Chapter 12
Changing the Story: women and trauma in narratives of mental illness
Katie Holmes

Suzie Quartermaine's Expression of Interest (EOI) for the Australian Generations Oral History project was upbeat. As requested, she had succinctly summarised the 'main experiences, issues and events' in her life history. These included: being adopted and meeting her biological family; studying; travelling; meeting her partner; her brother's struggle with schizophrenia and subsequent suicide, an event which coincided with her pregnancy and then abandonment by her partner: 'Suddenly I was a single parent to a newborn, living on the pension and in grief and shock over my brother's death and my partner leaving me. Over the next eight years, my strength and my education brought me back from the brink of my own suicide and depression'. In the time between Suzie submitting her EOI and her interview, however, her life had once again changed dramatically. The sudden death of her mother in a bicycle accident left Suzie bereft, barely able to summon the strength to leave her home for at least a year. Rather than a forward-looking story of recovery and hope, grief and despair haunted her narrative. Suzie was thoughtful and articulate about her life and the recurring experiences of depression which shaped it. Her intensely moving story of private pain finds echoes in more public narratives about women and depression.

In this chapter I explore the life histories of three women, and consider the frameworks within which they made sense of their experience of mental illness and the gendered nature of these narratives. Mental illness comes in many varieties and degrees of severity. The three women discussed here all experienced what they labelled as 'depression' or sometimes 'post-natal depression'. Although many interviewees spoke about depression, I focus on these particular women because of the richness of their discussions.[1] My interest is not in the clinical accuracy of their self-diagnosis. Rather, I accept their terminology, while recognizing that what is today labelled 'depression' derives meaning from a particular

historical and cultural context; it is not 'a unitary, global, trans-historical pathology'.[2] My focus is on how changing historical conditions have provided different narrative frames within which women talked about the trauma of mental illness. I also suggest that gender shapes both their experience of mental illness and their ways of telling; as important as what they say, is the way they say it.[3]

When we embarked on the Australian Generations project, which gathered life histories from 300 individuals, we did not set out to find people with experiences of mental illness but, like Suzie (b.1975), many volunteered this information.[4] Thanks to the rise of a 'therapeutic culture' that encourages talking about self, there was a greater willingness to talk about mental illness than participants had displayed in a similar project conducted in the 1980s.[5] In economically developed countries, therapeutic culture is fascinated with emotional and psychological life and this pervasive interest now manifests in a range of discourses, social practices and cultural artefacts, including the life history interview.[6] The narratives of self which emerged from the Australian Generations project are themselves historically shaped and located, and this is evident in the discussions of mental illness and the readiness of many interviewees to talk about emotional trauma.

It is implicit in the interviews that the experience of depression was itself traumatic and linked to other traumatizing experiences, although the women discussed here did not invoke the word 'trauma'. Sexual and domestic abuse have been widely recognised as traumatic; as sociologist Katie Wright notes, 'the concept of trauma has become the dominant way of understanding the psychological effects of abuse'.[7] Such recognition has been the result of feminism's exposure of the realities of many women's lives. As the opening chapter in this collection notes, women's trauma, so often the result of domestic and sexual violence experienced as part of their everyday lives, is ubiquitous. Feminism located the source of much of women's trauma in the family and the unequal power relations between men and

women, which can remain hidden behind closed doors to the detriment of women's mental health.[8] The language used to talk about this kind of trauma is noticeably different from that of post-traumatic stress disorder (PTSD). It is private, feminised, and inherently political. The articulation of such trauma as 'depression' provides a label that is both socially acceptable and that privileges a psychological, rather than a political or structural, understanding of the underlying causes.[9]

In Australia, successful men, especially politicians, judges, sportsmen, have been among the most outspoken advocates for mental health awareness and their stories have helped to normalise public discussion of this once-taboo topic.[10] Their narratives have generally told of the stress of their public lives, the pressure upon them to perform, the challenges they experienced as men in accepting their mental illness, and the relief they have received through medication and counselling. It took courage for these men to come forward and their trauma is evident. It in no way diminishes their suffering or the value of the public efforts to observe that the number of men who have spoken publicly about their struggles with mental illness far outweighs that of high-profile women who have felt able to endure public scrutiny of their private pain. One exception was media personality and model Charlotte Dawson, who had been very public about her anxiety and depression and was vilified on social media for her openness. She took her own life in 2014.[11]

Despite the high visibility of men in recent efforts to destigmatise mental illness, women historically have far out-numbered men in the treatment and incarceration for it.[12] Contemporary studies suggest that women are one and a half to two times more likely than men to report or be diagnosed with depression and twice as likely to be prescribed psychotropic drugs.[13] Nonetheless, their stories do not feature prominently in public narratives. For women, long-held gendered archetypes of the hysterical or overly emotional

woman make public disclosure a far more treacherous path to navigate than it has become for men.[14]

