with a physical or mental impairment/disability (Butler, R & Parr, 1999: 4-5). This model is also recognised as failing to adequately address the nature of 'differences' between individuals' experiences of living with physical or mental impairment/disability (*ibid*). Furthermore, and particularly relevant to the theory developed throughout the thesis, the social model fails to address the relational aspect of the 'self' and society and the impact this

has on everyday life experiences of individuals living with a physical or mental impairment/disability. As Parr & Butler, R (1999: 5) note:

“...there is a dialectical relationship between the individual and society – a constant reciprocity between subjective experience and the intersubjective milieu of everyday life”.

(ibid)

The strengths of the development of the social model to recognise the very real issues which can arise from impairment *e.g.* fatigue (Morris, 1991; Thomas, 2002) is recognised as the biosocial model and can also be applied to the experience of depression/mental health (Butler, R & Parr, 1999). It is important to note that depression is accompanied by physical changes, including fatigue, which can impact upon an individual's willingness and ability to 'perform' 'self' socially when depressed.

Galvin (2005) also highlights the fact that it is not simply the physical social world that 'disables' individual identity, rather, social stigma perpetuates the discourse that constructs the 'disabled identity' as a deviation, a transgression from the 'norm' and this can, at least in the early stages of coming to terms with a disability, influence an individual's sense of 'self' and create a crisis of identity (*ibid: 398-399*).

Social stigma can and does have an impact on individuals' willingness to be defined by identity categories. For those who experience depression, the lack of physical markers means that society lacks the empathy and

understanding to legitimise their illness. However, research from disability studies suggest that physical markers do not always invite respect and empathy for individuals living with a disability within society (Davis, 1997; Michalko, 2002; Wendell, 1996; Galvin, 2005). On the contrary, many disabled individuals feel it is more difficult to be accepted first and foremost as the person they are, rather than the disability/illness with which they live. The shift in self-identity that takes place when individuals are coming to terms with a chronic illness or disability is as much about accommodating the social impact of the change in the 'performance of self', the 'doing' of self-identity as it is with the 'being' of 'self' as an individual living with a disability or chronic illness. As Wendell, (1996:27) points out:

"it was easier to identify my 'self' as disabled to myself, than it was to identify myself as disabled to others..."

In terms of depression, it is clear that comparisons can be made between the social model of disability, in the sense that it is the social stigma and cultural sanctioning of depression as a deviant identity that means it is not granted legitimacy as an illness. It is the impact of the social cultural arena that renders the depression identity one that few, if any would aspire to be defined by. However, there is a crucial difference between the experience of depression and the experience of chronic illness/disability; while both can be recognised as embodied and lived experiences of 'self', depression as an illness experience is not typically

experienced consistently on a day-to-day basis. Furthermore, although the experience of depression is an embodied experience in that it is characterised by both physical and mental symptoms, the physical symptoms are not typically 'markers' through which society can 'read' depression.

This may be an influential factor in the reluctance of society to sanction depression as a legitimate illness; it also represents a paradox. At once the lack of physical markers means that individuals can 'perform' a 'self' of their choosing socially and actively resist the ascription of a 'depression identity' that may mean little to them in terms of their subjective, embodied experiences. This allows them to (re) create the 'normal self' socially and avoid the stigma that accompanies it, and the necessity to (re) define 'self' primarily in terms of their depression experience. However, it also means that it is difficult for them to challenge the stereotypes and stigma that make depression an aspect of self-identity that individuals do not wish to share socially. On a more practical level while the individual may well change as a result of their depression experience they can, through performing the 'normal self' ensure that how society categorises, and individuals relate to them does not change too dramatically. This is in contrast to the research evidence from 'physical' visible disability studies that highlight the extent to which physical markers can often change how individuals are perceived in society, and how this in turn impacts upon their (re) definition of 'self' subjectively (Galvin, 2005).

Expectation & Aspirations of 'Self'

As discussed previously, it is possible, following Jenkins, (1996), and Butler, (1990) (and research findings from the field of disability studies discussed above) to recognise that society has a key role to play in legitimising identity categories. The research findings presented here highlight that this is particularly the case in terms of depression as an illness identity. 'Markers' on the body serve to signify illness; they enable society to 'read' the body as evidence of legitimate illness. However, depression, with its composite lack of physical 'evidence' and the attendant social stigma, renders the depression identity one that individuals may not seek to have validated or legitimised on a social level. This is not simply about denying an identity, although it is an important aspect to note that individuals can, and do actively resist some identity categories. In this case, it is about acknowledging depression as part of self-identity on a subjective level, but having the agency to resist being defined and circumscribed by it socially.

Self-identity then, can be seen as being largely defined by expectations of and aspirations for 'self'. The refusal to be defined by depression socially, reflects the aspirations for 'self' that individuals have; for a 'self' not defined and circumscribed by depression; a self they have control over and a 'self' they can relate to subjectively and ontologically. Individuals can resist the depression aspect of their identity by 'performing' a 'normal self' socially. This performance, as discussed previously, does not legitimise the identity on a subjective level. On the

contrary, it creates an awareness of the non-essential nature of identity, in that the 'doing' of identity can create the 'illusion' of some 'essential self' socially. It is the pre-depression 'normal self' that individuals are attempting to (re)create with their performances, even though they recognise that the 'normal self' that was, pre-depression, has changed in light of the depression experience.

This is in contrast to the assertion from Butler (1990) that the 'doing' of identity is indicative of a passive individual, unquestioningly reaffirming the 'essential' nature of identity by conforming to the social scripts that create the illusion of the 'interiority' of identity.

Rather, during depression we see individuals with agency, consciously 'performing' 'self' to create the illusion of an 'essential self' in the midst of a 'loss of self'. There is recognition at this point, on the part of the individual that there is no 'doer' behind the performance (as the 'self' is lost at that moment in time). There are, of course, days when the depression experience is too overwhelming and it becomes impossible to 'perform' 'self' socially. These 'bad days' are a characteristic of the depression experience and individuals may withdraw socially as far as possible during these periods. However, where possible, the performance of 'self' is empowering in the sense that it allows the individual, as discussed above, the ability to resist being defined socially by their depression. It also allows a negotiation on the part of the individual as to how much impact their depression has on their 'self'

subjectively, especially the ability, however fleeting it may be, to continue with their daily lives during depression.

The ability of the individual to 'perform' 'self' socially is based upon their experiences and social expectations and aspirations for the identity categories they inhabit. However, it is the pre-depression taken-for-granted experience of 'self' and self-identity that individuals identify as their 'authentic, normal self'. The 'normal self' was experienced as a seamless whole of 'being and doing', a reciprocal relationship that ensured a cohesive and coherent experience of 'self'. The relationship between the 'being and doing' of 'self' (the performance and performativity of identity) serves to legitimise 'self' and self-identity both subjectively and socially. The cohesion of 'self' enables the individual to go about their daily life largely unconsciously, performing within the many facets of self-identity.

The perceived benefits to be gained by maintaining a semblance of 'normality' of 'self' socially during depression can have important implications for both 'self' of the moment and 'self' of the future, as discussed above. In light of this, a further issue explored in the research was the perceived benefits for individuals if they were to 'come out' about their depression socially, and whether the increased awareness of depression this may bring about would necessarily be a 'good thing'.

'Good Days, Bad Days' & 'Coming Out'

As discussed previously, depression, as an illness is experienced primarily as an illness of 'self'. While there are a set of recognisable symptoms that amount to a medical diagnosis of clinical depression, the experience and severity of the depression varies, not only between individuals, but also for an individual. This became evident during the research, for example, an individual may have several episodes of depression that are mild/moderate, and then experience a severe episode. During the depression experience they may well have 'good days' and 'bad days' (Charmaz, 1991). For those who experience chronic depression, these may be regarded as 'peaks and troughs' with perhaps weeks of a return to 'being oneself', before the depression returns. Several of those taking part had been severely depressed and hospitalised on numerous occasions, yet had periods, in some cases several years, where they had lived their lives free from depression.

However, while depression had been a major factor in their lives, only a minority of those taking part were open about their depression with anyone other than close family and/or friends; some did not even tell family members, and many were reluctant to disclose their depression at work. As discussed earlier, the social stigma associated with depression may be a key reason that individuals chose to only partially acknowledge their depression as part of 'self' both subjectively and socially. However, there is also a further 'dilemma of self' facing the individual if they did wish to 'come out' socially about their depression experiences.

During the interviews, all those taking part were asked whether they thought it would be a 'good idea' to 'come out' about depression socially'. The initial reaction tended to favour this option, several noting that it would be positive if they could legitimately seek help, 'take time out', or not feel the pressure they feel to 'perform self' when depressed:

"I think so, 'cos you get a lot more help, people can't help you if they can't see you're poorly".

(Helen)

"...I don't think there's anything wrong with saying you've been depressed"

(Mandy)

However, not all were as supportive of the idea. It was noted that depression is an individual illness, it can mean different things to different people and its impact can be felt in many ways. It is also clear that the reaction from society is not uniform and for example, some employers may be more supportive than others. Friends and family may try and understand; they may not. Ultimately there is the overshadowing awareness that the opinions of others, and subsequently their perceptions and expectations of individuals could change once they were aware that the latter experienced depression:

"I think, you know, certainly within the circle of people who you, you know, interact with frequently...not just so that they treat you with kid gloves or anything and I do find sometimes you know...they'll say, 'oh well, don't take anything else on', and I'll think, 'well look, I'm alright, I can take it', you know?"

(Gemma)

"...People don't need a big parade to, you know, walk down the street saying 'I suffer from depression'. People are scared to talk...because of their [society] reaction, not because they're ashamed of themselves or the way they feel...if they could be assured that society isn't going to turn their back on them..."

(Wendy)

The general perception is that depression continues to be misunderstood and stigmatised within society and this no doubt influences the extent to which individuals embrace the depression aspect of their identity. For many, depression may well become part of 'self' on a subjective level, but it remains hidden as far as possible on a self-identity social level: once again, it became clear that individuals do not wish to be defined by their depression experiences.

It is also important to note that the incorporation of depression as part of 'self' on a social level produces a further dilemma for individuals socially. On the one hand, by 'coming out', they may create the 'space' needed to

allow themselves to just 'be', without having to feel pressured to 'perform' the 'normal self' that is lost during depression; however, there are implications associated with this. As discussed above, the 'coming out' of someone who experiences depression can change the way others perceive and relate to the individual, it can also change expectations and aspirations associated with 'self' socially.

Research has highlighted the problems that are associated with this, for example, the way in which individuals may be perceived first and foremost as being defined by their illness by others and society (Galvin, 2005; Michalko, 2002; Wendell, 1996). By 'performing' 'self' socially individuals are resisting having the depression aspect of their identity sanctioned. However, if depression was sanctioned socially, totalising their experiences of 'self' on a subjective and social level, it may well increase their sense of a 'loss of 'self'', as is evidenced through research into disability and identity (Galvin, 2005). This may then influence individuals' decision to adopt a depression 'illness identity' that subsequently (re) defines their experiences of 'self' and their 'self-identity' in the future in relation to their illness (Charmaz, 1991; Galvin, 2005; Wendell, 1996).

However, as discussed earlier, the experience of depression is more complex than the experience of physical illness. In terms of a (re) definition of 'self' and self-identity for example, it is important to note that unlike the permanent nature of many chronic and severe illnesses,

individuals may well have days when the depression is more manageable than others, when they are almost experiencing a 'return to self'. They may well have days where they are not feeling depressed; they will have 'good days' and 'bad days'. This is increasingly likely with mild and moderate depression experiences. As noted earlier, even those who experience chronic depression may well have periods when they are not feeling depressed.

This is one of the key problems associated with the notion of an 'illness identity'. 'Coming out' socially about the depression aspect of their self-identity may mean that individuals' self-identity and perceptions of 'self' are re-defined in relation to social stigma, in a similar vein to the ascription of the 'disabled identity' to individuals with a physical illness/disability; as such, socially they may be subsequently (re)defined primarily by their depression, and categorised as a 'depression identity'. A re-definition of 'self' and self-identity as primarily a 'depressed identity' within society cannot accommodate or take account of the fact that depression is experienced on many different levels and can vary in severity. Most importantly, it cannot account for the fact that individuals do not feel to be, or wish to be, defined by their depression.

