New Workers – Depressed Workers

A Discursive Investigation of the Experience of Depression in the Workplace

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Certificate of authorship/originality

I certify that the work in this thesis has not previously been submitted for a degree, nor has it been submitted as part of requirements of any other degree except as fully acknowledged within the text.
I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

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Lorraine Heather West

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Abstract

This thesis arose out of my professional engagement as a therapist, with people suffering depression, and from my recognition of the significance of such people's workplace experience in times of significant workplace change. Worker depression is now widely identified as a significant and growing problem by employers, by governments and by international authorities such as the World Health Organisation. By the end of the 20th century, it had become a significant site for policy, leading to the collection of data and the development of management 'tools' at all these levels. Actions formed by such new policy range from workplace interventions to the establishment of government-funded bodies, such as *beyondblue* and the *Black Dog* Institute in Australia, charged with both research and information dissemination.

An understanding of the context in which depression is increasing requires an exploration of two 20th century phenomena: on the one hand, the changing workplace of the advanced capitalist societies; and on the other, the ways in which depression itself has come to be diagnosed and treated, and consequently understood, as a medical phenomenon. There is a substantial literature on the contemporary workplace, and on the diagnosis, treatment and management of depression. Very little is available, however, dealing with the experience of individual workers who have been diagnosed with depression. This is the area the thesis is concerned to explore.

In order to undertake this task, two significant methodological moves have been made, away from the 'realist' orientation of much of the available literature. The 'genealogical' move, drawing on Foucault, is the move concerned to understand how things are as they are and not otherwise, to ask questions such as: How has depression come to be a more and more common diagnosis in the late 20th - early 21st centuries? What is it about workers' experience of the workplace that is making such diagnoses more likely? Might it be the case that more workers are increasingly unhappy and that unhappiness, particularly manifested somatically, through bodily 'symptoms', is increasingly likely to be diagnosed and treated medically, as depression? The 'discursive' move, drawing on Foucault, together with Nikolas Rose and Judith Butler, is the move that works with the understanding that selves are not simply given, existing autonomously. Rather, persons are constituted as selves – as subjects – in and through their active participation in the social worlds they come to inhabit. The mechanisms of

this participation are the characteristic ways of acting and speaking – the discourses – of social institutions. Learning such discourses involves not only learning how to act appropriately but also to become a certain kind of self.

For workers in the neoliberal workplace, this means learning to be the autonomous, flexible worker of overt requirements while simultaneously learning to live with increased demands for hours of work and levels of work output, together with escalating levels of surveillance. It is not surprising that many workers experience this workplace as increasingly stressful. Such stress, when medically diagnosed and treated as 'depression', offers a new kind of subject position to those affected.

The heart of the thesis is an interview study which explores the narrative stages a set of workers diagnosed as depressed detail as they account for their progressive 'resubjectification' as depressed workers. Five stages, involving the narrative positioning of different selves or subject positions, are identified from detailed readings of the interview data: these are the narrating of psychologising, internalising, somatising, medicalising and pharmacologising positionings. The identification and naming of these stages draws substantially on the work of Nikolas Rose and his identification of key 20th century selves. The identification of these as narrative or discursive stages in the retrospective reconstruction of resubjectified selves is the original contribution of this thesis.

Prologue

This research evolved through my professional practice as a Systemic Family Therapist (SFT) practitioner, facilitating a post-discharge, year-long psychotherapy group with people diagnosed as depressed. The context of the research, set within my professional practice, draws on the detailed narratives of group participants' experiences of workplace change and the subsequent effects on their lives. Over the course of a year-long psychotherapy group, I noticed the repetitive pattern of stories being told about how changes in the workplace had contributed to increased levels of stress, with a consequential diagnosis of depression. Surprisingly, despite individual differences – in age, workplace, occupation, gender and number of years of employment – the group participants all told versions of the same story. All participants detailed rapidly changing workplace practices in terms of downsizing, relocation, corporate mergers, increased responsibility with reduced numbers of staff, increased financial targets, increased workplace surveillance and accountability and so on.