The dominance of such notions has significant implications for the ways in which women can talk about mental illness. As Kimberly Emmons observes, 'while depression in men tends to be presented as a stark departure from "normal" feelings or emotions, depression in women is more likely to be understood as an outgrowth of women's complex emotional lives'.[15] For women whose lives have historically been lived within the 'private', domestic sphere, depression can be seen as an exaggeration of this state, when sufferers experience being overwhelmed with the quotidian demands of life.[16] These cultural and structural contexts of women's lives are entwined in their 'lifeworlds' – the 'routinely patterned everyday world in which [individuals] exist'.[17]

The intimate environment of an oral history interview creates a space in which women can attest to experiences of mental illness that diverge from the more visible accounts of prominent men in important ways. Talking about a world of relationships, family, and emotions is something for which women have an available language. Having spent time in therapy, the three women discussed in this chapter demonstrate an ease in telling their narratives of depression. In doing so they reflected different interpretive frames for their experiences and in particular the therapy they received: depression as circumstantial, as a result of trauma, as a chemical imbalance; therapy as treatment, as empowerment, as medication. They also revealed the ways in which public discourses have shaped individual subjectivities and offered individuals the language through which to contest gender ideologies and make sense of individual trauma.

These women are products of their times, which shape how lives unfold and how they make meaning of those experiences. Two of the women I discuss here – Sandy and Alison – come from the post-war, baby boomer generation. Suzie is of the next cohort, the so-called

Gen X. The major social changes which their lives traverse provide the context for their life experiences. One of the most dramatic changes was in the position of women and the new opportunities for them to pursue an education and career.[18] Second-wave feminism drove these broadening horizons and, in the notion that 'the personal is political', provided a new form of critique. Thus, at the same time as it was becoming more acceptable to talk about private life and private pain, feminism provided a language with which to analyse the political structures which formed the source of much of women's suffering.[19] The three stories examined here reflect the legacies of these two interlinked developments. Although the women did not necessarily identify as feminists, their lives and their stories reveal the impact of feminism on the opportunities available to them, and the ways they understood their experience of depression and the trauma.

Sandy

Sandy Carter (b. 1947) came from a working-class background and was the first in her family to finish high school. At the age of 13 she was assessed as over-stressed with the worry of exams and prescribed Valium for depression. 'When I was in school it was definitely seen to be something really wrong with me.... Now I see that there was something wrong with the circumstances ... it was a normal reaction to a bad situation.'[20] Sandy's 'circumstances' included a mother who suffered depression and took 'under-the-counter' weight-loss pills, which made her moody, volatile, and liable to 'take to her bed' for days. Sandy now interprets her mother's mental health issues, and those of her grandmother, as appropriate responses to their circumstances: poverty, difficult marriages and home environments, and social expectations that could not be met. With the exception of poverty, those conditions were repeated for Sandy.

In Sandy's narrative the mental health problems of her grandmother and mother were seen at the time to lie with the individual: they were the problem, not the circumstances, and

there was no ‘treatment’. In the mid-1970s, a time when ‘the normal thing was to take medication’, she was diagnosed with depression. ‘It was seen as something wrong with me ... and in retrospect, the same as my mother, it was the circumstances that were pretty difficult’. Only 18 months after the birth of her second child, Sandy ‘wasn’t doing that well.... For the next 20 years I was intermittently treated for depression because it became quite the thing to do ... if somebody wasn’t coping’.

Reflecting a shift in psychiatric thinking about the aetiology of depression, Sandy now locates the sources of her depression externally. In the 1970s, counselling ‘started out being how to convince you that the situation you were in was ok’ and working out how to put up with it. She believes the counselling and medical professions simply prescribed medication, rather than helping her – or other women – to address problems in their circumstances. By the early 1990s, Sandy came to see that her commitment to looking after her six children, keeping house, moving countries and cities regularly as she followed her husband for work came ‘at my expense’. Sandy’s husband had numerous extra-marital affairs and the marriage finally ended when she learnt that he had passed a sexually transmitted disease to her, and that a number of the illnesses and an ectopic pregnancy she had suffered could be traced to it. Sandy’s realisation that the marriage was making her physically and psychologically ill – that the situation, not herself, was the problem, – enabled her to leave the relationship. By this time, the attitudes she encountered in therapy was, ‘“maybe you’re right, maybe your circumstances are not ok and what do you want to do about it?”, which gave you a bit more independence – treated you like a normal person’.

Sandy’s understanding of her life history is refracted through the lens of the women’s liberation movement and its impact on popular and medical understandings of the family, gender roles, and the oppressive nature of patriarchal power, an issue she drew attention to in her EOI. The narrative arc of her interview moved from a life of significant restrictions to one

of greater independence and empowerment. As indicated through her mother's and grandmother's experiences, women's disempowerment had implications for their mental health, what Betty Friedan called 'the problem that has no name'.[21] Sandy linked her personal struggle with mental illness to the changing historical position of women, and her story of healing became a narrative where the cause of mental illness shifted from the individual to the environment. Evident throughout the interview is a feminist critique of patriarchy, which enacted a gender hierarchy to the detriment of women's mental health.[22]

The growing awareness of the oppressive nature of the family among the counselling services Sandy accessed, and the increasing legitimacy of those services, is also evident in her interview.[23] The initial blindness of counsellors or doctors to the role of Sandy's circumstances in her distress suggests an unwillingness or inability to question a model of marriage that saw it as the woman's responsibility to subsume her own needs in those of her husband. The shift between her earlier and later encounters with mental health care also reflects a growing awareness among health professionals and the general public of trauma as more commonplace (not just restricted to Holocaust survivors and war veterans) and as rooted in an external event, not a personal failing.

