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“Beyond Blues” – Where is Oppression in the Depression Debate?

I would like today to speak about what I believe to be a significant gap in the current discourse about Depression. Depression as it is profiled and conceptualised is dominated by the *biomedical model of health*. There is a real omission in understanding and treating Depression from a broader *social context* of health. Depression stands along side heart disease and diabetes as one of the most common health problems and anti-depressant medication is up there among the most prescribed medications. This is of particular concern for women, because women are diagnosed at twice the rate as men and of all those prescribed medication women are prescribed at twice the rate as men (Williams et al 1995).

The general community is given the impression that depression is a biochemical imbalance in the brain, treatable by medication and or ECT if it is really bad. If counselling is advised there is a push for it to be within the frame of the behaviourist model of psychology known as Cognitive Behaviour Therapy. It is often suggested that this be administered by a clinical psychologist, the allied health professional group vying for second position after medicine.

Anti-depressant medication is certainly useful and for some it is the best solution. There is also truth in the fact that the way we think about ourselves and the world impacts on how we feel. However this medicalised, rationalised approach aids in the oppression of women by presenting a paradigm that doesn't make room for other perspectives on what the Depression might really be about.

Most significantly by its over-emphasis on biology it doesn't have to acknowledge and therefore challenge on any meaningful level the impact of socially created oppression on the community.

Most significantly it is interventionist and comes from a 'doing to, administering to position' rather than an empowering approach of utilising a safe space with time and in context to allow the depressed person to unwrap and discover the *subjective meaning* of this depression. It also often doesn't allow for Depression as a very normal response to loss, be that a person, country, culture, freedom. Systemic and Psychodynamic theorists speak of depression as having a purpose, of being a communication in itself, perhaps about attachment and separation, perhaps about anger and rage.

So what is depression and how do we understand it?

The 'American diagnostic and statistical manual of mental health disorders', DSM IV-R, is a widely used diagnostic tool in determining the existence and type of Depression. Officially one can be said to suffer from Depression if they experience all or most of a group of symptoms and that these symptoms persist for a period of 2 weeks or longer.

They include:

Sadness, emptiness, diminished interest in pleasurable activities, significant weight changes, insomnia, agitation, lack of energy, feelings of worthlessness, diminished ability to think, concentrate and recurrent thoughts of death. Depression is also divided into various types.

Most populist literature, including the 'Beyond Blue' Depression Initiative website describes what depression looks like and briefly says:

Individuals may be predisposed to Depression

- Individuals with low self-esteem are more vulnerable to depression;
- Depressed individuals have lowered levels of neurotransmitters and higher levels of hydrocortisone within their brain chemistry; and
- Social factors from what I have read are significantly under-rated. Most notably is the absence of information on possible causes and emphasis is placed on diagnosis and treatment. It sometimes mentions that twice as many women than men suffer with depression.

Many or most people with depressive symptoms will visit their GP. The GP then has to decide on a course of treatment or referral. Following the bio-medical model the GP will then refer the sufferer on to a psychiatrist much as they would if someone required any other specialist medical service beyond the GP's capacities and resources. I'm not suggesting this is wrong, most GP's have neither the time or resources to address ongoing depression.

Psychiatry then in our culture is set up as the discipline that holds the body of knowledge, they are the 'experts' on Mental Health which includes Depression. The evidence or assessment of a psychiatrist holds enormous weight legally.

Diagnoses of Depression or the other popular diagnosis for women 'Adjustment Disorder' is often made after one or two consultations. Having worked in both government and private mental health facilities as well as hearing the stories in counselling of women's experiences with psychiatrists, it is astounding how quickly diagnosis and treatment is prescribed on very little knowledge of the woman's lived experiences of oppression.

It is astounding just what questions are not asked and how often the approach is one of 'paternalistic advice'

We need to remember that while there are some very fine psychiatrists who forgo top dollars to give time, develop an empathic connection and get educated outside the medical model square, this discipline is dominated by white upper middle class men. Many of whom have had no training in basic counselling skills let alone the psychotherapies. They also have the status and autonomy to not have to be terribly accountable for what they do.

The *medicalising* of mental health problems omits oppression as a significant causative factor. Medicalisation is that process through which more and more aspects of life are defined as medical problems, requiring specialist medical intervention (Illich 1975) and ensures a dependence is set up on the medical profession.. The medical profession then and its scientific, body/mind split has a monopoly on the discourse around 'mental health' in terms of the general populations thinking. It means it has a monopoly on treatment in particular on pharmaceutical treatment. Depression like diabetes is seen as *pathology* something disordered within the individual and treatment is largely targeted at the individual.

The maintaining of the biological model is necessary in maintaining the lucrative market place for pharmaceutical companies. Pharmaceuticals are owned by male dominated powerful wealthy multinational corporations who heavily market their products, and all products need a market. The touting of 'Depression as the epidemic of the 21st century' provides such a market. The market and optimum production is

necessary for economic growth which is the primary goal of the current national government and the current global powers. It is in the interests of economic rationalism and an unswerving commitment to global market forces that the dominant model of health care remains the 'medical model'. But is it really economically cost effective in the long term and is it really cost effective in terms of social capital?

The World Health Organisation states that "peoples social and economic circumstances strongly affect their health throughout life, so health policy must be linked to the socio-economic determinants of health"

NSW Health's policy document '*Strategic Framework to Advance the Health of Women*' (2000) states as its guiding principle that 'health is determined by a broad range of social, environmental, economic and biological factors. That health status and outcomes are linked to gender, age, socioeconomic status, ethnicity, disability, location and environment'.

The link between being a woman and her health status is *socially determined by the inherent inequalities that being a woman brings*. As previously stated women are diagnosed with depression at twice the rate as men. It is my opinion that most emotional and psychological problems including those problems that constitute Depression are caused by Oppression. Even the biologically based idea that Depression is heredity can be conceptualised as generational oppression.