These workplace change stories had not been accounted for in the management of participants' depression in the hospital setting. Inpatient management had focused on the provision of a supportive therapeutic environment, daily depression and anxiety groups, pharmaceutical interventions and regular medical consultations to monitor their medical progress. It became clear from their narratives that, while workplace changes had not been deemed relevant to the diagnosis of depression, by either health professionals or patients themselves, the effects of workplace change had nevertheless emerged as a common theme within this group.

Chapter 1

Worker depression: a new site for policy

Introduction

Depression has a long history in western culture. From the Ancient Greeks to the Elizabethans and beyond it was known as melancholy, from its supposed origins in an excess of black bile in the body of the sufferer. In the 20th century it has come to be generally referred to as depression, referring to the lowering of spirits, or mood, that is characteristic of the condition, along with a decreasing ability to act and to experience pleasure, a growing sadness and, at its most severe, thoughts of or even the carrying out of suicide. These characteristics have been described consistently over this period, or 'anatomised' as Robert Burton has it in his monumental study, *The Anatomy of Melancholy*, first published in 1621.

Depression has been variously treated and prescribed for. In the 17th century, blood-letting or phlebotomy was one of the most common forms of medical therapy. According to the theory behind this practice, a mystical equilibrium between several bodily fluids maintained human life. Excess blood would disturb the balance and result in illness (Burton 2001, p. 237). Blood-letting prevailed until the 18th century. The current era has seen the rise of the selective serotonin-uptake inhibitors (SSRIs), based on the hypothesis of a serotonin imbalance in the brain as the cause of depression (see Chapter 2). Only in the late 20th century, however, has depression become a site of public attention and, most particularly, of public policy. What seems to have turned depression into such an object is a steady increase in the incidence of depression, including worker depression. This chapter sets out to give an overview of the scale of the increase, as documented by international and national health and labour bodies, and of responses to that increased incidence as background to the specific research questions of this thesis, with which the chapter concludes.

There have been two kinds of organisational response to the increased incidence of depression: first, by national governments in terms of policy initiatives; second, in terms of institutional responses to worker depression by the medical profession and by human resources practitioners within workplaces, that is, by those directly involved with workers experiencing depression. This chapter will provide only a snapshot of

responses to this contemporary problem. It will be the task of the next chapter to provide a more fine-grained account of changes through the course of the 20th century to, respectively, the workplace and the diagnosis and treatment of depression. The intention, in approaching that task from a genealogical perspective, is to shed light on how the current state of affairs has come about. The material of Chapter 2 suggests that a complex interaction has taken place between actual conditions of work for many late 20th century workers and the patterns of diagnosis and treatment of worker unhappiness at a time of widespread availability and medical prescription of new forms of medication.

The work of this introductory chapter begins with an essentially realist account of current perspectives on worker depression. From this springboard, a series of questions will be raised which identify possible strategies for understanding the 'problem' of worker depression. It is within this context of possible questions and research strategies that the actual research questions of this thesis will be articulated. The chapter concludes with an account of the overall structure of the thesis, including chapter outlines.

1.1 The increasing incidence of depression

Depression has changed during the course of the 20th century from being a stigmatised and privatised personal phenomenon to being a significant object of public attention and policy at national and international levels. What seems to have brought about this change is evidence of the increased incidence of depression worldwide, including increased levels of worker depression. For much of the 20th century, depression was experienced as individual suffering by relatively small numbers of people. By the end of that century, depression was no longer hidden but acknowledged as a significant and growing problem that needed to be addressed.

The major international bodies concerned respectively with health (World Health Organization – WHO) and with work (International Labour Organisation – ILO) have identified and expressed concern at increasing levels of depression worldwide. Various kinds of numerical accounts suggest the perceived scale of the problem. WHO suggests that depression is now second only to heart disease as the cause of worker disablement in the Geneva ILO News, a Reuters report detailing the findings of the ILO survey. The

nature of the concern, as well as the scale of the problem, is spelled out as follows by WHO:

> Depression is an important global public health problem due to both its relatively high lifetime prevalence and the significant disability that it causes. In 2002, depression accounted for 4.5% of the worldwide total burden of disease (in terms of disability-adjusted life years). It is also responsible for the greatest proportion of burden attributable to non-fatal health outcomes, accounting for almost 12% of total years lived with disability worldwide. Without treatment, depression has the tendency to assume a chronic course, to recur, and to be associated with increasing disability over time (World Health Organization, 2007)
>
> Retrieved July 26, 2007 from http://www.who.int/whosis/whostat2007_10highlights.pdf