The challenge to traditional family structures that empowered Sandy to free herself from an abusive and exploitative marriage could also serve to fuel a backlash against women who dared to resist oppression. With greater financial resources and professional connections, Sandy's husband fought for and won custody of their three sons, claiming that she was 'abandoning her children'. The court's judgement hints at an insidious and pervasive mindset: what 'sane' mother would abandon her children? In choosing to leave her abusive husband, Sandy implicitly challenged the family structure – the core unit of patriarchal power. In doing so she jeopardised her capacity to be seen and treated as a responsible, capable mother. Sandy's experience points to the limits of the seemingly unlikely alliance

that developed between the mental health professionals and feminism, with the former lacking a critique of the revolutionary structural change needed to fundamentally alter power relations.[24]

Alison

Sandy's experience pin-points the decades of the 1970s and 1980s as a hinge for changing narratives of women and mental illness. Just five years younger than Sandy, Alison Fettell (b.1952) had a more positive experience navigating mental illness and accessing empowering support to escape a destructive marriage.[25] Alison also grew up in a working-class household in western Sydney with a mother who, like Sandy's, had struggled with depression. Alison described her mother as 'often sad', perhaps grieving the death of her second child, who died two days after birth. Alison and her siblings made their own way to school in the mornings, while her mother stayed in bed, 'in her own funk'. At the age of four, Alison was sexually abused by a neighbour, a 'white-haired old man'. She only recalled this abuse decades later, during a gynaecological examination by a doctor who 'was the spitting image' of her abuser. She 'freaked out' and had an 'instant memory' of the abuse. Alison identified this as a 'repressed memory' – a term which became used, somewhat controversially, in the 1980s and 1990s for the recollection of (usually sexual) abuse, sometimes decades after it had occurred.[26] Less repressed for Alison was the memory of sexual abuse endured over a number of years at the hands of the neighbour's son. He was a teenager—already 'a young man'—and she was 'probably six, seven, and eight'.

It was many years before Alison was able to deal with the legacy of this trauma. Her older abuser owned the foundry where her father worked. She described her father as her 'protector', but she felt unable to tell him, fearing that 'he'd have killed them ... or something would have happened and he would have lost his job'. She thinks she tried to tell her mother, but couldn't 'verbalise it properly'. When Alison subsequently remembered the abuse and

discussed it with her mother, her mother remembered that Alison used to hide behind her legs whenever the neighbour was around. Alison observed: 'but she didn't put it together, or chose not to – I don't, I don't know what'. The ambivalence in this comment suggests a wish perhaps that her mother had been more attentive to Alison's childhood distress and able to see her child's pain. Her mother had a breakdown about the time of the first abuse Alison suffered, compounding her sense of abandonment.

Alison is clear about the impact of the abuse. She blames the repeated abuse by her teenage neighbour for her 'incredible shyness', her inability to concentrate at school, and her consequent poor academic performance. Her suffering is evident in suicidal ideation at age 15: 'something in me jumped in front of that train but I was still on the platform'. Suicidal thoughts were the catalyst for Alison to leave school and find work. She married at 17 and had two children by the age of 20. In her mid-twenties she had her 'first hit with anxiety'. After the birth of her third child in 1982, at the age of 30, she suffered post-natal depression. Alison was careful to note that she did not think of hurting her child, but the three children 'were at risk of not having a mother'. Alison's clarification of this point suggests her awareness of the broader 1970s discussion about the prevalence of child abuse (physical and emotional, rather than sexual) and post-natal depression.[27] She sought help from a therapist, 'thinking they'd lock me up'. Instead, her 'sojourn into therapy' began. One of the therapists she saw taught her self-hypnosis and meditation: 'I think it saved my life.' The contrast with Sandy's experience is striking. Alison made no mention of being prescribed medication; indeed, she made no mention of seeing a doctor – it was a therapist who offered her life-saving strategies that she still practices for dealing with her depression.

Post-natal depression brought Alison to therapy, but that encounter led her to far-reaching insights about her past and present. Therapy helped her to recognise her husband's 'manipulative' behaviour and to acknowledge that by the time her daughter 'was about two,

the marriage was over and I was sleeping in the lounge room …. And I, I decided that, you know, I probably wasn't going to survive really if I stayed .... I thought that I would not exist. That I would almost be annihilated if I stayed.' Therapy gave Alison the tools for recognising the existential threat posed to her by her marriage and the fortitude to extricate herself.