The current lack of sophistication within society to allow identity categories to be changeable, malleable and non-definitive means the social sphere can pose increased challenges to individuals who experience depression on a social level. While the 'coming out' of

individuals should be an empowering experience, many of those taking part in the research were aware of the negative connotations associated with this.

Furthermore, it was noted that the increased awareness of depression as an illness, and as such an identity in society, without a concomitant increase in understanding within society does not necessarily ensure the process of 'coming out' would be a positive one. The depression aspect of identity may well be incorporated into 'self' and be influencing individuals' experiences of 'self' during periods in their lives; however, since the depression experience is generally characterised by periods where the individual is depression free, it does not ultimately define them. As one of the research participants noted:

"What the hell is a 'depressed person' anyway?"

(Mandy)

Conclusion

For Jenkins, (1996) and Butler, (1990) the social arena is crucial to the production, reproduction, legitimisation, sanctioning and policing of identities. However, one of the crucial themes to emerge from this research study is the fact that individuals can resist the social ascription of identity. Furthermore, it is the subjective, ontological aspects of 'self' that are crucial to the legitimisation and validation of self-identity.

Individuals have to experience the 'being' of identity to invest in it. It is not enough to socially sanction, legitimise or validate an identity through a series of bodily acts, expressions, dress and speech - through 'doing'. If the performance of identity fails to elicit previous expectations and aspirations associated with 'self' on a subjective level by the individual then it is evident that the 'doing' of identity socially does not automatically ensure the 'being' of identity. This can impact on an individual's willingness to invest in identity. The 'performance' of the 'normal self' by individuals can be seen as empowering in that it shows agency to resist the ascription of a 'depression identity' socially. The performance can also bring an awareness of the non-essential nature of identity categories for individuals as they become aware of the possibility of fashioning a 'self' of their choosing. While it is possible to recognise that the breakdown of the relationship between the 'being and doing' of identity can bring about a crisis of identity on an individual subjective level, individuals can and actively do negotiate the extent of the impact that depression is to have on their 'social self'.

The lack of physical 'markers' to validate the depression experience may be seen as a reason for the lack of empathy and the tenacity of the stigma that continues to surround mental illness. However, research evidence from the field of disability studies highlights the fact that having such 'markers' is not always a positive experience for an individual. On the contrary, it becomes difficult to 'perform' a 'self' that is not defined first and foremost by the disability or illness that the physical 'markers'

present to society. In this sense, it is both the physical and cultural social world that serves to disable individuals who live with a physical disability or a chronic illness. The dissonance that transpires following the onset of physical disability or chronic illness may be seen as the tensions that result from the subjective experience of 'self' and the social ascription of identity following the 'performance' of 'self' – the doing of 'self' living with a disability/illness. The sanctioning of the 'disabled identity' socially has the performative effect that individual is perceived first and foremost as a 'disabled person'. The tension this creates at the level of 'being and doing' may well result in the individual coming to terms with a 'new identity' to accommodate the social sanctioning of the 'disabled identity'.

In this light it is also possible to recognise the impact that the social sphere has on the reluctance of individuals to be more open about their depression experience, and more resistant to be defined by it. While for some the lack of physical 'markers' ensures the continued lack of empathy and legitimacy afforded to depression as an illness, it is an important factor in their ability to 'perform' a 'self' that is not socially sanctioned as 'depressed', and pivotal in their ability to resist the ascription of a 'depression identity'.

As the research narratives have highlighted, individuals can and do resist being socially and consequently subjectively defined by depression. For many the refusal to allow depression to be the definitive aspect of 'self', while acknowledging it as a *part* of self-identity

brings with it an awareness that facilitates increased control over the depression experience and its impact on their 'self' and their experiences of 'self' and self-identity.

The account of the impact that the social arena has in the formation of self-identity and the subjective experience of 'self', in particular through the 'being and doing' of identity that has been developed throughout this chapter could be further utilised in other academic fields that are concerned with the impact that the social arena has in the formation of social identities, self-identity and experiences of 'self' This could include areas such as disability studies, ethnicity studies and gender studies. The approach could offer an insight into how society can influence the experience of 'being' and 'doing' of disabled identities, ethnic identities and gendered identities and be adapted across other disciplines.

The concept of identity categories and their impact on 'self' and self-identity will be explored further in the following chapter by examining the impact of one of the key identity categories widely theorised to be a crucial factor in self-identity, depression and experiences of 'self', the identity category of gender.

CHAPTER SIX

Gender's Impact on 'Self' During Depression

This chapter will explore the impact of gender on 'self' and self-identity during depression. It will highlight how some of the most dominant discourses surrounding gender and depression are reflected in the narratives of those taking part in the study. Through the narratives of the individuals taking part in the study it will also highlight the impact of gender roles and gendered identities on subjective experiences of 'self' during depression. The chapter will then go on to highlight how individuals may become consciously aware of gender and its impact upon their experiences of 'self' and self-identity (both subjectively and socially) for the first time during the experience of depression. The recognition that gendered social roles and gendered identities are externally imposed onto individuals and not a reflection of 'natural' gender identity offers individuals a further possible site of resistance to the ascription of identity categories. In this case, the opportunity to resist being defined by one aspect of their 'self', their 'gender', both subjectively and socially.

The chapter takes as its starting point the fact that we are compelled to have identity and that we may be compelled to have gender. However, it allows for the fact that individuals' subjective experiences of 'self' and self-identity may not necessarily be defined by gender.

Identity, Gender & 'Self'

As discussed in previous chapters, the depression experience can have a profound impact upon an individual's sense of 'self', both subjectively and socially. However, it was noted that while society may be influential in the legitimisation and sanctioning of identity categories, the influence is not necessarily the deciding factor as to whether individuals invest in identities. The research findings presented here suggest that individuals can and do resist the ascription of certain identity categories, and may actively negotiate the extent to which they allow identity categories to define their self-identity. This is particularly evident with the case of depression and the extent to which individuals take a measure of control over the impact it has on their self-identity. Through accommodating depression as a marginal part of 'self', individuals are asserting their unwillingness to be defined by it.

This element of control is particularly empowering as it allows individuals to resist the stigma and social censure that surrounds depression. This control serves to 'protect' the 'newly aware' 'self' during depression when 'self' is experienced as 'lost' to the individual. Importantly, in terms of 'self', resisting being defined primarily in terms of their depression allows individuals to preserve their expectations and aspirations for their 'newly aware self'. By accepting depression as *part of self*, individuals acknowledge that the depression aspect of their identity has the potential to influence their future experiences of 'self'. The acknowledgment and acceptance of depression as a 'part of self' allows

the 'newly aware self' to recognise the potential of 'self' to experience depression; this makes the possibility of experiencing depression in the future less threatening, with increased control over the experience on the part of the individual. This process is in contrast to current theories surrounding identity and illness where individuals are alleged to adopt an 'illness identity' as they come to terms with a permanent or chronic illness (Galvin, 2005). Further, in terms of depression, the findings suggest, contrary to Karp, (1996), that individuals do not simply incorporate a 'depression identity'. Rather, individuals may actively negotiate where their depression will sit in relation to their 'self' and self-identity.

The relative weakness of these theories in relation to the experience of depression has been noted and reflects the problems inherent within the field of identity and illness. However, as noted earlier, there is also a wealth of research that identifies gender (either as gender roles or gendered identities) as a causal factor in the experiences of mental illness in general and depression in particular (Busfield, 1996; Showalter, 1987; Ussher, 1991; Prior, 1999).

Gender and Identity

The concept of gender has been theorised to such an extent that it is generally regarded as a prerequisite for self-identity and subjective experiences of 'self' (Butler, 1990; Jenkins, 1996; Synott, 1993). Whether gendered identity is given meaning and substance to

individuals through the social construction of gender roles, socialisation into gender specific roles, or, alternatively, whether gender is only granted legitimacy through discursive practices, there is no doubt that gender continues its tenacious stronghold as being regarded, in terms of identity, as that which is 'evident' (Oakely, 1972; Chodorow, 1978; Synott, 1993; Butler, 1990).

Gender and Depression

While an individual's perception of their gender may influence their experiences of 'self', can we simply assume that it is a central salient defining feature of the experience of 'self' and self-identity? Much research into the rates of mental illness has taken the concept of gender as a relatively un-problematic 'given' and theorised it as such (Chesler, 1972; Busfield, 1996; Prior, 1999). However, asserting the female gender identity or 'femininity' as a causal factor in the experience of depression (be it in the influence it has in the diagnosis process *as per* Busfield, (1996), or whether the female gender role is of itself indicative of mental illness *as per* Chesler, (1972) and Broverman, *et al.* 1970), fails to address the large numbers of men who experience depression.

As discussed earlier (Chapter 2), the numbers of men who experience depression are far greater than those who experience what are typically regarded as 'male mental illnesses', such as personality disorders and substance misuse (Prior, 1999; Busfield, 1996; Pilgrim & Rogers 1993). If these figures are given careful consideration then it is possible to

recognise the manner in which the category of mental illness in general, and depression in particular, has been subjected to its own 'gendering'. This process has initiated a cycle of gender specific research into mental illness rates that has served to perpetuate the notion of men and women as separate and opposite, with distinct experiences, which are, allegedly, influenced to a large degree by their gender, be it, gender roles or gender identity.

This standard approach, beginning with the premise that gender is a definable concept that 'means something' to men and women has a number of weaknesses. Initially, even if we were to take gender as relatively un-problematic, how can we assume that it means the same thing to, or has the same impact on all individuals? As discussed earlier (Chapter 2) the key criticisms of feminism's use of the collective term 'woman' came largely from women (Baca Ziinn, *et al.* 1986; Bordo, 1990; Bailey, 1993; Nicholson, 1994). The emerging field of Men's Studies show similar problems emerging around the concept of 'man' and its use to convey the experiences of 'men' (Petersen, 1998; Hearn, 1996; Connell, 1995). Furthermore, the continued reliance on gender as an analytic concept is subject to increased problematisation in the light of current theories that question the theoretical and epistemological basis of the term (Butler, 1990). As discussed earlier, the concept of 'gender identity' implies that individuals have some 'essential' defining sense of 'self' that is experienced as gendered. However, how useful is it to begin theorising on the basis that gender identity is a central and

defining feature of 'self' in the experience of depression when 'gender' as an identity category has been shown to be historically and culturally specific, highly political and socially constructed through dominant discourses (Foucault, 1976; Butler, 1990; Showalter, 1987; Ussher, 1991)?

As the narratives have highlighted throughout the study, individuals do not necessarily evoke the concept of gender as a defining feature of 'self' when they are discussing ideas and perceptions of their subjective experiences of their 'self' before, during or after the experience of depression. The 'self' is experienced on many differing levels, and as highlighted earlier, the 'doing' of identity does not necessarily imply that this elicits the associated gendered 'being' of identity. Rather, it suggests that the 'doing' of identity, as *per* Butler, (1990) is itself 'gendered'.

Gender, 'Self' and Depression

Prior to the experience of depression the subjective experience of the 'doing' of gender may be undertaken relatively unproblematically as the 'self' is experienced as cohesive and coherent. At this point the reciprocal relationship between the 'being and doing' of identity allows individuals to go about their daily lives without thinking about 'doing' or 'being' a gendered 'self'. The cohesiveness of 'self' that is a result of the reciprocal relationship between 'being and doing' identity, ensures that performances are performative: the 'doing' of gender (socially and subjectively) is taken as evidence of the 'naturalness' of gender, gender

roles and gendered identities. However, while we may be socially compelled to dress, act and speak, to 'perform' as 'men' and 'women', the process does not necessarily imply that there is an 'essential' inner 'self' that elicits the subjective experience of 'being' a 'man' or 'woman'. Rather, following Butler (1990) it is possible to recognise that the 'doing' of gender is not evidence of an essential gendered interiority: "there is no 'being' behind 'doing', effecting, becoming; 'the doer' is merely a fiction added to the deed –the deed is everything" (*ibid*:25).