The data on the increasing incidence of depression is articulated in three ways: in terms of the predicted growth in the percentage of overall disease burden, in terms of estimates of the percentage of population affected and in terms of costs. While the data on overall disease burden and on cost are articulated very precisely, though not always in ways which make for easy comparison between countries, estimates of the numbers of people involved tend to be more impressionistic, drawing more on the rhetoric of journalism, perhaps, than the hard figures of the economist. For example, the 2000 ILO survey examines mental health in the workplace in Finland, Germany, Poland, United Kingdom and United States. The rising costs of workplace stress, with depression increasingly common, suggest that in a work context:

> One in ten office workers in Britain, the United States, Germany, Poland and Finland suffers from depression, anxiety, stress or burnout. Information glut resulting from technological advances, the pace of globalization, dysfunctional office politics, work insecurities after a decade of downsizing are some of the main contributors. Depression in the workplace is now the second most disabling illness for workers after heart disease, according to the survey by the World Health Organization, the International Labour Organization (ILO 2000) survey found (Geneva ILO News) (Reuters report detailing the findings of the ILO survey).

And, even more impressionistically, the Australian Institute of Health and Welfare suggests that, '[e]veryone will at some time in their life be affected by depression, their own or someone else's' (1998, p. 21).

With respect to cost, the story becomes more complex. For governments, the costs include health care, insurance payments and the loss of income at a national level (Gabriel & Liimatainen, 2000). These costs can be expressed both as monetary figures but also as a percentage of GDP, making comparisons across nations possible. Thus, for

example, the 2000 ILO survey estimates the cost of workplace stress in the European Union at 3–4% of Gross National Product (GDP), with a similar amount being spent on related mental health.

The Australian Bureau of Statistics report, *Mental Health in Australia: a snapshot 2004-05* (2006, p. 2), groups mental health and behavioural problems under the following headings: anxiety disorders; mood disorders (including depression); alcohol and drug use disorders. Half of all persons reporting mental health and behavioural problems in the 2004-05 National Health Survey had mood (affective) disorders such as dysthymia (chronic depression) and major depression. The ABS estimate of expenditure on mental health services in Australia was $3 billion, accounting for 38.4% of total recurrent health expenditure in 2003-2004. *Beyondblue*, the national government-funded depression initiative, casts a somewhat wider net in estimating the cost of depression to the Australian economy. Its current figures indicate that:

> Depression costs the Australian economy $3.3 billion in lost productivity each year. Six million working days are lost with another 12 million days of reduced productivity. Economic studies indicate that each employee with untreated depression and related conditions will cost their organisation nearly $10,000 a year (2007, par. 5) Retrieved January 25, 2009 from http://www.beyondblue.org.au/index.aspx?link_id=4.66&oid=418.

A significant element of the cost of worker depression is costs to workplaces themselves. Direct costs include those associated with high rates of labour turnover and increased costs of recruiting and training staff and, where employers are responsible for this (as in the USA), health insurance. Indirect costs are those connected with reduced productivity, including absenteeism (its 'visible' face) and 'presenteeism' (where workers are physically present but their capacity to work effectively is significantly impaired). These costs are reported to be escalating. For employers, costs in the USA were estimated to be more than US$51 billion per year in 1996 in absenteeism and lost productivity, excluding medical and pharmaceutical bills. By 2000 these costs had risen to $83 billion, 69% of which was for lost employment, sick leave and premature mortality (Greenburg, Kessler, Birnbaum, Leong, Lowe, Berglund, & Cory-Lisle, 2003; Berto, D'Ilario, Ruffo, DiBirgilio, Rizzo, 2000).

1.2 The emergence of depression as a site for policy

The compilation of statistics on the incidence and costs of depression, both internationally and nationally, is indicative of a new policy context leading increasingly to active intervention at the national level. Such intervention is centrally concerned with early identification of depression, with a view to earlier treatment. Early intervention is intended to minimise the severity of individual episodes of depression and hence significantly reduce costs.