Alison's narratives about her childhood abuse and dysfunctional marriage harness the feminist critique of the 1970s, which in turn informed the increasing attention on child sexual abuse that marked the 1980s. As Shurlee Swain notes, the '(re)discovery of child abuse in the 1960s was, by the 1980s, overwhelmed by a focus on child sexual abuse, characterised as the most extreme transgression of the supposed innocence of childhood.' Children were seen to be innocent victims, most vulnerable in the family home, a place 'made dangerous by the patriarchal power that it embodied.'[28] By the 1980s, child sexual abuse was a concern of legal, political, and media attention, with a focus on the mental health implications.[29] Although Alison did not use the language of 'trauma', her account draws directly from the feminist recognition of child sexual abuse as traumatic, with enduring legacies.

Feminism's critique of the traditional family called into question conventional notions of marriage and sexuality, opening up the possibility of a lesbian alternative. One of the other crucial factors in Alison's narrative about this time is her involvement in a women's soccer team. Here she found friendship, camaraderie, and a glimpse of an alternative life. A lesbian couple on the team was Alison's first encounter with homosexuality. Alison decided that she 'would possibly try what it was like to be with another woman'. Her first sexual experience with a woman was a 'defining moment', when she 'decided that [she'd] be staying on that side of the fence'. The axis of her lifeworld shifted, even if, as Alison notes, she was 'the only gay in the village' for many years.[30]

Therapy continued to feature centrally in Alison's narrative. In the 1990s, in a stable relationship with her partner, Alison found 'an excellent therapist in the city'. The work of

addressing the legacy of her childhood sexual abuse commenced in earnest. One day, 'on the spur of the moment', she decided to confront the younger of her two abusers. She found him at his work. Legs shaking, she 'sat opposite him with his big desk and just told him what I thought of him and got an apology. He said "What do you want from me?" And I said, "Just an apology. You need to know how important that was and how wrong it was and that I want to make sure you're not doing any of that again. And that you are sorry that you did it."' Buttressed by the support of her therapist (and her partner), Alison had grown from a 'incredibly shy' teenager to a courageous woman with an unflinching desire to face the traumatic legacies of her past.

Suzie

Despite different experiences of therapy, Alison and Sandy shared an understanding of emotional pain as intensely private, even if they appreciated its broader political context. Suzie Quartermaine, whose story opened this chapter, is of a younger generation than Sandy and Alison, and her experience of mental illness and the way she spoke about it reflects this generational difference.

In the mid-1970s, her maternal grandparents forced their unwed 17-year-old daughter to give Suzie up for adoption, despite the willingness of her paternal grandparents to raise her. Her adoptive parents had an adopted a son, and three years after Suzie's adoption, had a biological son. Aware that she was adopted, she had what she describes as a happy childhood in central Victoria.[31] Suzie's first encounter with mental illness was through her brother's schizophrenia. She described him as 'beautiful, kind hearted – all of that – but socially he just, his whole life he never fitted in'. One night, at age 30, he 'made himself a cup of coffee, put the coffee cup on the washing machine as he went out the laundry door for a smoke, and he never come back inside. He hung himself. Just spur of the moment'. Suzie was pregnant at the time and building a new house in Melbourne with her partner. Suzie 'couldn't really

plunge into too deep a depression. I was really aware of looking after my baby. But then I had Ava and her dad left me. So that all happened within five months'. Suzie's suggestion that her responsibility to her unborn child initially staved off depression supports her belief that her first experience of depression resulted from an accumulation of traumatic events, which shattered her resilience.

Suzie's partner had begun an affair while she was pregnant. With a three-week old baby and in the car on their way to choose carpet for their new house, he told her '"I don't want to be with you anymore"'. Suzie recalls: 'My God, I had this brand-new baby. Oh, brand new house that we hadn't even moved into and he just bailed on me'. The narrative of the deceitful male partner was a powerful one in Suzie's story, as it had been in Sandy's, with a marked impact on their mental health. Suzie moved back to Wangaratta to be close to her parents but, needing to distance herself from their grief over their son's recent suicide, she moved into her own place. That was 'when things got pretty dark for me. Um 'cause I was home alone with the baby all the time and she was so easy I had a lot of thinking time'.

In this period, Suzie regularly fantasised about suicide, planning how to kill herself and have someone find Ava. One night as she imagined this scenario, she looked down the hallway and saw her dead brother

> standing at the very end of the hallway and his eyes were burning bright like light. Like he was just staring at me. Not evil but like, 'You've gotta get past me first if you wanna go and do that'. That's the message I got from the way he was staring at me. And, yeah, never thought about it again after that.

In discussing her readiness to contemplate suicide, Suzie recalls that 'it took me a long time to fall in love with Ava'. She believes this to be the result of a very difficult labour, which Ava almost did not survive and a traumatic post-delivery experience. Desperate to save the baby, the doctors and nurses took her away and Suzie was left in the birthing room 'all by

myself in these stirrups'. Ava was in a humidicrib, which stymied Suzie's ability to bond with her newborn in the first few days of Ava's life. When discussing her readiness to contemplate suicide, Suzie observed that without a powerful connection to her baby, 'taking my own life didn't seem as bad'. Suzie sought help for her depression, saying that she 'did have counselling and stuff but at the end of the day it didn't change anything'. In light of her brother's death and her partner's betrayal, her depression was an appropriate response to her circumstances. Significantly, Suzie did not name this period of depression as 'post-natal depression', preferring to see it as a response to her life situation.[32]

Suzie got a job in Melbourne when Ava was 18 months old and began to reconstruct her life, but not for long. Suzie soon

> fell into a massive depression ... The first bout was circumstantial – I was just shattered. That second bout when [Ava] was about two was depression as diagnosed, chemical. Yeah, that was really bad. But I managed to hide it. Like I managed to keep working and all of that.