The performance of 'self' during depression is undertaken to create an illusion of 'self'; this may be sanctioned and legitimised socially. However, the 'doing' of gender socially does not necessarily bring about the 'being' of gender on a subjective level. As with the 'doing' of identity, the 'doing' of gender, does not necessarily mean that an individual's subjective experience of 'self' will be of a 'self' that is somehow essentially gendered. On the contrary, the breakdown of the relationship between 'being and doing', 'self' and self-identity during depression and the lack of cohesion and coherence to the experience of 'self' and self-identity during this period may mean that individuals *become aware* of 'doing' gender in their experiences of 'self' and self-identity for the first time. This will be discussed in more detail below.

Self Identity, Gender & Depression

As discussed in-depth earlier in the thesis (Chapter 2), gender as an identity category can be seen to be socially constructed and policed, and

has been used with remarkable tenacity to ensure the polarisation of the sexes as distinct, opposite and natural. Butler (1990) aimed to disperse the 'gender myth' by exposing the institutionalisation of heterosexuality and the policing of gender roles in society through the enactment of social 'scripts' that prescribe the continuation of gender. Certainly, as discussed earlier, gender has been consistently theorised as a causal factor in the experience of depression (Showalter, 1987; Ussher, 1991; Busfield, 1996; Prior, 1999), and utilised, in particular, as a concept to explain the over representation of women in the diagnostic rates of depression. Theories have generally accounted for differences in the rates of depression between women and men through the social construction of, and socialisation into, gender specific roles. Given the central importance afforded to 'gender' in theories of depression, all those taking part in the study were asked for their opinions as to why they believe women are more likely to be diagnosed as suffering with depression than men.

Many of the individuals taking part in the research could not offer a reason as to why women may be more likely to suffer from depression than men. Typically, responses from those who did express an opinion could be seen as reflecting the dominant discourses that surround perceptions and theories of mental illness within society. There was a mixed response to the question, but generally narratives identified either the impact of and differences in either sex roles/gender roles, or

alternatively, made reference to the impact of gendered identities. These will be discussed below.

Sex Roles and Depression

Several individuals made reference to the perceived biological differences between men and women, which in their opinion led to the higher propensity for women to experience depression:

“ I still think it has a lot to do with hormone imbalance, which of course I know men have hormones, testosterone and that but...with women that might be why women tend to get depressed more, but that's the only thing I can think ofbut that's being a woman isn't it?”

(Paula)

“I think women.... they're built differently, they, you know, the body's structured differently, they, [women] their bodies have to cope with a lot more”.

(Wendy)

The narratives of these individuals may be referring to what are regarded as 'essential' biological differences between the sexes, and the impact these have on the increased likelihood of women to experience depression. The discourse utilised reflects the 'biology as destiny' gendering of the sexed body. They are looking to make sense of women's' apparent increased likelihood to experience depression

through what they regard as the most obvious difference between the sexes – the biologically different bodies of men and women. It is these biological differences that are perceived as the basis of gender differences in the rates of depression. This can be seen as reflecting Butler's assertion that gender is widely perceived as being firmly entrenched within the sexed body, and that this notion is legitimised socially through dominant biomedical discourses (Butler, 1990). However, as Butler stresses, it is important to note that the body was gendered before it was sexed (Laqueur, 1990; Butler, 1990, as discussed in Chapter 2) and the subversive effect this recognition has upon subsequent ideas around gender 'essentialism'. The above narratives reflect the continued general perception that exists within society: gender differences have their basis in the biological, corporeal, materiality of the sexed body.

Medical discourse has pathologised the female body throughout history, and these discourses have justified and 'naturalised' the perceived 'essential' biological weakness of the female body in general, and the perceived instability of the feminine 'mind' in particular (Showalter, 1987; Ussher, 1991). The narratives presented above suggest that women may see their bodies as 'naturally' more susceptible to depression because of perceived 'natural' biological differences in relation to the male body. Moreover, the narratives also highlight the fact that the experience of depression is perceived to be an embodied experience by individuals, an important aspect which Butler's theory fails to adequately

address. Individuals' experiences of 'self' and self-identity take place within a lived body (Butler, 1990). Furthermore, the body is the key means through which gender is 'performed' and 'read' as evidence of the 'naturalness' of both sex and gender (both subjectively and socially); this is the process that renders performances as performative and subsequently 'naturalises' the gendering of an individual's experiences.

The legitimisation of perceived 'natural' biological and psychological sex differences between women and men serves to justify the notion of 'natural' gendered identities and 'natural' gender roles within society (Oakley, 1972). Given the strength of this discourse it is perhaps unsurprising that several of the individuals taking part in the study also identified the impact of gender roles on individual experiences as a causal factor in the increased likelihood of women to experience depression.

Gender Roles, 'Self' & Depression

All those taking part were asked why they thought that women experienced depression more than men:

"...You've got to work, come home and the women have still got the washing to do and still got the shopping to do, fellas' have just got no thought, they just don't think about what's happening with a woman...I think they're [women] just taking too much on, some women just can't cope with it"

(Stephanie)

.... "If men go out to work and they come home and that's their responsibilities over. But the women have to do the other things, the running of the house...going to work....men think house work's a doddle and 'why can't you do all that while you're cooking tea and doing the ironing'..."

(Tracy)

I think, they just take, women just take on, more things, not necessarily physical things like two jobs or something. But emotionally just take on a lot. I mean I do in my...boyfriend who I live with, I see so much more going on than he does. And that's maybe why he's fine, and you know, he's only got two or three things that he's thinking about, whereas I've got about twenty, and trying to think about all those. Men are much more, can focus much more on one or two things, whereas, women I think, just try to take on everything.

(Anna)

"There's more to, more responsibilities. We take everything on. They go to work for eight hours and that's it. Well, that's a bit, but... we've got the responsibility of the house and, I have the responsibility of everything. They don't worry as much as us because they don't have the worry. I say to [partner] 'I'm going to give you everything to do' and he says now that he wouldn't be able to do it. He comes home from work after eight

hours and that's it. Sleeps, goes back to work. He sits and relaxes in the chair"

(Jane)

"Well I think it's understandable why women get more depressed than men because for years and years, there's been so many restrictions on what they can do...expectations on what they will do, there's still this, 'You will leave your job at such and such a time, to stay at home, in a very poorly valued position, of looking after children', and the label of what you do, , 'Oh I'm just a housewife', well it's, you know you can't get a more difficult job...and if you're at home, for that length of time, it's, really, it's understandable and it grinds you down. I think somebody who's not normally open to depression...develop low [self] esteem over a period of time, especially if they're isolated, so it's really doesn't come as a shock to me nowadays ... that they do suffer. I don't think it's down to a gender thing as opposed to down to a circumstance thing...I'd be very interested to find out how many men actually stay at home, looking after children and, and feel the same way"

(Mark)

The above narratives may be seen as reflecting individual perceptions and experiences of the gendered social roles of women and men in society. These gendered roles are believed to place the burden of additional workload for women through the addition of 'domestic roles' associated with the home, in addition to paid employment outside the

home. This, it is suggested, places an increased burden upon women and subsequently they are more likely to experience depression (Busfield, 1996). However, it should be noted that the characteristics associated with women and depression, specifically the stereotypical assumptions of women as the 'weaker sex' are not reflected in the narratives.

Rather, the suggestion is not necessarily that domestic roles are themselves conducive to mental illness. On the contrary there is a conscious awareness that it is the way in which society has gendered the roles to such an extent that they are seen first and foremost as low status and 'women's work'. It is the additional work load that is problematic and there is not a concomitant assumption that the roles are gendered on an individual subjective basis. That is, the women in question are not stating that this 'domestic role' is their 'natural role', and that paid employment should be seen as an addition to this.

The experience of depression and its impact upon the experience of 'self' and self-identity (in particular the conscious awareness of 'doing' 'self' within the roles that constitute self-identity), may see individuals *becoming consciously aware* of gender as a social construct that serves to legitimise the unequal distribution of work on the basis of their gender; which in turn impacts upon their experiences of 'self' and self-identity. The narratives of these individuals highlight the fact that gendered roles are not necessarily undertaken by individuals because of some essential

'feminine identity' that translates into the desire to undertake domestic chores: there is no 'being' behind the 'doing' of domesticity. The 'doing' of the 'female role' within the home does not ensure the associated 'being' on the part of the individual. There is no suggestion that occupying these roles elicits the 'being' which is subsequently experienced as 'essential femininity'. Rather, the conscious recognition on the part of individuals that certain roles are gendered on the basis of their sex, highlights the fact that these roles do not automatically reflect a subjective sense of 'being'. Nor is it that undertaking 'self' in the 'doing' of gendered roles transforms their experiences into a 'natural' extension of an individual's 'self'. Rather, the experience of depression and the breakdown of the relationship between 'being and doing' at this time may make individuals aware of the impact that the social construction of gender roles has on the subjective experiences of 'self' and self-identity:

(Talking about what aspects of self-identity may have influenced the experience of depression)

"I think, to me, it was the fact that I took on my mum's role [within the family after mother died]...I became the 'mother' of the family...seen as this strong matriarchal figure and the one who was holding it all together for everyone else. I felt that was my downfall really, trying to be strong and portraying this image, of something I thought I was, but in reality I wasn't...I do think it was a woman thing. I felt I should fall into my mum's shoes if you like and keep everything running smooth for everybody else...I don't think a man would have felt like that...I don't think my

brother did...to get up and do the cleaning and things, he had me, you know, the female of the family to do those things..."

(Mandy)

The gendering of social roles may have an impact upon individual perceptions of self-identity. For example, in this case, domesticity may be bound up with the role of 'wife', or 'mother'. These roles and their opposites 'husband' and 'father' are inherently tied up with the gendering of identity. The terms, each with a cohort of characteristics, dictate how to 'do' the gendered identity both on a personal and social level. It is possible, following Butler (1990) to recognise that the polarisation of these terms posit gendered identity as 'natural'; opposite yet complementary, composite and definitive of 'self', and are crucial to the continuance of the political significance of gender and the justification of gender 'difference' within society.

However, as the above narrative highlights, the experience of 'being' does not automatically follow the 'doing' of gender roles. The conscious awareness that the 'being' of 'self' can be experienced as detached from the 'doing' of gender roles described above raises an awareness of the impact of socially constructed gendered roles on individual experiences of 'self'. The conscious recognition of this may become a focal point of resistance for individuals in terms of assumptions of the 'naturalness' of gender. Contrary to Butler's (1990) assertion that individuals unwittingly reproduce gender through the enactment of social

scripts which are performative, here we witness an individual consciously aware of the 'doing' of gender roles and the fact that the experience is not in line with the subjective experiences of 'self'. There may be an attempt to reproduce the female 'mother' role, but this is experienced as just that, a performance. Importantly, the performance is recognised as such, with no subjective 'being' to reinforce and sanction this on an individual level as 'natural'

As noted earlier, individuals can and do negotiate and resist the ascription of identity categories as definitive aspects of 'self'. The lack of 'being' associated with the 'doing' of gender roles described in the narratives above offers a potential site of resistance to individuals to challenge the 'naturalness' of gender roles in society.

Gendered Identities & Depression

As discussed earlier in the chapter, leading theories of gender and mental illness suggest that the persistence of socially constructed gender roles, along with the gender specific socialisation process, influences the experience of depression for individuals, in particular for those individuals ascribed with the female gender identity within female gender roles (Busfield, 1996; Brown & Harris, 1978; Broverman *et al.* 1970). However, as discussed earlier, the experience of depression is characterised by the breakdown of the relationship between the 'doing' and 'being' of 'self' and self-identity on a subjective level. The 'loss of self' articulated by individuals during depression is recognised when the

'doing' of identity fails to elicit previous expectations and subjective experiences of 'being' associated with 'self' and self-identity. The narratives of individuals do not support the theory that gender is a salient feature of their experiences during this period. Rather, depression is characterised by a perceived 'loss' of their 'self', which is experienced as an inability to experience the performance of self-identity as coherent and cohesive; a 'natural' extension of 'self'.