"Oppression" as defined in the Macquarie Dictionary means: to exercise authority or power over, to subdue or put down, to burden with cruel or unjust impositions, to restrain, to lie heavily upon the mind. To this I would add 'to silence'.

Oppressions are experienced differently throughout the world from gross violations to the more subtle oppressions experienced in western democratic nations and the oppressions inherent within its systems. The dominant medical model of health by its very nature is particularly oppressive to women. The current discourse on Depression is a part of this Oppression because it most often doesn't attempt to understand, explore or analyse, preferring a biological explanation.

Women are oppressed simply by not developing a sense of '*entitlement*' in a way that is often developed in men. It comes from being placed as 'secondary to'. Women are raised to aspire to being nurturing, attending, women are the primary caregivers to the community as volunteers, to aging parents, to children, to remembering to purchase a gift for her mother in law's birthday. Women have been traditionally raised to place themselves in a supporting role to their male partners desires and aspirations. Women have been traditionally raised to 'not expect too much for themselves'. There are exceptions of course, but I truly believe that outside the 'educated middle class' not a lot has changed for women in where they are placed.

Women are also oppressed by the *level of violence* they are subjected to. While both girls and boys are subjected to childhood sexual abuse evidence suggests it remains higher for girls, particularly from brothers and stepfathers, domestic violence is primarily actioned by men against women as is adult rape.

Sex role stereotyping is oppressive to women as Historian Judith Allen (1982) states when she observed that the bedrock of most habitual wife-bashing was the man's view that the woman had been insufficiently obedient, subordinate and attentive to his needs and desires. This involved definite and traditional ideas of proper sex roles within marriage and most men appear to have considered their violence to be

completely justified and requiring no remorse of apology. This obedience was institutionalised in the traditional vows a woman made to her husband in marriage.

A 1999 study by Roberts and others found that women who experienced both adult and childhood abuse had the highest rates of psychiatric diagnoses for depression, anxiety, phobias, drug dependence and harmful alcohol consumption. These women also had high rates of lifetime post-traumatic stress disorder.

Robyn South (1999) in her study on the 'treatment of Adult survivors of Child Sexual Assault in Mental Health clients' found that where childhood sexual abuse was a core issue in their psychological makeup, it was most often unacknowledged, disbelieved, ignored or put in the too hard basket.

I believe that much of which is '*normal adaptive responses*' to trauma and to grief and loss in its myriad of forms is pathologised. By 'adaptive' I mean one adapts to abnormal situations the best way one knows how. So if a woman becomes depressed because it is not safe to get angry then the depression is adaptive not maladaptive. Women are silenced by living in unsafe situations, from having been conditioned to 'get on with it', from needing to put the needs of family first or any number of possibilities.

Silencing comes also from having health professionals omit to address and validate experiences that cause psychological distress. The dominant psychiatric and psychological community is grossly irresponsible for not responding and addressing the mental health legacies suffered by abused women and men. It is systemic abuse by omission to ignore a widespread mental health problem that has been largely caused by male oppression and violence. It is an act of abuse to 'pathologise' these women. The needs of these women are therefore picked up by the community sector, particularly the women's health sector.

While working in a private mental health facility a few years ago I was struck by the number of women who would be referred for anxiety and depression groups. In getting to know these women and beginning to unwrap what was behind their insomnia, lack of energy, feelings of inability to cope etc were thoughts of feeling bad about themselves because of what they were thinking and feeling.

As it transpired an inordinate number of these women were abused as children or lived with family dynamics that were oppressive, many were in current emotionally domestic violent situations, others carried enormous burdens of many losses. Others were living out a life that wasn't reflective of who they were.

It astounded me to discover that most were diagnosed with depression or adjustment disorder, almost all were medicated, most had not had questions asked of them that would seek to explore what might be really troubling them, or if they had it was not taken any further. Few had their oppressive experiences validated. Almost without exception this 'lack of acknowledgement of the impact of psychological trauma' was interpreted by the women as not important, therefore what they thought and felt was irrelevant, stupid or 'faulty thinking'. External oppression becomes internalised and the critical inner voice reinforced.

A woman needs to know she is being listened to without judgment in order to feel sufficiently safe and trusting enough to begin to communicate what is troubling her. Ruth Wajnryb, author of "The Silence: How Tragedy Shapes Talk" (2001) and daughter of Holocaust survivors states that "there are no words to convey trauma, what we can do she says, "is to create a space where there is a role for the listener,

create a space where the survivors can talk and not have it interpreted pathologically”

So what can we as NGOs do?

- NGOs can have a *voice* in a way that government employees cannot. We can write to the media, write articles, and speak out in promotion of a *social model of health*;
- We can get ourselves organised to find ways of *measuring* what we do to provide *evidence* for treatments that come from a *holistic* perspective;
- We can utilise agency *statistics* to lobby for services and speak about the issues that women raise, particularly those tucked behind the term Depression that are related to male violence;
- Services have become increasingly *compartmentalised*, with alcohol and other drugs, sexual assault, mental health, eating disorders divided into separate areas, when in reality many women deal with the lot, or behind the predominant manifestation of distress are very similar causes;
- We can incorporate *community development* into our work to raise the awareness of mental health consumers, so that consumers are more informed their options and their rights; and
- We can form partnerships with other sector to encourage an exchange of skills and develop capacities to respond to our clients more appropriately.

In conclusion, I would just like to say that the appropriation of Depression by the medical model of health and its disciplines with their over-emphasis on biology takes away the relationship between mental health all other factors. This is devastating from the point of view that it requires no political response, no change by governments to the social order. It escapes responsibility and places it upon the individual through biological pathology.