Prompted by a friend who had suffered depression, Suzie went to a doctor who prescribed medication and told her it would take about two weeks to work. 'And one day I'm lying on the couch—'cause that's all I'd ever do when I was at home—and I remember the moment those tablets kicked in. And this black fog just lifted and it was gone just like that. And I'm still on tablets today'.

Suzie's understanding of her different experiences of mental illness is striking and reflects two different ways of understanding and treating depression. The most significant factor in her first depression seems to be her partner's abandonment and financial abuse. Years later she came to believe that he had a 'fear of commitment' – a common cultural narrative about men in relationships – but at the time she experienced his desertion as deeply personal: 'I felt like I was nothing'. Suzie describes this first depression as 'so slow … it had

been kind of circumstantial. So I just, how can you change your circumstances? You can't really'. In contrast, during her subsequent 'massive depression', the circumstances did not seem to warrant the intensity of her experience and a clinical diagnosis and medication, and her strikingly positive reaction to the medication, seemed to confirm a chemical cause. All it took was a visit to a doctor: 'it was as easy as that really'.

The two types of depression Suzie talked about are known in the medical literature as 'reactive' depression, a response to life experience and circumstances, and 'endogenous' depression, a chemical imbalance in the brain. The idea that depression could be caused by a chemical imbalance – primarily low levels of serotonin – was first hypothesized in the 1960s and tested in the 1970s. In the 1990s a range of drugs to treat this 'imbalance' became widely prescribed. There is now considerable debate about the validity of the hypothesis that a chemical imbalance causes depression.[33] But for Suzie and millions like her, the belief that her depression had a chemical basis made sense and the drugs seemed to work.

When Sandy and Alison sought treatment for depression, the idea of it being caused by a chemical imbalance was not the dominant understanding. Sandy had been prescribed Valium not as fix for a chemical imbalance, but as treating something wrong with her emotional self-regulation, notably anxiety and depression. Both women posited the structural conditions of their lives and, in Alison's case, the childhood trauma of sexual abuse, as the underlying causes of their mental illness. In Suzie's narrative, the cause was alternatively her circumstances or faulty brain chemistry; the first she felt she had no control over, and the second seemed easily fixed.

Conclusion

The idea of 'life's circumstances' hides a multitude of meanings and factors. The lives of all three women, and the nature of their trauma, were profoundly shaped by gender, as was the telling of their experiences. Through their own experience of depression, Sandy and Alison

both came to understand that their mothers had also suffered depression and were not emotionally available, or, in Alison's case, able to protect her from the abusive, predatory neighbours. All three women were in relationships with men who were emotionally, physically, or financially abusive, or all three. They all suffered depression following the birth of a child; their reproductive lives were thus a powerful embodied context for the contours of their depression. As Jane Ussher observes in her discussion of the medicalization of 'women's misery', the 'very use of the medicalized term "depression"' amongst women in oppressive heterosexual relationships 'acts to depoliticize women's distress'.[34] The lifeworlds of all the women indict structural inequalities in the family and the broader culture and society.

In talking about their life circumstances, Sandy, Alison, and Suzie crafted the narrative arc of their stories in ways which reflected both their gender and their generation. Sandy's and Alison's narratives ride a wave of changing historical conditions, which offered them personal opportunities unavailable to their mothers. Propelling both their lives and their narratives, broader social changes, spurred largely by feminist liberationist ideas and agitation for women's opportunities, helped them to understand and escape oppressive relationships. Each woman seemed also to acknowledge, implicitly in Alison's case, and more explicitly in Sandy's, that the story she was telling had a political edge: Their intimate lives, including the experience and nature of their depression, exposed the truth of the 1970s feminist message that 'the personal is political'. Also telling, is the fact that neither mentioned their experiences of depression in their EOIs. This part of their story was revealed only in the context of the oral history interview. While the therapeutic culture has made talk of personal suffering acceptable, mental health was not revealed as a motivating reason for contacting the Australian Generations project.

Suzie's EOI showed no such reticence. Suzie came of age in a therapeutic culture, unlike the baby-boomers Sandy and Alison. Recent changes in media and entertainment have also affected a shift to a public confessional mode and have created an online culture of constant self–narrativisation, whereby Facebook and Twitter naturalise the generation of public narrative out of private experience. For Suzie, technology had played an important part in her recent period of deep mourning and depression following the loss of her mother. The iPhone, an invention she described as 'awesome', enabled her to maintain contact with the outside world when she felt unable to be physically social.