These perceptions are based upon individual notions of a subjectively experienced 'self' that they recognise as defining who they are. It is possible to recognise that the undertaking of the female gender role in society, constructed upon the mythical foundations of the 'naturalness' of 'essential femininity', does not necessarily reflect individuals' experiences, aspirations and expectations for 'self'. As the research evidence has highlighted, the lack of 'being' associated with the 'doing' of gender roles on an individual subjective level during depression (for both women and men), and the subsequent disquiet this can create, may well place stress upon the already tenuous relationship between the 'doing and being' of a gendered 'self' and 'self identity'. This is evidenced by the narratives of individuals and will be discussed in more depth later in the chapter. Importantly, those individuals who could identify the impact of gendered social roles on their experience of depression, did not express any indication that undertaking these roles elicited the concomitant experience of a gendered 'self'. However, there was a recognition and awareness of gender and its impact at this time.

While no-one appealed to the notion of some 'essential femininity' as a causal factor in the experience of depression, one individual did highlight the impact of socialisation and subsequent identity issues as influencing the impact of depression.

Gendered Identities?

(Why do you think women suffer from depression more than men?)

... "I wouldn't put it down to, me personally, I wouldn't put it down to my gender, I'd put it down to my upbringing...My opinion is if women get more depressed it's probably because....there's not many women I know who are very selfish in the sense of 'I let other people run around to do everything for me'....They don't like other people to do things for them, they do it themselves...I think women take more on board from...they're more astute and can pick up a lot more....I think women are inbuilt, genetically inbuilt to take on, more on board, you know it's all this, men physical strength thing, yeah, fine, fair enough, but when it comes to emotional thoughts and feelings and things like that I think women are just magnets".

(Sue)

While the individual in question clearly states that in their opinion gender is not instrumental in the experience of depression, they do go on to highlight the impact of socialisation and also make a passing reference to perceived biological differences between men and women (reflecting

the discourses around the biological determinism/essentialism of gender). The biological differences referred to within the narrative are utilised to suggest that women are in fact predisposed to be more caring than men. The above narrative may appear to reflect the stereotypical gendering of identity, wherein the female is socialised to be more likely to be equated to 'emotions' and relational aspects of relationships, while men are perceived to be objective and less relational (Chodorow, 1978; Busfield, 1996). There is also a suggestion within the narrative that these differences may be biological in basis. In this instance however, it is asserted that the emotional strength of women (their ability and alleged apparent willingness to take on higher levels of stress) subsequently increases their likelihood to experience depression. In this instance, there is a recognition that the 'self', may be more likely to be 'un-selfish', and so by definition, more caring. The key factor to note is that these characteristics are not primarily associated, on a conscious level with the individual's gender, but are identified with their self-identity. This may evidence the earlier suggestion that while we are compelled to have identity, we do not necessarily see or experience ourselves as 'gendered': the ascription of gender identity does not ultimately ensure that characteristics of 'self' that are socially gendered as essential qualities of 'femininity' or 'masculinity' are experienced as 'gender', nor as a definitive aspect of the subjective experience of 'self'. Rather, through depression individuals become aware of gender's impact upon their experiences.

Given the key role afforded to gender in the theories of mental illness (Showalter, 1987; Ussher, 1991; Busfield, 1996; Prior, 1999) it is perhaps not surprising that gender roles, gender identities or gendered bodies, are reflected in the discourses individuals utilise in their explanations for gender differences in the diagnostic rates of depression. Mental illness in general and depression in particular have been articulated within discourses that have a long and sustained history of justifying gender difference and inequalities between the sexes in society on many levels. These in turn have evoked notions of the essentialist nature of gender, be it through biological, essential or social determinism (Oakley, 1972; Chesler, 1972; Broverman *et al.* 1970; Chodorow, 1978; Ussher, 1991; Busfield, 1996; Prior, 1999). These discourses do find their way down into everyday discourses that construct our perceptions of normality. This is evidenced by the individual narratives presented above.

Even the work of Butler (1990) who aimed to highlight the non-essential nature of gender identity can be recognised as replacing the 'essential determinism' of gender identity with the non-essential determinism of gender. While Butler highlights the non-essential nature of gender identity very effectively, it has to be acknowledged that the theory allows little resistance to the pressures to 'perform' 'self' in a society where gender is sanctioned and policed through social censure on a daily basis. The theory has the strength to challenge the essential nature of gender identity, yet can be seen as effectively replacing essentialism

determinism with non-essentialism determinism. However, the determinism it implies is by no means less potent on a social or individual level to the continuance of gender categories that are in and of themselves normative, prescriptive and inherently political. As such the theory tends to deny individual agency to resist the ascription of gender identity (McNay, 2004).

The continued reliance upon the concepts of both gender roles and gender identity in the experience of depression detracts attention away from the individual experience of depression, and the impact this has on individual lives and experiences of 'self' and self-identity. It also serves to continue to 'gender' the depression experience.

The 'Gendering' of the Depression Experience

As discussed earlier in the chapter, reasons behind the gender differences in the rates of depression was not something that all the individuals taking part in the study felt they could offer an opinion on, suggesting that gender is not a salient feature of their subjective experiences, or that people do not think about depression more widely. In contrast to several of the female participants, who could offer suggestions as to why rates of depression might be gendered, none of the male participants regarded gender roles or gender identity as something that might influence the likelihood of depression. On the contrary, several of the men taking part commented that this was the

first time they had thought about depression as being a 'gendered illness':

"I'm really not used to thinking of it in terms of gender. I think of it as a fairly general thing...for me it goes more with....personality type. Somebody whos not that confident, reflective...someone who's head's up to something most of the time".

(Terry)

"...If you hadn't have said that [women are more likely to become depressed than men] I wouldn't have known that women had it more than men....apart from my auntie, that's the only woman I know that's ever had it, men, I know a few of them that's had it".

(Steve)

This is perhaps not too surprising and it may seem obvious that men would not relate to the idea of depression as a typically female malady, particularly as they, as 'men' have suffered with depression. It is also important to note that the dominant discourses available surrounding depression are predominantly concerned with the female gender identity as a causal factor. This leaves men with little opportunity to make sense of their depression in the gendered terms available. They therefore appear more likely to see depression as an identity issue, an issue of 'self' and not related to their gender as such. There was also recognition among those taking part that diagnosed rates of depression among men

were not necessarily a true reflection of the numbers that actually experienced depression:

“...I don’t think men talk about it as much because it’s...seen as a weakness, you know, ‘can’t say you’re depressed’...I can’t imagine men talking to their mates about being depressed....they don’t talk about meaningful things, you know, like women do...I think...deep within them they would see it as a weakness, you know, and men don’t like to show their weakness to other men....”

(Mandy)

“...I suppose being a man, it’s regarded more as a weakness and when you do suffer with it you’re, you regard yourself even worse because you know you’re not supposed to show weakness like this.”

(Mark)

“The only think I could think...is that men generally speaking, talking generally, tend to avoid doctors, anything to do with doctors...I think it’s that sort of attitude It’ll be alright, it’ll go away, whereas...women are more likely if there’s a problem to go and see the doctor”

(Robert)

Once again it is possible to recognise the impact that social stereotypes of gender and mental illness have, and how they influence the perception of depression in society. The male gender role stereotypes

reflected in the above narratives reflect the apparent perceived 'weaknesses' of men who succumb to depression. This is in contrast to the 'strong' unemotional and rational male 'ideal' that is privileged as characteristic of 'masculinity' and 'real men'(Broverman *et al.* 1970; Chesler, 1976; Busfield, 1996). This perception has a negative impact upon the depression experiences of men, who may then be increasingly reluctant to seek help and advice when they do experience depression.

Men & Masculinities

The social stereotypes that accompany gender roles and gender identities continue to be policed and sanctioned within society, serving to perpetuate the gendering of the depression experience. Research into the field of Masculinities and Men's Studies have highlighted the fact that the male gender role and the concept of 'masculinity' can mean many things to many different men and vary significantly depending upon the historical and cultural context within which these concepts are constructed (Petersen, 1998; Connell, 1993). Dominant discourses may be utilised to construct 'masculine ideals' within society, but these constructs are unlikely to reflect the day-to-day experiences of 'self' for all men. Dominant ideals of masculinity fail to account for the differing interpretations of 'doing' masculinity and where other aspects of self-identity sit in relation to it, for example, the experiences of working-class men (Messner, 1993; Connell, 1993; Hearn, 1996; Segal, 1993). Research has also highlighted that the social construction of masculinity can be restrictive on the experiences of men and further, that not all men

have the level of autonomy and independence that masculinity is believed to nurture (Edley & Wetherall, 1996:107-108). Nor do all men feel empowered within the social sphere just because the construction of male dominated discourse has positioned 'masculinity' as the dominant social position and as the 'natural' order of things. In effect, these accounts fail to address the issue of how constructions of masculinity mesh with other social dimensions (*ibid*).

It is also possible to recognise the political implications of the social censure that surrounds men and depression; particularly the impact it has on deterring men from seeking help and accepting a diagnosis of depression. The continued reliance on the female gender identity as synonymous with the depression experience serves to continually position women as mentally, and physically the 'weaker sex'. Men who experience depression may well find it difficult to relate their experiences of 'self' and self-identity to a concept –'depression'- that has been consistently gendered as female. This process then reinforces the stereotypical 'ideal' of the rational, objective 'real man' who should not experience depression. As such, in this context, the male gender role can be seen as being restrictive to men, effectively denying them the perceived legitimacy to experience depression and be 'real men'. This compounds their existing problems during depression, for example, of perhaps not being able to work, being emotional and so on.

The Impact of Gender roles on the Depression Experience

Gender roles as constructed and policed within society may well fuel ideas of 'essential' gender identities. However, to what extent is gender reflected in the experiences of individuals who do experience depression and what exactly is the impact of gender during depression? The following section will examine the subtle ways that gender impacts on the experiences, expectations and aspirations of 'self' and self-identity during the experience of depression. There will be a particular focus on the narratives and discourses that individuals utilise to make sense of their experiences of depression.

The 'doing and being' of gender roles

As discussed repeatedly throughout the thesis, as individuals we are compelled to have identity; and we are compelled to have 'gender': it is assigned at birth with relatively little choice in the matter. However, that is not to say that individuals inevitably experience their sense of 'self' as 'essentially' gendered. Nor does it necessarily imply that they are ultimately defined by gender in terms of their subjective experiences of 'self' and self-identity. The social sanctioning and censoring of gender roles and gendered identities may police the 'doing' of identity on a social level. However, this does not automatically translate into a subjective awareness on the part of individuals that their 'self' requires, as a prerequisite, a 'gendered self': On the contrary, gender identity is one of the many identity categories that orbit individual ideas of 'self'. Its impact upon notions of 'self' and self-identity have been theorized as a

key definitive aspect of 'self', yet individuals do not necessarily experience the 'being' of their self-identity as essentially gendered. Rather, during depression individuals may become aware of the extent to which gender roles *are not* a 'natural' role that reflects some 'essential femininity or masculinity' on their part. Furthermore, individuals may become aware of the extent to which impact of gender is prescriptive and restrictive upon their opportunities and experiences of 'self' and self-identity.

The impact of gender upon self-identity will inevitably be experienced differently for each individual. Expectations and aspirations of 'self' may well be influenced by the social gendering and subsequent sanctioning and censure of social roles and identity categories (Butler, 1990). However, while individuals may be socially compelled to experience self-identity as gendered, as the preceding narratives have highlighted, this is not necessarily to the level of determinism that defines or constitutes their subjective experience of 'self'. However, individuals may well be socially compelled to 'perform' a gendered 'self' within gendered social roles (*ibid*) and this may well impact upon their experiences of 'self' during depression.

As discussed earlier in the thesis, the depression experience is characterised by the breakdown of the relationship between the 'doing and being' of identity. This results in a subsequent loss of cohesion in the experience of 'self', that is often articulated by individuals as a 'loss

of self'. The impact of the breakdown of the relationship between 'doing and being' identity is inevitably felt more by individuals in the key roles that constitute their 'self' and self-identity. The manner in which these key roles are gendered in terms of individual experiences and aspirations, along with social expectations, and the subsequent impact this has on the experience of 'loss of self' during depression, will be explored in more detail below.

Doing & Being during Depression: the gendering of experiences?