The world-wide context within which interventions can be located is summarised by WHO in terms of the following four statements about depression:

- it is common, affecting about 121 million people worldwide;
- it is among the leading causes of disability worldwide;
- it can be reliably diagnosed and treated in primary care;
- fewer than 25 % of those affected have access to effective treatments (World Health Organization, 2008). WHO initiative in public health. Retrieved November 5, 2008 from http://www.who.int/mental_health/management/depression/depressioninph/en/

To this health and treatment focus, the second relevant international body, the ILO, adds a workplace perspective and points to the specific nature of the economic effects of depression in the workplace. The OECD, a major regional player, spells out the human capital thesis underpinning economic activity in the European Community, where human capital is conceptualised as 'the knowledge, skills, competencies and attributes that allow people to contribute to their personal and social wellbeing, as well as that of their country's' (Keeley 2007, p. 3).

In expressing agreement with such a conception, the Council of Australian Governments (COAG, 2006) incorporates 'health outcomes' as 'a significant determinant of Australian living standards', while the health of the worker 'determines their capacity to participate and be productive in the workforce' (p. 18). An increasing understanding of the nexus between health and economic productivity with respect to mental health issues, especially depression, has led to ongoing commitment to *beyondblue*: the national depression initiative. Established in 2000 and funded by the Commonwealth in conjunction with the State Governments, *beyondblue* initially was given only token support by some states. In 2005, however, support was extended for a

further 5-year period with more substantial resources. *Beyondblue* was established to play 'a key goal in raising community awareness about depression and reducing stigma associated with the illness' (2008, p. 1). In taking on such a task, it is mindful of the difficulties:

> *beyondblue* was established in the Australian context of the World Health Organization's projections of an increasing global burden caused by depression. Depression is currently the highest medical cause of disability worldwide and predicted to be the second highest medical cause of death and disability worldwide by 2020. Few countries have attempted a national response and other national programs that have attempted to engage the wider community to change attitudes on mental health have had limited success. Retrieved October 9, 2008 from http://www.beyondblue.org.au

A central, overarching concern in the national and international attention to depression seems to be the escalating cost of worker depression, both for nations and for employers. Costs involved are both direct, in terms of medical and pharmaceutical expenses and health insurance, and indirect, in terms of lost productivity. Depending on the nation, direct costs may be entirely borne by government, as in Australia with its national medical insurance and pharmaceutical schemes, or partly by employers, as in the United States, where the workplace is the major source of health insurance and medical costs. Indirect costs are borne by employers in terms of worker absenteeism and 'presenteeism'. The increasing cost to US employers must be regarded as a significant factor driving the scale and focus of medical and human relations concerns in that country, and the nature and extent of both research and intervention in worker depression.

Apart from international bodies concerned with health and labour and national governments, a range of other institutional bodies have an interest in worker depression. These include medical bodies, particularly involving psychiatry and occupational medicine, employers and employer bodies, unions and their peak bodies, such as the Australian Council of Trade Unions (ACTU) in Australia, and human resources practitioners. Their interests encompass identification and treatment, costs, prevention and causes. Much of the concern of such bodies is articulated through the gathering of data on incidence and costs and through participation in preventative programs aimed at early identification leading to treatment. Research with an orientation to identifying contributing factors in the workplace itself has not been dominant. Where such research does exist, it is likely to draw on a generalised notion of 'worker stress', not always

noting factors in the contemporary workplace itself which might be contributing to an increase in stress. The concluding section of Chapter 2 will specifically address this research literature, in the context of the exploration of work and depression through the 20th century.

This chapter merely identifies a number of the bodies which have indicated an interest in workplace depression and the broad nature of their concern. There are important critical literatures on depression from within feminisms. In this study the choice was made not to focus on feminist critical literature because the study was designed to take up post diagnosis issues not pre diagnosis issues. As noted in the prologue, there were no overt signs of gender difference in the stories told by the group participants – they all told versions of the same story. The focus of the study was not on gender, but a set of relationships between work and the conditions that led to the diagnosis. These feminist literatures are an important resource for further studies.

Medical bodies include the American College of Occupational and Environmental Medicine and the American Psychiatric Association in the United States and, in Australia, The Black Dog Institute. The American College of Occupational and Environmental Medicine publishes the *Journal of Occupational and Environmental Medicine* and its last issue for 2008 focused on worker depression.