Aged 38 when I interviewed her, Suzie's life story was not as distilled as Sandy's or Alison's, whose narrative arcs are clearer to them in the fullness of time. Her EOI suggested that it was her 'strength and education' which 'brought [her] back from the brink of [her] own suicide and depression', reflecting, perhaps, the currently vogue idea of resilience as the antidote to trauma and mental illness. Subsequent events challenged that trajectory. Whereas feminism had been central to the older two women, it was taken for granted in Suzie's narrative. 'I never let being a girl stop me doing anything' she observed confidently, and was determined that she would not repeat the gendered division of labour which had characterised her parents' marriage. But gender shaped her life in other ways: in her choice to be a pre-school teacher (and the lack of other options put forward by the school's career counsellor); in the trauma of her daughter's birth; in her financial and emotional vulnerability when her partner deserted her; in raising a daughter as a single mother; in the depression she suffered as she grieved the dramatic, rapid changes in her circumstances. Despite these reproductive and economic constraints, Suzie implicitly rejected the idea that her gender might have limited her options, or that she might want to pursue a career: 'It hasn't been about my career at all. 'Cause, you know, being a single parent, you just have to do what you can'. For Suzie, being a mother was her 'number one job'. In claiming the importance of her work as a

mother, Suzie was also creating a narrative she could live with.[35] She asserted choice in the context of shattering events beyond her control.

A further way in which the narratives of all three women are shaped by gender is their focus on the intimate, domestic nature of their circumstances and their pain. Their narratives not only reveal the embodied nature of mental illness and its relationship to women's reproductive lives; they take us into the heart of their relationships and expose the ways in which, as the opening chapter in this book argues, much of women's trauma is a function of everyday life experiences. This is in stark contrast to the public narratives of elite men's struggles with depression where the context and pressure of their professional lives appears to trigger an emotional unravelling. In men's public 'truth-telling' about mental illness, their narratives of depression invariably describe 'falling into' an intensely emotional space – one usually reserved for women – and an emergence from it with the aid of medication. Depression is thus an aberration, although the idea that it is acceptable for some men – particularly privileged white men – to talk about their emotional state and thus challenge dominant understandings of masculinity, has been welcomed by many.[36] For Sandy, Alison, and Suzie, who as women are culturally identified as more emotional than men, their narratives of depression suggest an extension and intensification of that emotional, domestic realm. In the arc of their life stories, coming out of depression is expressed as an entry, and for Suzie a re-entry, into the possibilities of education and employment.

Women's entry into public life carries many perils, including the risk of being seen as too emotional and, relatedly, too bound by the hazards and demands of our reproductive capacities. It has thus been important for women to cordon off their private selves from their public, professional lives. To speak openly about mental illness risks being seen as an unstable woman and a possible risk to one's children. Sandy's experience is a reminder of this harsh reality and the potential for charges of madness or mental instability to be

mobilised against women. Alison's explicit assurance that despite her own profound depression she was not a risk to her children, echoes this fear. In this context, the private narrative of sexual or domestic trauma bequeathed by feminism is far more empowering: if a woman's mental illness is rooted in patriarchy's treatment of her, as opposed for example, to a biologically determined emotional instability, then a safer space is opened in which women can articulate their narratives of trauma with less risk to their position in the family. Freed from her oppressive husband for example, a mother's mental health can stabilise and her capacity to care for her children be enhanced.

The stories of the women discussed here remind us that mental health constructs, such as trauma, depression, and their treatments, have a history. The readiness of Sandy, Alison, and Suzie to talk about their periods of depression reflects the therapeutic culture in which they live, just as their experiences reflect changes in that culture over time. Suzie's second and most recent experience of depression (c. 2007) suggests the increasing use of medication as a treatment; her understanding of it as a chemical imbalance reveals both the pathologisation of depression as an illness at the same time as suggesting the return to an understanding of the individual as the problem, even if its basis is 'chemical'. Given the preponderance of women amongst the sufferers of depression, this has significant implications for how women are treated and how they understand their condition. Sandy and Alison's stories suggest the importance of feminism, as critique and as a social movement, in enabling them to make sense of their lives and their psyches. The more depression is viewed and treated as a chemical imbalance, the easier it will be to dissociate it from the circumstances of women's lives and the cultural context in which they live. And the more readily the political and structural nature of women's private trauma will be rendered, once again, invisible.

My thanks to Lindsey Earner-Byrne for the conversations which helped shape this chapter, the Melbourne Life Writers and Christine Brett-Vickers for their helpful suggestions on earlier iterations of it and the editors for excellent work. The Australian Generations project was funded by an Australian Research Council Linkage Grant, supplemented with financial and in-kind contributions from the National Library of Australia, ABC Radio National, Monash University and La Trobe University.

References

1 For further discussion about the extent of mental illness amongst participants in the Australian Generations project, see, Katie Holmes, 'Talking about Mental Illness: Life Histories and Mental Health in Modern Australia', *Australian Historical Studies* 47, no. 1 (2016): 25–40. Although the three women discussed here were from different generations, they shared the privilege of being white women in a country where the rates of mental illness amongst Aboriginal women far exceed that within the majority white population.