As has been discussed throughout the thesis, the experience of a breakdown of the relationship between the 'doing' and 'being' of self - identity during depression is evidenced through the narratives of the individuals who took part in the study. These narratives do not support the theory that individuals' subjective experience of 'self' is primarily gendered *as per* Jenkins (1996). However, the experiences of 'loss of self' articulated by individuals, particularly in relation to the 'doing' of 'self' and self-identity (both socially and subjectively), can be recognised as reflecting the impact of gender on their subjective experiences. While the impact of gender may appear subtle, in terms of the discourses utilised by individuals, it does not necessarily dilute the tensions it creates for individuals. During depression individuals attempt to align their experiences of 'self' ('being') with the social and subjective expectations and aspirations associated with gendered roles ('doing').

This became increasingly evident when individuals were asked to describe what depression meant to them, in their own words:

"...Depression is terrible. It affects your entire life.....you can't cope with your children; you can't cope with your job...because everything is a problem. You feel like you're not yourself... And [stresses] they [children] become a problem, you don't have like love anymore. They become a problem. And like you'll want to do something for them but you can't do it, because this keeps you down. You know like you have school meeting, you want to go...but you're scared...it will have other people there and you think you are an outcast."

(Tara)

"I'd just had this baby who was wonderful....and people were saying to you 'Oh, this wonderful baby' and I'm sat there, again feeling emotionless, thinking, you're going through the motions saying, 'yeah, he's lovely', but not feeling it, do you know what I mean?..."

(Mandy)

"I was angry with myself the whole time because I wasn't in control and I didn't know what to do about it.....I was letting the kids down and I was letting my parents down.....I start feeling guilty because I'm not managing very well, I'm going to have to ask somebody for help, I'd try not to, which is what I did, I did without and end up going in hospital"....

(Liz)

"I was just twenty, twenty two at the time, I've never experienced it [depression] so I didn't know what was happening to me, and it, I just

had no interest in anything.....I found sleeping extremely difficult, I wasn't interested in the baby, I wanted to run away..."

(Paula)

" My kids are my life, they are what kept me going when I was at my darkest...and I couldn't see a light, I had to go on for them, I had to be normal ...I maybe wasn't as happy as a mum as I should have been, but I felt like I didn't live, I just survived"

(Jane)

"It was his [second child] christening day, everyone was coming round and I just thought I had the baby blues, I did.... But it was just; I wasn't even looking forward to the day. I'd have just rather everybody had gone, taken him, got him christened and just left me on my own. I couldn't stop crying, I used to wake up in the middle of the night to give him his nightly feed and I could not get back to sleep and I used to sit and watch the light around the curtain, just getting lighter... I just used to cry and couldn't be bothered to get washed, bathed, oh, I couldn't watch telly, all I could do all day was just to feed the kids, that's all I had the energy to do...I mean, I love my kids and I played with them and kissed them, all the normal things that a mum does, but just nothing ever, nothing made me happy, I was just crying all the time..."

(Helen)

While the individual narratives do not express any specific subjectivity as 'women', how they relate to their children or family during depression was generally perceived as problematic. The fact that their 'nurturing'

roles became a 'problem' and the apparent loss of, or absence of 'love' for their child(ren), highlights the fact that the 'doing' of parenting is not eliciting the expected subjective 'being' associated with this role. The problem is not only tied up with experiences of the perceived loss of, or absence of 'love', the 'being' of motherhood, but also the 'performances'. This suggests that in these cases the female self-identity is in part concerned not simply with parenting abilities, but the gendered nature of parenting, specifically nurturing and motherhood.

The conscious awareness that family and children become a 'problem' during depression, coupled with the lack of ability to 'do' things with them, and the conscious undertaking of the 'performances' that constitute the role, highlights the fact that the 'doing' of motherhood is no longer eliciting the previous experiences, or expected experiences of 'being' a parent /mother during depression, *i.e.* it is not 'natural'. As such, it is possible to recognise that during depression experiences, gender may not necessarily be experienced on an individual subjective level as definitive of 'self' and self-identity. On the contrary, for the individuals above, there is an awareness of the impact that gender has on expectations and experiences of 'self' and self-identity.

The social gendering of individual identity categories and social roles and the subsequent ascription of a gendered identity to individuals on the basis of these roles, does have an impact on the experience of 'self' during depression. As the narratives evidence, this impact can be seen

as being primarily experienced through the breakdown of the relationship between the experience of 'doing and being' of identity. It is the ascription of gender identity and the gendering of roles within society that sets out the social scripts that dictate not only the expectations of and how to 'do' gendered roles, it also defines the experience of these roles: how to 'be' a gendered identity (Butler, 1990).

Individual perceptions of what it is to '*be*' in gendered roles are nurtured through social scripts that are policed and sanctioned within society (Butler, 1990). These social scripts ultimately construct and legitimize what is 'natural' and 'normal' for individuals to expect to experience within certain identity categories and roles (*ibid*). For example, the gendering of 'parenting' can be seen to generate the distinct and separate roles of 'mother' and 'father'. These roles are sanctioned socially as distinct; each one 'gendered', with certain characteristics that become associated with them. They are subsequently rendered distinct and complementary, as natural extensions of a gendered self-identity.

Consequentially they become translated into the proposed 'being' and 'doing' of the specific gendered identity. The social construction and legitimisation of perceived expectations and aspirations associated with the experience of these roles can be recognised as the driver which inspires individuals to invest in identity. The gendering of identity (e.g. 'parent' becomes mother or father) is resultant upon individuals' taking up these gendered identities and 'performing' key roles within them.

The Social Construction of the 'Naturalness' of Gender?

The narratives quoted earlier highlight the impact that gender has on the experiences of individuals. During depression individuals' experiences of 'self' within the key identity/social roles they occupy are often at odds with what they *expect* they should be, or what they aspire to be within the roles. It is the breakdown of the relationship between 'being and doing' that again becomes evident. The lack of cohesion of 'self' which characterises the breakdown of the relationship between 'being and doing' 'self' means that individuals become aware that there is a conscious need to perform a gendered identity. Something that is socially constructed as 'natural' - 'motherhood', becomes a chore, a conscious effort to undertake. The lack of coherence to individual experiences at this time can be seen to reflect the impact that the gendering of roles has for the experiences of individuals. It has become ingrained within society that motherhood is perceived as a natural extension of the female gender role, fatherhood the natural extension of the male role. Subsequently it is the 'doing' of the performance of 'motherhood', or 'fatherhood' that breathes life into the myth of the 'essentialism' of gender; both subjectively and on a social level (Butler, 1990). The more 'natural' that gender and gender roles appear to be ingrained, the more difficult it is for those who have not experienced depression to understand and empathise with individuals' inability to 'perform' these roles:

"...Some people was just like, 'Oh, she cries most of the day', it was just like I felt ill, you know... they just said, 'Oh, she's gone a bit loopy, she had a baby, a few tears....my mum was like... 'Oh, give yourself a kick up the arse and shut up moaning and get on with it', but you know, you just don't need somebody telling you that do you? ...

(Helen)

The above narrative highlights the extent to which the 'naturalness' of gender roles within society serves to perpetuate the difficulties faced when experiencing depression. The conscious undertaking of the 'doing' of gendered identity without the accompanying and associated 'being' can be a stark and threatening experience. This is especially the case when society creates and sustains the notion that these gendered roles are 'natural' evidence of gender identity: the 'doer behind the deed'. Up to this point, as already discussed, an individual may not have thought of their 'self' or self-identity in terms of gender, or experienced gender as a central, definitive aspect of 'self' and self-identity. Importantly however, at this point they may become consciously aware of gender and its impact upon their experiences and expectations for 'self' and self-identity for the first time.

".. I didn't think that having children and being married was going to be like this and I expected to be doing a lot more with my life than I'm doing with it now".

(Helen)

Individual experiences may not be articulated in terms of a gendered 'self', as discussed above. However, while the concept of gender may not be definitive of subjective experiences of 'self' and self-identity, the ascription of gendered identities on the basis of the construction of gendered roles, can and does impact experiences of 'self' and self-identity.

The Impact of Gendered roles and Gendered identity

The impact of gendered roles on gendered identities during the experience of depression was reflected in the narratives of individuals who tried to make sense of where their depression came from:

"I got married and it was all different...that's what I think it was that caused it [depression] going from the single life and having everything.....and then getting married and your own house and your kids....I didn't have a bad marriage or my kids weren't bad or anything like that....I think it was just, you know, having bills to pay and always worried about where the next meal was coming from and getting a job.....things like that."

(Steve)

The gendering of social roles and identity categories is evident in the above narrative. The individual does not express any subjectivity as 'a man', but the experience of depression is perceived to be related to the

change in the social roles that are socially sanctioned and gendered; specifically the transition from the social role of 'single male', with little responsibility, through to the role of husband and father. In this case, it is specifically the gendered role of heterosexual 'male provider' for the family (Connell, 1993; Pleck, 1987). This reflects the expectations of 'being and doing' associated with the male husband/parent 'fatherhood' role. It also highlights the fact that gendered roles may have differing impacts on 'self' and self-identity: it is not only the female gender role that can impact on the experience of depression. The impact of masculinity ascribed to men was also apparent:

"...The way I do it [during depression] ...getting out of bed, or actually getting through life is to know that I have to do it, so that the mortgage gets paid, so that the family doesn't suffer....because of this invisible man who's just shuffling around the house...Know what you're there for and just do what you're there for..."

(Kevin)

"My main motivator....when I was actually suffering with it [depression], is kind of, put who you are on one side and just regard yourself as being responsible for supplying....and that is my role. I have relevance, I actually provide the money so that my family can do it and it's very negative, well it is...does, it destroys your self...your personality and you just bury it so you can get through, completely..."

(Mark)

The above narratives highlight once again how individuals may not subjectively experience gender as a definitive aspect of their 'self, or as a salient feature of their self-identity. During depression, through the breakdown of the relationship between the 'being and doing' of 'self' it becomes evident that individuals *become aware* of gender and reflect upon the conscious effort required to undertake the 'doing' of gendered roles. The impact of gender on individuals' experiences of 'self' is felt most prominently in the key social roles that they occupy and their experiences reflect the conscious effort of 'doing' these roles when experiencing depression. The conscious awareness of 'doing' gender (in the cases above the 'doing' of the male gender stereotype of men as the family 'breadwinner') makes individuals aware of the manner in which identity categories are gendered; whether that is through an awareness of the actual lived and experienced 'unnaturalness' of 'motherhood' for the first time; or a conscious awareness of 'self' as 'breadwinner' and 'provider' for the family for the first time. The impact of gender may be experienced in different ways by women and men. However, it is important to note that it is not only the female gender role that may be influencing the experience of depression; the male gender role also has an impact on the experiences of men during depression (Connell, 1993; Hearn, 1996; Edley & Wetherall, 1996; Segal, 1996).

This is a key problem associated with the theories that assert gender roles and gender identities, in particular the female gender role as a causal factor in the experience of depression. As previously discussed,

according to Butler, (1990), to be convincing as a female or male requires little more than the enactment of the necessary prescribed social expectation of what constitutes evidence of 'femininity' or 'masculinity'. For Butler, (1990), it is 'performance' in accordance with pre-existing 'social scripts' that is perceived as evidence of 'natural' gender identity.

However, the impact of 'being' and 'doing' gender during depression may be experienced differently for men and women; these differences can be seen to reflect the social gendering of roles that prescribe the associated expectations, aspirations and experiences that legitimate them on a social and subjective level. It is clear from the narratives of individuals who experience depression that the experience of depression can make individuals aware of having to 'perform' gender and this does impact on the experience of 'self' during depression. However, this is not to support the idea that the female gender role or gender identity in particular is conducive to the experience of depression. Rather, what emerges is the impact of the social gendering and sanctioning of roles, and the influence these have in ascribing identity to individuals. Gender identity can be prescriptive and restrictive and at odds with the manner in which individuals wish to experience their 'self' and their self-identity:

(Talking about experience of motherhood and the influence it was believed to have on her experience of depression)

“[Partner]... Has said in the past ‘well you wanted kids, now you’ve got them’...but I never thought that there wouldn’t be one minute in the day where you would be on your own...that’s why I love going to work...if I started at four [arrive early]...I go to the canteen, I talk to human beings, adults...I sit there and I don’t know, I’m not a mum anymore...I aren’t [Helen], mum, wife, housewife, I’m [Helen], interesting person, somebody to talk to, somebody who works...I’m a different person, and you’ve got like two identities and I like that”

[Helen]

As the above narrative highlights, individuals may actively seek to challenge the ascription of ‘being’ and ‘doing’ gendered roles and assert the agency to ‘be’ and ‘do’ a ‘self’ of their choosing; a ‘self’ that is not necessarily defined or experienced through gender, but through a ‘self’ that can be many different things to different people, at different times and in differing contexts.