The American Psychiatric Association (APA), through the associated American Psychiatric Foundation, has had a more active involvement with the issue through the publication *Mental Health Works* (2007). The focus of this publication is summed up in its slogan – 'A mentally healthy workforce – It's good for business'. This program has been developed in collaboration with J P Morgan Chase, a major global financial service operating in fifty countries. Such a collaboration between medicine and business suggests a particular way of operationalising the human capital thesis referred to above, as it is presented in this publication: 'Investing in a mentally healthy workforce is good business, for it lowers medical costs, increases productivity, lowers absenteeism, raises presenteeism and decreases disability costs for the organisation' (2008, p. 1).

The focus, not surprisingly, is on returning depressed workers to work as soon as possible. The most effective way of achieving a productive return to work needs to be carefully thought through, however. Researcher Daniel J. Conti, Vice President and Director of EAP, and Medical Director, Wayne N. Burton of JP Morgan Chase, note

that the scenario laid out in the following interview fragment is hardly a plan for getting back to work:

> Employee: I saw my doc. The doc says I'm depressed and I need to be off from work. He gave me a prescription and said come back in six weeks.
>
> Employer: What are you going to do for the next six weeks?
>
> Employee: I don't know—just stay at home I guess (Conti 2007, p. 7).

Conti (2007) notes that: 'Medication alone will not remotivate or revitalise the employee—some form of psychosocial intervention is required to get an early return to work' (p. 4). Further, 'It's important to separate true disabilities from workplace issues, such as facing the stigma of illness or dealing with escalating interpersonal issues as work' (p. 4). Conti explains that, wherever possible, short-term disability should be managed within the company:

> By bringing disability inside the company, JP Morgan Chase is better able to monitor cases, understand the interplay of work and health, and assure that people have follow–up and support in the workplace. Our goal is not for managers to start diagnosing employees … but to teach them how to intervene appropriately and effectively and how to get the employee to the right workplace resource, before the problems reach the threshold of disability (2008, p. 4).

Such an approach, 'bringing disability inside the company', is undoubtedly in step with the epidemiological perspective at the international and national policy level, which has made the phenomenon of increased worker depression increasingly visible. There is, however, an ongoing but barely articulated tension between this visibility and the individualised approach to diagnosis and treatment: the predominant medical approach is in terms of an imbalance in individual brain chemistry leading to individualised treatment with appropriate pharmaceutical products. Such an individualised approach is in effect a continuation of the centuries-long view of depression as an individual pathology, with its origins in some personal or moral inadequacy or fault in the individual (the view which led to denial and stigmatising in the past) or as a biochemical malfunction (the dominant contemporary view). Combined with this individualised medical perspective on treatment and diagnosis, contemporary human resources practice is based substantially in psychology, a form of knowledge predominantly concerned with the functioning of the individual.

Such individualising orientations make it less than surprising that, despite the massive changes in work over the course of the last century, consideration of the workplace

itself as a causative agent in the increase in the diagnosis of depression has not been a major focus of attention, either by doctors and psychiatrists or by specialists in human resources in the workforce. The recent issue of the *Journal of Occupational and Environmental Medicine* devoted to worker depression, discussed in some detail in Chapter 2, is a case in point. The issue of stress, which can be understood and responded to medically in individualised ways, is certainly raised. But issues concerning the changing nature of work, much less its changing meanings and the consequences for workers are rarely addressed.

This thesis is concerned with precisely such questions, in a context where

- depression is predominantly understood medically in biochemical terms, not as unhappiness and
- work is seen in terms of a productivity/profit/consumption nexus rather than in terms of meaningful activity that contributes directly to the welfare of workers and their immediate community.

Given that the 20th century has been a time of extraordinary change in work in advanced capitalist/postindustrial societies, the nexus between depression and work suggests a fertile field for research investigation. The focus of this thesis is on the lived experience of a small number of people diagnosed with depression while employed in the (paid) workforce. In order to contextualise this work, however, a much wider net will be cast, in the subsequent chapter (Chapter 2), providing a map of significant changes that have occurred both in the workplace and in the diagnosis and treatment of depression throughout the 20th century.