2 For an extensive discussion of the medical history of the term 'depression', the association of women with it, see Jane M. Ussher, 'Are We Medicalizing Women's Misery? A Critical Review of Women's Higher Rates of Reported Depression', *Feminism & Psychology* 20, no. 1 (2010): 10-11, 24.

3 I have discussed elsewhere the ways that key structural patterns of class and gender inequality shape the stories about mental illness. See, Holmes, 'Talking about Mental Illness'.

4 The Australian Research Council funded the Australian Generations Project (2011-14), which was a collaboration between Monash University, LaTrobe University, the National Library of Australia, and the Australian Broadcasting Commission. Each of the interviews ran approximately four hours long and traversed the life course of the interviewee.

5 Katie Wright, *The Rise of the Therapeutic Society: Psychological Knowledge & the Contradictions of Cultural Change* (Washington, DC: New Academia, 2011), 8.

6 On social practices and cultural artefacts of the therapeutic culture, see Wright, *The Rise of the Therapeutic Society,* 1–2. For a discussion of the rise of the therapeutic culture in Britain, see Hera Cook, 'From Controlling Emotion to Expressing Feelings in Mid-Twentieth-Century England', *Journal of Social History* 47, no. 3 (2014): 627–646. For discussion of the life history interview, see Alexander Freund, '"Confessing Animals": Toward a Longue Durée History of the Oral History Interview', *Oral History Review* 41, no. 1 (2014): 1–26.

7 Katie Wright, 'Speaking Out: Representations of Childhood and Sexual Abuse in the Media, Memoir and Public Inquiries', *Red Feather Journal* 7, no. 2 (2016): 25.

8 Wright, *The Rise of the Therapeutic Society*, 21. Joseph E. Davis locates the first public articulation of child sexual abuse as a narrative with the victim at its centre, as occurring in New York in 1971 at the New York Radical Feminist's first conference on rape. Davis suggests that the power of this new narrative was its bringing together the discourses from 'child protection and antirape movements' and their attention to 'the victim of abuse and emphasis on victim innocence and injury.' Joseph E Davis, *Accounts of Innocence: Sexual Abuse, Trauma and the Self,* (Chicago: University of Chicago Press, 2005), 29.

9 See Davis, *Accounts of Innocence,* ch 9 for an extended discussion of this issue, and the implications of an approach where sexual abuse becomes a 'signifier of psychological problems' (9) in adults, irrespective of other circumstances.

10 The list is long, including West Australian Premier Geoff Gallop; former federal Minister for Trade, Andrew Robb; Federal Court judge Justice Shane Marshall; actor Garry McDonald; footballers Nathan Thomson, Wayne Schwass and Alex Fasolo; Olympic swimmers Kieran Perkins and Ian Thorpe; businessman James Packer. See, Wright, *The Rise of the Therapeutic Society*, 171–72.

11 https://www.news.com.au/charlotte-dawson-found-dead-after-long-and-public-battle-with-depression/news-story/4d3f4302f5fad49af82ffab4b90e6e8e Accessed 26 April 2019. Other

examples of prominent women who have spoken publicly about their mental illness include Queensland parliamentarian Linda Levage and sportswomen Lauren Jackson and Jana Pittman. The greater readiness of younger women to speak and write about their experiences of mental illness is reflected in two 2019 publications: Clare Bowditch *Your Own Kind of Girl* (Crows Nest: Allen & Unwin, 2019); and Georgie Dent, *Breaking Badly: How I worried myself sick* (South Melbourne: Affirm Press, 2019).

12 Barbara Taylor, *The Last Asylum: A Memoir of Madness in Our Times,* (London: Hamish Hamilton, 2013), ch. 19. See also Jill Julius Matthews, *Good and Mad Women: The Historical Construction of Femininity in Twentieth-Century Australia* (Sydney: George Allen & Unwin, 1984). For a more detailed discussion of the over-representation of women amongst those being treated for mental illness, see, Bernadette C. Hayes and Pauline M. Prior, 'Women as the "Madder" Sex', in *Gender and Health Care in the United Kingdom: Exploring the Stereotypes*, ed. Bernadette C. Hayes, Pauline M. Prior, and Jo Campling (London: Macmillan Education UK, 2003), 123–39.

13 M. Piccinelle and F.G. Homen, *Gender Differences in the Epidemiology of Affective Disorders and Schizophrenia* (Geneva: World Health Organisation, 2007). See also Jane M. Ussher, 'Are We Medicalizing Women's Misery?'.

14 Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980,* (New York: Pantheon Books, 1985); Phyllis Chesler, *Women and Madness,* (New York: Doubleday, 1972).

15 Kimberly Emmons, 'Narrating the Emotional Woman: Uptake and Gender in Discourses on Depression', in *Depression and Narrative: Telling the Dark,* ed. Hilary Anne Clark (Albany: State University of New York Press, 2008), 112.