The narratives of the individuals in this study highlight the fact that there is no essential ‘femininity’ or ‘masculinity’ that is dictating their experiences of ‘self’ and self-identity. On the contrary, the depression experience is characterised by the conscious awareness of the necessity to ‘perform’ key roles that constitute self-identity; it is these

roles that are gendered. If society continues to sanction the role of 'breadwinner', key earner and provider for men; and 'home-maker', domesticity and nurturing for women, then it is not surprising that this is where the tensions will arise. These roles can be seen as the social construction of the 'naturalness' of gender they have not evolved as the result of some essential gendered characteristics of individuals; the 'doing' of gender. On the contrary, during depression gender becomes something that individuals may find themselves consciously performing for the first time, as the cohesion of 'self' that was pre-depression no longer elicits the 'being' of 'doing' gendered roles. Individuals may find themselves longing for a 'self' that does not have to experience restrictions and prescriptions about how they should 'be', on the basis of externally imposed identity categories and the impact these have on the subjective experience of 'self'. This process is the same for men and women but experienced differently due to the dichotomised approach to gender in society. This newly emerging awareness of gender and its impact upon 'self' that transpires during the depression experience can offer a site of resistance to challenge the 'naturalness' of having to 'do' gender in the future.

Conclusion

While the contemporary criticisms of gender theory, in particular the continued reliance on the term 'woman', or 'man' has been subjected to a warranted criticism in the social sciences, it remains the key epistemological base for the theorising of gender and mental illness.

There continues to exist an implicit assumption that the over representation of women in mental health statistics is a result of some essential 'femininity'. Gender identity continues to be theorised as a definitive aspect of 'self' and self-identity, influencing life experiences and social expectations of 'self' both on a subjective level and within society.

In terms of mental illness, it has been noted that gender, be it gender roles or gender identity, has been central in the theorizing of differences in the rates of mental illness. The contradictions and dilemmas this approach produces can be evidenced by the lack of research into men's experiences of depression and the impact of 'masculinity' on rates of depression. It is asserted that the men do not suffer with depression on the scale that women do because their 'masculinity' means that they are less likely to seek help with personal distress (Busfield, 1996; Chesler, 1972). It is also suggested that they are less likely to confide in family and friends when they are depressed. This approach substantially supports the practice of rendering men and their experiences of depression as insignificant, and reinforces the female identity as inherently susceptible to depression as a result of some 'essential femininity'. The additional impact of this approach may result in men being reluctant to accept the possibility that they are suffering with depression, because it is regarded primarily as a 'female malady', or a reflection of a 'weak' man. It also substantially restricts the ability of individuals who do experience depression to be seen first and foremost

as 'individuals' who have the strength to battle through what is an intense and personal experience of 'self'.

Individuals do not necessarily define themselves primarily by reference to a 'gendered' self, as the narratives of individuals presented within highlight. What emerges when listening to individuals who suffer with depression, is a complex interplay of experiences that are at odds with what individuals expect to feel and experience in the various roles that define their experiences of 'self' and constitute their self-identity . These are the more subtle ways in which gender roles and gender identity impact on the subjective experience of depression, particularly during the breakdown of the relationship between 'being and doing' of 'self' and self- identity. The subsequent lack of cohesion in the experience of 'self' can witness individuals *becoming consciously aware of the impact of gender on their 'self' and their self-identity for the first time.*

Mental illness has a profound impact on the lives of both women and men; it is an intensely personal and individual experience the complexities of which can not be captured through a reliance of evoking some form of essential 'femininity' or 'masculinity' as a causal factor. This approach evokes the sense of the determinism of gender, assuming that all individuals are defined by, and have little or no resistance to the 'experience' of gender. However gender does not ultimately circumscribe individuals' experiences, nor does it dictate their subjective experiences of 'self'.

On the contrary, depression can bring to light the 'illusion' of gender, and serve to highlight the socially constructed 'naturalness' that is considered characteristic of the concept of 'gender'. As such, individuals become aware of gender and its impact on their experiences for the first time, opening up the possibility of agency to question taken-for-granted assumptions about the 'naturalness' of gender and gender identity.

The account of the impact that gender has in the experience of 'self' during depression that has been developed throughout this chapter could be further utilised in other academic fields concerned with the nature of gender roles and gender identity. This includes the impact that gender can have on experiences of 'self', and the manner in which gender is interrelated and interconnects with other social identity categories. This could include areas such as gender studies, including gender, mental health and gendered illness experiences. This approach could also offer an insight into how gender can influence the experience of 'being' and 'doing' 'self' across other identity categories, such as ethnicity, age, sexual orientation, disability and so on.

CHAPTER SEVEN

Conclusion: Experiencing the Meaning of Depression:

Gender, Self and Society

The aim of this thesis has been to gain a deeper understanding of the experience of depression and its impact upon individuals' experiences of 'self' and self-identity. Building upon existing literature around self-identity and illness/depression, the thesis has further developed current theories of identity and illness to address the complexities and intricacies that can be seen to be characteristic of the depression experience and its impact upon 'self' and self-identity. This has been achieved by listening to the narratives of individuals who experience depression and attempting to understand what the experience of depression *means* to them in terms of identity: that is, hearing individual subjective experiences of 'self', self-identity and gender.

Developing a post-Structuralist perspective, as *per* Foucault, (1984; 1984a) and Butler, (1990) the thesis began on the premise that, contrary to much contemporary thought and theorising, 'identity' has not always 'been there'. Rather, it is fundamentally important to note that the very notion that 'identity' has to be 'thought about', dwelt on, the fact that we are compelled to think about ourselves as defined by an 'essential self' and judged by a 'moral self', has not always been the case (*op.cit*). The emergence of the concept of 'self' and the subsequent rise of

'individualism' has created the climate for the 'natural' nature of identity to be inscribed on an individual level and established and legitimated on a social level. Both Foucault, (1984; 1984a) and Butler, (1990) have effectively shown that identities are discursively constructed and given meaning and substance through the dominant discourses that lay claim to the 'truth' in any given era. In effect, identity categories are better seen as discursive constructs. As such, it is possible to recognise that there can be no 'essential self' behind identity, only the prescribed need to experience one's 'self' in terms of socially defined and constructed identity categories.

However, on the practical day-to-day level of people going about their daily lives, it is important to note that while identity may not have meaning outside of discourse, this does nothing to detract from the 'reality of self' that individuals' experience both subjectively and socially. People do seek to make sense of their 'self' and society and they generally do this by reference to some idea of a subjectively experienced, 'essential self' that has meaning for them. It is this perception of 'self' that individuals' experience as their 'authentic self' and it is through ideas of an 'authentic self' reflected in experiences of 'self' and self-identity that individuals navigate both their inner and social worlds.

This does not, however, mean that theory has to take as its starting point the existence of 'self' in essential terms. Rather, it is important to

acknowledge that individuals are 'compelled' to have identity. This does not detract from the fact that identity can not exist outside of discourse. It does not necessarily bring about the 'end of the subject', as post Structuralist accounts have been accused of (Salih, 2002:12-12). On the contrary, it can place the 'subject' or rather the experiences of the 'subject' back to the centre of theory.

The overriding aim of this thesis has been to explore the impact that depression has on subjective experiences of 'self' and self-identity in terms of the 'being and doing' of identity *as per* Butler (1990). This is a new approach to understanding the experience of depression and the impact it has on individual identity. Re-directing the focus of research from looking to explain gender differences in diagnosed rates of depression, to attempting to understand *the experience* of depression has facilitated an exploration of what the experience of depression *means* to individuals in terms of identity. This has allowed for a deeper insight into the complexities of the experience of depression and its impact upon identity highlighting issues that might not otherwise be considered. Further developing Butler's theory of performativity and extending it on an empirical level has allowed an insight into the tenuous relationship that exists between the 'being' and 'doing' of 'self' and self-identity. This has allowed an exposition of the role that the social sphere has in identity formation, and the agency of individuals to resist or negotiate what identity means to them on a subjective level.

The findings presented within this thesis have highlighted the fact that depression, as an illness, is an intensely personal and individual experience. Its impact will be felt differently by each individual, and each individual may have differing experiences, depending on the severity, duration and the context in which the depression is experienced. The experience of depression is also primarily an embodied experience of 'self' and the impact it can have on individual experiences of 'self' and self-identity can be tremendous. Day-to-day experiences change as the 'natural' nature of 'self' and self-identity becomes increasingly challenged and individual perceptions of 'normality' slip further away.

The Impact of Depression on 'Self' and Self-identity

Current theories surrounding the impact of the experience of depression and/or chronic illness on 'self' and self-identity champion the theory that the 'self' in the face of the onset of chronic illness or depression is re-defined. This (re) definition of 'self', is alleged to result in the emergence of a new 'depressive identity'. In the case of chronic illness, a 'new self'; evolves that is defined in relation to the onset of illness/disability (Karp, 1996; Chamaz, 1991). However, as the findings of this study suggest, this is not necessarily the case. The process of accepting depression as part of 'self' is more complex than the subsequent emergence of a new identity that is defined by their depression experiences.

'Being & Doing' Identity

Developing and expanding the work of Butler, (1990), Chapter Four sought to address the inconsistencies within these theories to better understand the impact that depression has on individual experiences of 'self' and self-identity.

While for Butler, (1990) the 'being and doing' of identity is theorised to highlight the non-essential nature of identity, there are theoretical weaknesses inherent within this theory. Initially, the theory fails to adequately address the embodied nature of identity and the fact that individuals' *experience* identity; it *means* something to them. This is how individuals make sense of their lives; their relationships (to 'self' and others) and society. The narratives of the individuals taking part in the research have highlighted the fact that individuals do have a notion of an 'inner self'. Furthermore, before the onset of depression, this 'inner self' is experienced as a reflection of an 'authentic self' in terms of subjective experiences of 'self' and self-identity. It is the perceived 'loss' of this inner 'authentic self' that individuals seek to make sense of during their experiences during depression.

Through developing and extending the work of Butler's, (1990) theory of the performative aspect of the social performance of identity (the 'being and doing' of 'self' and self-identity), it is possible to explore the impact of depression on experiences of 'self' and self-identity in greater depth to

obtain a richer understanding of the impact that depression can have on identity.

In relation to the experience of depression, it is possible to recognise that the notion of an 'authentic self' articulated by individuals may better be understood by extending the theory of 'being and doing' identity. Although Butler is not explicit, there is an implicit assumption that the 'being and doing' of identity (performance and performativity) is characterised by a reciprocal relationship. This relationship ensures that subjective experiences of 'self' and self-identity are both coherent and elicit a sense of cohesion to experiences of 'self' and self-identity. That is, the experience of 'self' and self-identity are subjectively and socially performative as a result of the performance of identity. Essentially, this coherent and cohesive sense of 'self' and self-identity can be seen to rest upon the existence of this reciprocal relationship, and furthermore, by implication this relationship is, by its nature, self-sustaining.

At this point, the 'doing' of identity is experienced as a 'natural' expression associated with the 'being' of identity. The 'being' of identity is experienced subjectively and is in line with expectations based upon previous subjective and social experiences associated with the 'doing' of identity. Following Butler, at this point, the performance of identity is performative, that is, the performances of 'self' and self-identity are experienced as coherent and cohesive and perceived as evidence of an inner 'self', both subjectively and socially.

The narratives of the individuals taking part in the study suggest that a crisis of 'self' takes place when experiences of 'self' and self-identity, once natural and 'normal', becomes something that has to be consciously 'produced' and 'performed'. This period is articulated by individuals as the subjective experience of a 'loss of self'. At this point, the performance of 'self' and self-identity is undertaken by individuals as they attempt to (re)create an illusion of the 'self' that was, before the onset of depression. Developing and extending Butler's (1990) theory of 'being and doing' further to the experience of depression, it is possible to recognise that during depression the reciprocal relationship that exists between the 'being and doing' of identity breaks down

The subjective experience of a 'loss of self' can create tensions for individuals as the experience reinforces the notion that there is an 'authentic self' which they are experiencing as 'lost'. However, simultaneously, their ability to (re)create the illusion of 'self' through performance subverts the notion that this 'self' is 'essential', by bringing to light its constructed and so non-essential nature, hence raising existential questions. Also, the dilemma that people face in coming to terms with the notion that depression may well be an aspect of their 'self' and self-identity involves facing the possibility that the tendency to experience depression may have been an aspect of the 'pre' depression 'authentic self' all along.

Once individuals have accepted that depression may be an aspect of their 'self' they become aware of their potential to experience depression in the future and subsequently accommodate depression as an aspect of their self-identity. This process does not necessarily involve the emergence of a new identity as such (as *per* Karp, 1996 and Chamaz, 1991), but rather, the individual becomes 'newly aware' of the potential of depression to influence future experiences of 'self'.

This 'newly aware self' is not a new identity as such; rather it is the result of the synergy that has been created by negotiating where the depression aspect of their identity will sit in relation to 'self' and self-identity. The 'newly aware self' which incorporates depression as an aspect of 'self' and self-identity now recognises that the relationship between 'being and doing' identity is tenuous by nature and that self-identity can be a conscious performance. As such, there is the recognition of the potential for the relationship to breakdown in the future. Having experienced 'self' as lost and performed an illusion of 'self', by a 'self' that was detached from the 'doing', the notion of an 'authentic self' is revealed to be a myth. Consequentially, individuals may recognise at this point that a 'return to self' that was, pre-depression is not possible and accept that experiences of 'self' may never be the same.

At this point it is possible that the expressed wish to return to a semblance of 'self that was, pre-depression, may be recognised as a

desire to *experience* a 'self' that is characterised by a sense of coherence and cohesion: for performances to be performative; the reinstatement of the 'being and doing' relationship. This subjectively experienced coherent and cohesive 'self' is characteristic of the performative aspect of performances. It provides the foundational stability that allows individuals to go about their daily lives without consciously thinking about the performances that are necessarily part and parcel of self-identity on a social and subjective level.

However, the experience of the fracture of the relationship between 'being and doing' that preceded the crisis in identity may never leave individuals. As such, the newly aware 'self' accepts depression as part of 'self' and self-identity, but also importantly, is aware of the performance/performativity aspect of identity.

By applying and extending Butler's theory of 'being and doing' identity to depression in this manner it is possible to address another weakness inherent to the theory – the agency of individuals to resist being defined by the depression aspect of their identity.

The conscious performance of 'self' and self-identity during depression highlights a possible site of resistance to the definitive aspect of identity categories. Individuals may accept that depression is part of their 'self' and self-identity, but importantly, they may consciously resist being defined by it through the performance of 'self' and self-identity socially.

The newly aware 'self' recognises that performances can be just that, a performance, and importantly, that aspects of 'self' and self-identity can be negotiated in terms of where they sit in relation to 'self' and self-identity. This opens up the possibility of recognising that aspects of 'self' can be resisted and are not necessarily totalising in terms of identity.

The findings highlight that developing and extending Butler's theory of 'being and doing' to the experience of depression allows a deeper understanding of the relational aspect of 'self' and self-identity and the impact that this can have on individual experiences of 'self'. It also allows for a consideration of what it means to experience depression in terms of 'self' and identity. Furthermore, by extending the theory in this manner it is possible to address the inherent problems of Butler's theory in relation to agency. The account developed throughout the thesis allows individuals to take a measure of control over their experiences of 'self' and how they are perceived by others and society in the future. By developing Butler's theory it is possible to provide an account of the experience of depression as fundamentally an embodied experience of 'self'.

This is in contrast to one of the key themes in Butler's theory, the assertion that identity has no substance as such, and is in fact merely the enactment of (pre) scripted acts of bodily comportment, speech, dress, and so on. However, this assertion fails to address the individual experience of 'being' an identity. Subjective experiences of identity are

fundamentally embodied experiences of 'self', this is particularly the case during the experience of depression. Individuals *expect to experience* identity subjectively. It is those experiences that give *meaning* to individual identity. These expectations may be based upon prior experiences, socialisation or social expectations. Importantly, these experiences of 'self' within the varying roles that constitute self-identity are what individuals refer to as a measure for the 'being' of identity.

By developing the work of Butler (1990) further, it has been possible to highlight the embodied, relational and experienced nature of identity and explore the processes involved in the 'being and doing' of identity. 'Self' and self-identity may be discursively constructed, and the ascription of socially constructed identities may prescribe definitions of identity. However, the research findings presented throughout the thesis highlight the fact that individual experiences within identity categories vary, and the experiences of 'being' associated with identity are fundamentally important if individuals are to invest in identities.

The experiences of 'self' and self-identity during depression highlight the weaknesses in Butler's theory of identity, not least the inability to account for the relational, embodied and experienced nature of 'self' and identity. As the narratives of individuals has evidenced, the impact of depression on 'self' and self-identity is complex. While Butler (1990) appears to assume that the relationship between 'being and doing' (performance and performativity) was reciprocal and self-sustaining, the

research has highlighted that crises of identity can and do occur when this relationship is fractured. At this point while it may still be possible to 'do' identity, the 'being' is lost.

This addressed another problem inherent in Butler's theory. For Butler, the 'doing of identity is crucial to performativity. However, the narratives of individuals presented here suggest that the ability to perform of 'self' and self-identity socially is not necessarily enough to validate the performance on an individual subjective level. Performances may be granted legitimacy socially as individuals' consciously (re) create an illusion of their 'self' and self-identity, but they are experienced as just that: a performance.

It is also important to note that it is the performative aspect of 'being' identity that facilitates the experience of identity as coherent and cohesive for the individual. In a sense, contrary to Butler's assertion that there is no substance to identity, in that the 'doing' or the 'deed' is everything, it is possible to recognise that the 'being' of 'doing' identity is experienced as substantive to individuals through the coherent and cohesive experiences that reconcile the 'being' of 'self' to the 'doing' of self-identity. The significance of this aspect of 'being and doing' identity is evidenced by the fact that the breakdown of the relationship results in a crisis of identity for individuals that is so profound that its impact may never leave individuals.

In terms of 'self' and self-identity, the study has highlighted how, through developing and extending Butler's theory of performance and performativity it is possible to gain a deeper insight into the complexities of the experience of depression and its impact on 'self' and self-identity. Developing these ideas further, the research also explored the impact of the social arena in the construction and sanctioning (or not) of identity categories. The analysis highlights the extent to which these theories fail to address that it is the subjective, ontological aspects of 'self' that are crucial to the legitimisation and validation of self-identity on a personal level.

As was discussed in Chapter Five, leading theorists Jenkins, (1996) and Butler, (1990) both place great emphasis on the social arena as a central element in the production, reproduction, legitimisation, sanctioning and censoring of identities. However, the findings from this study evidence the fact that people can and actively do resist being defined primarily through the social ascription of identity categories

That is, while society may be instrumental in the production of, and meaning assigned to identity categories, it does not always ensure that individual's experience the identity as definitive in terms of 'self' and self-identity. The narratives of individuals who experience depression highlight the extent to which they can be seen acting with agency to resist being defined by the depressive aspect of their identity (i.e. the 'performance' may obscure the depressive part of their identity which

allows individuals to choose performance and therefore they may never experience a full return to performativity).

As discussed earlier while self-identity may be socially sanctioned and legitimised or validated through the 'doing' of identity, if the performance fails to elicit previous expectations and aspirations associated with the 'being' of 'self' on a subjective level, it is not sanctioned on an individual level. That is, contrary to the theories that suggest that the social arena is crucial to the reproduction and sanctioning of identity categories, if the social 'doing' of identity fails to elicit the subjective 'being' associated with it, then it is evident performances are not necessarily ultimately performative.

The research findings highlight the fact that individuals do have agency to resist being defined socially by their depression. This is evidenced by the willingness and ability to perform 'self' socially even when 'self' is detached from the experience. The 'performance' also brings an awareness of the non-essential nature of 'self' and identity categories for individuals. This new awareness of 'self' may see individuals becoming aware that 'self' can be many things, which can subsequently open up the possibility of 'doing' 'self' differently. This is evidenced for example, by the narratives of the individuals taking part in the study who adopted lifestyle changes and/or new outlooks on life with the aim of resisting the experience of depression in the future, or, negotiating the impact it is going to have on their future experience of 'self' and self-identity.

While the individuals were making conscious decisions about their future experiences of 'self', they were also fully aware of the stigma and lack of empathy that surrounds depression socially and the impact that this has on their willingness to fully embrace the depression aspect of their 'self'. Although depression is first and foremost an embodied experience, the lack of physical markers to socially validate their experiences as a legitimate illness was noted by many of those taking part in the study. Several of the individuals saw this as the reason for the general lack of empathy and the social stigma that continues to surround the concept of mental illness on a social level.

However, as was discussed, research findings from the field of Disability Studies suggests that having physical 'markers' may sanction illness/impairment as legitimate, but this is not always a positive experience for 'self' and self-identity (Butler, R. & Parr, 1999; Galvin, 2005; Michalko, 2002; Wendell, 1996). On the contrary, physical markers make it difficult to 'perform' a 'self' socially that is not seen first and foremost or defined by the disability or illness. As such, physical 'markers' are utilised socially to inscribe a 'disability identity' onto individuals. The ascription of a 'disability identity' can make it difficult for individuals who live with chronic illness and/or disability to be seen primarily as an individual with a multi-faceted identity. In this sense, the 'doing' of an identity of the individual's choosing is restricted in the first instance by the reluctance of the social sphere to sanction performances based on individual perceptions of 'being'. This can largely be attributed

to the fact that the body takes centre stage in society and identity is read primarily through the body on a social level.

While there may be similarities in the experiences of those individuals with a physical disability or chronic illness and those who experience depression, particularly in the social stigma that exists, there are important differences between the two. Not least the fact that individuals who experience depression will have periods in their lives when they are depression free. They also may have more leeway to perform a 'normal self' socially without the performance being overridden by physical markers. If there were physical markers present they may well negate individual attempts to perform a 'normal self' that is socially sanctioned, the 'self' they experience themselves to 'be'.

It is also important to recognise the impact that the social sphere has on the reluctance of individuals to be more open about their depression experience, and their resistance to be defined by it. While for some the lack of physical 'markers' ensures the continued lack of empathy and legitimacy afforded to depression as an illness, it is nonetheless an important factor in their ability to 'perform' a 'self' that is not socially sanctioned as 'depressed', and pivotal in their ability to resist the ascription of a 'depression identity'.

As the research narratives have highlighted, depression has an impact on 'self' and self-identity that is far from straightforward. The thesis has

developed existing theories to facilitate a deeper understanding of the complexities and intricacies of an individual's experience of depression and what the experience of depression *means* to an individual, in terms of their subjective experiences of 'self' and self-identity. The findings from the study highlight the fact that self-identity is multi-faceted and that identity categories can mean different things to different people. While depression is but one aspect of identity, its impact can resonate through experiences of 'self' across all facets of identity. This is due to it acting as a heuristic device and the relationship between performance and performativity (i.e. highlighting the performative nature of all aspects of 'self' and self-identity).

This leads us to a further theme to be explored within the study. As noted above, depression is experienced as one aspect of identity and individuals actively resist it becoming the definitive aspect of their 'self' and self-identity. What then of other facets of identity, where they sit in relation to 'self' and their impact on experiences of 'self' during depression?

The concept of gender identity has a long and sustained history in the theorisation of differences in rates of mental illness between women and men. However, the findings from this study suggest that individuals do not experience their 'self' or self-identity primarily in terms of a 'gendered self'. As discussed above, experiences of depression are often

articulated in terms of a 'loss of self' and an expressed desire to 'return to self' once the depression lifts.