[16] Suzanne England, Carol Ganzer, and Tracy Tosone, 'Storying Sadness: Representations of Depression in the Writings of Sylvia Plath, Louise Gliick, and Tracey Thompson', in *Depression and Narrative: Telling the Dark*, 83–84.

[17] The terms comes from phenomenologist Edmuns Husserl. See Cook, 'From Controlling Emotion to Expressing Feelings in Mid-Twentieth-Century England', 630.

[18] Michelle Arrow, *The Seventies: The Personal, the Political and the Making of Modern Australia* (Sydney: NewSouth, 2019), 11.

[19] Jenny Kitzinger, 'Transformations of Public and Private Knowledge: Audience Reception, Feminism and the Experience of Childhood Sexual Abuse', in *Memory Matters: Contexts of Understanding Sexual Abuse Recollections*, ed. Janice Haaken and Paula Reavey (London, New York: Routledge, 2009), 86-104.

[20] Closed interview, pseudonym.

[21] Betty Friedan famously suggested that post-war American women's widespread unhappiness and fatigue was related to their lack of fulfillment in their roles as wife/mother/housewife. She described this as 'the problem that has no name'. Betty Friedan, *The Feminine Mystique* (Melbourne: Penguin, 1963), 16.

[22] Feminism has also been highly critical of the therapeutic culture and the tendency of the therapeutic to be oppressive of women. See Wright, *The Rise of the Therapeutic Society*, 36–37; Matthews, *Good and Mad Women*.

[23] For a discussion of the rise of the counselling profession in Australia see: Wright, *The Rise of the Therapeutic Society*, ch 4.

[24] On the alliance between the mental health professions and feminism, see Eva Illouz, *Saving the Modern Soul: Therapy, Emotions, and the Culture of Self-Help* (Berkeley: University of California Press, 2008), 115, 122. For a feminist critique of this argument, see Ussher, 'Are We Medicalizing Women's Misery?'.

[25] Alison Fettell, interview by Roslyn Burge, August 25 and 26, 2014, Australian Generations Project, transcript and audio recording, National Library of Australia, Canberra, https://catalogue.nla.gov.au/Search/Home?lookfor=Fettell%2C+Alison&type=all&limit%5B%5D=&submit=Find&limit%5B%5D=format%3AAudio

[26] For an extended discussion of the 'Memory Wars', see Davis, *Accounts of Innocence*, ch 8. See also Janice Haaken, 'Transformative Remembering: Feminism, Psychoanalysis, and Recollections of Abuse', in *Memory Matters* eds. Haaken and Reave.

[27] Arrow, *The Seventies*, 167.

[28] Shurlee Swain, 'Giving Voice to Narratives of Institutional Sex Abuse', *Australian Feminist Law Journal* 41, no. 2 (2015): 289, 293.

[29] Kate Gleeson and Timothy Willem Jones, 'Feminist Contributions to Justice for Survivors of Clerical Child Sexual Abuse', *Australian Feminist Law Journal* 41, no. 2 (2015): 202. See also Dorothy Scott and Shurlee Swain, *Confronting Cruelty: Historical Perspectives on Child Protection in Australia* (Carlton: Melbourne University Press, 2002), ch. 9; Wright, 'Speaking Out', 21.

[30] For a broader discussion of the relationship between women's liberation and lesbianism, see Arrow, *The Seventies*, 63–70.

[31] Suzie Quartermaine, interview by Katie Holmes, 16 April 2013, Australian Generations Project, transcript and audio recording, National Library of Australia, Canberra, https://catalogue.nla.gov.au/Record/6290934?lookfor=quartermaine%20%23[format:Audio]&offset=3&max=3. For further details about Suzie's life and excerpts from her transcript, see, *Australian Lives: An Intimate History,* eds Anisa Puri and Alistair Thomson, (Clayton, VIC: Monash University Publishing, 2017). Suzie's story of discovering the details of her biological parents can be found on pp.141-42. For Alison Fettell's story see *Australian Lives*, especially pp 60-2, 170, 258-60, 365-66.

[32] Suzie's symptoms and circumstances are well recognised as risk factors for postnatal depression. See: https://www.panda.org.au/images/resources/Resources-Factsheets/Anxiety-And-Depression-In-Early-Parenthood-And-Pregnancy.pdf

[33] See Johann Hari, *Lost Connections: Uncovering the Real Causes of Depression - and the Unexpected Solutions* (London: Bloomsbury, 2018), 33. See also Jane M. Ussher, 'Are We Medicalizing Women's Misery?', 14-15.

[34] Ussher, 'Are We Medicalizing Women's Misery?', 21.

[35] The phrase comes from Alistair Thomson. See, Alistair Thomson, 'Anzac Memories: Putting Popular Memory Theory into Practice in Australia', *Oral History* 18, no. 1 (1990): 25-31.

[36] Wright, *The Rise of the Therapeutic Society*, xx. Class remains a determining factor in both ideas and expressions of masculinity. Elite men have benefitted from a feminist movement that allows them a broader range of masculine behaviour, including the ability to break with gender conventions in relation to the expression of emotion and discussion of mental illness, without compromising masculinity.

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