The narratives of the individuals taking part in the study did not express their experiences directly in terms of a gendered 'self'. Rather, what emerged was the more subtle ways in which gender impacts upon experiences of 'self'. Interestingly, a further theme to emerge was the extent to which individuals, reflecting upon their experiences, *became consciously aware* of the impact that gender has on prescribing and restricting the opportunities and possibilities for individual experiences of 'self'.

The discourses utilised by individuals to make sense of their experiences of 'self' during depression reflected the dominant discourses that construct and legitimise gender as a social and individual reality. These included discourses around biological differences – the gendering of sex, and the gendering of social roles – which work to the detriment of both women and men. Importantly though, the discourses utilised by individuals highlight the fact that it is the social expectation to perform – to 'do' socially constructed gendered roles and the accompanying expectation that there will 'be' a gendered 'doer' behind the performances that impacts negatively on experiences of 'self' and self-identity during depression. This is in contrast to current theories that see gender identities 'doing' socially constructed gender roles as a result of socialisation into 'being' gendered; even if the

process that facilitates the incorporation of a gendered identity is socially constructed.

In relation to gender and its impact on experiences of 'self' and self-identity, a further aspect developed through the thesis is a critique of the manner in which the continued reliance on the concept of gender identity has informed theorising in the field of mental health. Chapter Two highlighted the extent to which the identity categories of sex, gender and gender-identity have been historically, socially and culturally constructed as 'natural' and 'essential' concepts to ensure the legitimisation of the notion of the sexes as discrete and separate categories, complementary, yet opposite (Butler, 1990). However, it was noted that it is not possible to assume that gender, or gender identity is a central definitive feature of an individual's subjective sense of 'self', nor even a salient feature of an individual's sense of self-identity. Rather, gender theorising has reified it as such. Taking these developments into account it becomes evident that there is a need to question the extent to which these concepts can be justifiably utilised as the key factor in the theorisation of gender and mental illness, as is evident in much current theorising in this area (Busfield, 1996; Prior, 1999). Rather, what has emerged is the extent to which mental illness has been subjected to its own 'gendering'.

The problematisation that surrounds the continued reliance upon the concepts of gender and gender-identity categories as key causal factors in the experience of depression has facilitated the further development

of current theories around identity in the area of 'self', self-identity and the experience of depression. These have been developed throughout the thesis. While the contemporary criticisms of gender theory, in particular the continued reliance on the term 'woman', or 'man' has been subjected to a warranted criticism in the social sciences, it remains the key epistemological base for the theorising of gender and mental illness. Gender identity continues to be theorised as a definitive aspect of the depression experience.

To avoid falling into the 'trap' of assuming that gender will be a key feature in individuals' experiences of 'self' and self-identity, the research began on the premise that while we are compelled to have identity, it does not necessarily follow that individuals' experience their 'self' as gendered. Rather, what emerged throughout the study was the extent to which depression can bring to light a conscious awareness of the impact that depression has on the life experiences of individuals. Upon reflection, the narratives of individuals highlighted the extent to which their social roles and possibilities for 'self' and self-identity were being prescribed and restricted through the ascription of gender and the gendering of roles.

These findings are in contradiction to Butler's, (1990) theory which sees individuals as passively (re) creating gender as they unwittingly follow social scripts that serve the continuance of gender. The evidence from the research presented throughout the thesis suggests that during

depression individuals become consciously aware that gender is socially constructed and is characterised by inequalities. This may witness individuals challenging their taken-for-granted assumptions about the 'naturalness' of gendered roles as their awareness of the social gendering of roles and its impact on their experiences become apparent. As became evident throughout the study, the experience of depression can bring to light the 'illusion' of gender, and serve to highlight the socially constructed 'naturalness' that is considered characteristic of the concept of 'gender'. As such, individuals can resist the performance of roles that do not reflect their aspirations for 'self' in the future.

There is little doubt that gender identity impacts upon the experiences of depression. However, it is contradictory to assert the female gender role as conducive to the experience of depression when gender is but one aspect of 'self' and self-identity, and individuals do not necessarily experience their 'self' or self-identity as inherently gendered. Rather, the continued reliance on gender as the key aspect of the depression experience reflects the continuation of a long and sustained 'gendering' of the depression experience. The approach has, and continues to deny men the legitimacy of their depression experiences and effectively naturalises depression as synonymous with women.

Furthermore, this approach fails to allow for the fact that gender means different things to many people, both men and women. It should be

noted that the research findings presented here suggest that rather than see gender as a key identity category, theory should be aware that all identity categories are to certain or lesser degrees, gendered. This is how the perception of gender, as an identity, is able to continue its stronghold within society. Gender is but one facet of identity, as with the depression facet of identity, individuals can and do have the agency to resist being defined by it, and negotiate where it will sit in relation to the idea of 'self' and self-identity.

To summarise the study as succinctly as possible, developing and extending the work of Butler (1990) and Jenkins (1996) has allowed a deeper understanding of the depression experience and what it means to individuals in terms of their sense of 'self' and self-identity. Importantly, developing the theory has allowed an opportunity to address some of the inherent weaknesses and (re)introduce different dimensions to the theoretical debate.

In the first instance, although Butler implied a reciprocal relationship between the 'being and doing' of identity, the importance of this relationship in the experience of 'self' and self-identity was never sufficiently addressed. It was implied that this relationship must be self-sustaining; however, the research findings highlight the tenuous nature of this reciprocal relationship and its importance in relation to experiences of 'self' and self-identity. This is evidenced by the crises' of

identity that are characteristic of the experiences of individuals once this relationship is fractured.

Secondly, for Butler, there is no substance to identity, the performance is everything. However, as the research findings have highlighted, depression is first and foremost an embodied experience of 'self'. Individuals *experience* 'self' and self-identity. This is evidenced by the experiences of the individual narratives of those taking part in the study. As the research highlighted, subjective experiences of 'self' and self-identity are legitimised by the experience of 'being' not 'doing'. While the role of the social sphere is crucial in the construction and sanctioning of identity, it is not enough to sanction it on an individual subjective level. Individuals have to *experience* identity as 'being' for it to be sanctioned subjectively.

Finally, it is important to note that individuals do have agency to resist being defined by identity categories that are socially constructed, prescriptive and restrictive. This is particularly the case if the characteristics of an identity do not reflect an individuals' subjective sense of 'self', but also, importantly, how they wish to be seen socially. During depression we see individuals acting with agency, performing a 'self' and self-identity that is presenting a partial social identity (in that it is not presenting the depression aspect of 'self' that has been accepted as a facet of identity to avoid it being a totalising identity) through the conscious performance of 'self' and self-identity.

As the thesis has highlighted, the development and extension of Butler's theory of 'being and doing' can provide a theoretical basis for developing a deeper, richer understanding of identity. By addressing the relational, embodied nature of identity it is possible to recognise that individuals can and do have agency to resist being defined by one aspect of their identity. Furthermore, it is important to note that if gender and depression, as aspects of 'self' and self-identity can be performed, then so can other aspects of identity. The findings have also highlighted that identity is also read through the body, and this can have important implications for 'self' and self-identity, particularly in resisting the social ascription of identity on the basis of physical impairment/disability.

Finally, this thesis has developed the theory surrounding conceptions of identity and illness by exploring the impact that depression has on experiences of 'self' and self-identity. By developing these theories further, the thesis has generated a deeper understanding of the experiences of 'self' through depression, what depression means to individuals, and the impact that the experience has on 'self' and self-identity. What emerges is the complex picture of the journey of 'self' as individuals navigate their way through the depression experience. The journey is characterised by the intricacies of negotiation and agency on the part of the individual as they seek to make sense of their depression in relation to 'self' and self-identity.

Importantly, this is not the only area that the development of this theory can relate to. More broadly, the study of identity could be substantially enriched by addressing the relational, embodied nature of identity, characterised by the reciprocal relationship between 'being and doing' identity. In order to gain a deeper understanding of identity, it is important to recognise and understand that while the social sphere may be influential in the construction of identity categories, it is individual subjective experiences of 'self' that sanction identity on an individual level. Furthermore, it is individual subjective experiences of 'self' that facilitate and nurture the agency to resist the ascription of totalising identity categories.

The account of identity and the subjective experience of 'self' that has been developed throughout the thesis could be utilised further in the academic field of 'self' and identity, and perhaps in particular, to the area of Disability Studies. This approach could facilitate a deeper understanding of the 'being' and 'doing' of disabled identities; but more importantly, it can highlight areas of potential for agency to resist the social ascription of the totalising nature of the identity categories.

Appendix 1

Interview Schedule/guide

Experiencing The Meaning of Depression: Gender, Self, and society

GENERAL DETAILS

Name:

Age:

Gender:

Marital Status:

Occupation:

Religion:

Ethnicity:

Nationality:

INTRODUCTION TO RESEARCH

Background, details of study, focus of interview – individual's story, confidentiality, publication, informed consent – consent for tape

Themes (guidance topics)

When did you first realise that what you were experiencing was something more than a simple case of 'the blues', or 'feeling down'?

Prompts/areas:

- *Was there a specific incidence that caused first visit to the doctor?)*
- *When did you first receive a diagnosis of depression?*
- *Is this your first experience of depression?*
- *What was your initial reaction to hearing your diagnosis ?*

Post diagnosis

Prompts/areas

- *How many episodes, severity, frequency?*
- *What treatments have you tried?*
- *Drugs?*
- *Counselling?*
- *Other?*

- *What was your experience of the treatments offered?*
- *Positive/negative*

Experience of depression & meaning

Prompts

- *In your own words can you explain what 'depression' means to you?*
- *Where do you think depression come from?*
- *Does it happen to you (external, core?), or does it come from within you?*
- *Internal/biomedical, part of self?)*
- *Has your experience of depression influenced how you feel about who you are, your self identity, in terms of: how you were?*
- *who you are?*
- *who you thought you would be?*

Do you believe that there are any parts of your identity (who you are) that influence your depression?

- *Gender identity*
- *Ethnic identity etc... how and why?*

Would you feel comfortable talking freely and openly about your experience with depression within your :

- *home sphere (family)*
- *social sphere (friends)*

- *work sphere (workmates, boss)*
- *who have you told about being depressed?*
- *(Who and who not- reasons)*

Do you believe that peoples' perception of you would change if they knew you experience depression?

- *If so, in what way?*
- *Reasons*
- *If not, reasons?*

Social Aspects of depression

- **How do you think depression is seen with society**

How do you manage going about your life on a daily basis when you are depressed?

- *Presentation of self- who you are thought to be, who you feel to be,*
- **How does having to get on with your life, while coping with depression impact on how you feel about yourself, who you are?**

Performance, contradictions between 'being' and 'doing'

Having suffered from depression, in your opinion, do you believe that it would help you, if you 'came out'?, (as in telling people very openly that you experience depression)

- *Would it help personally? (issues of self identity)*
- *Would it help socially?*
- *Would it help at work?*

End Of Interview

- How do you see yourself managing your depression in the future?
- Do you believe the help available to you could be improved in any way?

Uplifting closure

Appendix 2 – Diagnostic Criteria for Depression

Diagnostic Criteria for Depressive Episode

- A.** Symptoms must be present for at least 2 weeks; the person did not meet the criteria for mania or hypomania at any time.
- B.** (a) depressed mood most of the day and almost every day, uninfluenced by circumstances
 (b) loss of interest or pleasure in activities that are normally pleasurable
 (c) increased fatigability or decreased energy
- C.** (a) loss of confidence or self esteem
 (b) unreasonable feelings of self-reproach or excessive or inappropriate guilt
 (c) recurrent thoughts of death or suicide, or any suicidal behaviour
 (d) complaints or evidence of diminished ability to think or concentrate, such as indecisiveness or vacillation
 (e) change in psychomotor activity, with agitation or retardation (either subjective or objective)
 (f) sleep disturbance of any type
 (g) changes in appetite (decrease or increase) with corresponding weight change

NOTE: Depressive episode may be diagnosed as: **Mild** (at least 2 from B plus at least 2 from C for a total of at least 4); **Moderate** (at least 2 from B plus 3 or 4 from C for a total of at least 6); **Severe depressive episode** without psychotic features (all 3 from B plus at least 4 from C, for a total of at least 9 – no hallucinations, delusions, or depressive stupor).

Reproduced from (ICD-10, Hammen, 1997: 11)

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