1.3 Researching depression and work: some questions

Perhaps the first question that arises from the available data on worker depression concerns the increase in the incidence of depression itself. What has given rise to such an increased incidence? Was there something particularly unhealthy about the 20th century? If so, what? And why has it had this particular effect? Or, did something change about the practices of the diagnosis of depression? Have more people been medically diagnosed as 'depressed' who, in the past, might simply have been regarded as 'distressed' or 'unhappy'? To investigate such questions would lead into an investigation in a field such as in industrial sociology and would involve pursuing the

possible relevance of such factors as increased workload, increased surveillance, increased levels of responsibility and the consequent decrease in time with family or leisure time, in conjunction with (neo-liberal) discourses representing such changes as good, necessary, the new 'normal'. From such a perspective, current problems experienced by workers may be considered interim, as workers adjust to the new identities required by new workforce. This is not the focus of this research.

A further set of questions is concerned with possible relations between depression and the workplace. Might 20th century forms of work themselves be the unhealthy phenomenon giving rise to, or contributing substantially to depression? If so, how? And why? Is worker depression most appropriately regarded as simply a subset of depression-in-general or is there something specific about it? Why is depression among workers being increasingly diagnosed?

The pursuit of these questions involves a different focus, that is, on the medical and pharmaceutical industries. The 20th century has increasingly medicalised unhappiness: the continued expansion of diagnostic criteria for depression (described in Chapter 2) has expanded the range of forms of unhappiness caught in the medical net and diagnosed as 'depression'. This expansion has been paralleled by the development by the pharmaceutical industry of new kinds of medication for psychiatric disorders, including depression. This conjunction has seen an increase in reported cases of worker depression and in claims of successful treatment, both nationally and internationally. Although the rise in worker depression is an issue in itself for further research, it is not the focus of this present study. Rather, it, and other aspects of the diagnostic parameters of depression, is acknowledged here as part of the necessary background to the present work.

Providing at least partial or provisional answers to these two sets of questions is an essential preliminary – providing the necessary context – for exploring a third set of questions concerning the experience of workers diagnosed with depression. These questions include: What actually happens to workers diagnosed and treated as depressed – not in industrial or medical terms, but in terms of their experiences and constructions of what happened to them? How do workers diagnosed with depression experience their diagnosis and treatment? How do they experience these medical events in the context of

their prior experience as workers? What do they understand the connections to be? It is essentially with this third set of questions that this thesis is concerned.

The problem that this research study seeks to address is the effects of workplace change in the lived experience of a population of depressed workers. The rationale for this choice was that in the economic, sociological, biomedical and psychological literatures of worker depression – from the point of diagnosis to being offered medical and psychological interventions – there appeared to be no accounts from the workers' perspective of what the experience of workplace change was like for them.

My own background and experience as a practitioner of Systemic Family Therapy (SFT) has, of course, played a significant role in this choice of research focus. SFT is significantly different from other forms of therapy as it deals with people's interactional patterns and dynamics in groups. SFT maintains that individuals cannot be studied and understood separated from their context, culture, and history. The inclusion of the workplace as a site for the production of depressed workers led me to speculate what insights might be gained from the experiences and constructions of depressed workers themselves concerning what had happened to them that had not been included in their diagnosis of depression. Might the inclusion of context, culture and history contribute to a different understanding of workers' experiences of the processes that had lead to their diagnosis of depression? How best might one account for the fact that all members of the hospital therapeutic group that was the point of origin for the questions informing this research told very similar versions of the same story of workplace change? Could there be an untold story about the change from being a 'healthy worker' to a 'depressed worker'? In order to address such questions, this thesis offers a discursive analysis of stories told by a population of depressed workers about their experiences of workplace change and of their depression.

Two main research questions were developed.

- How do depressed workers understand the relationship between workplace change and their particular experience of worker depression?
- What does their experience of workplace depression tell us about the adequacy of current ways of conceptualising and managing worker depression?

A third question arises, one which needs to be asked, even though any detailed answer is beyond the scope of this study:

- What are the implications for future policy and practice in terms of managing worker depression? The scope of such implications ultimately involves macro and micro dimensions, encompassing national policy at the most 'macro' end and the everyday practices of doctors, psychiatrists and therapists at the 'micro' end. The possible shape of such futures will be addressed in the concluding chapter.

1.4 Thesis outline

The thesis is divided into two parts. Part I: Framings, contextualises the study and includes the first three chapters. Part II: The Study, forms the second part of the thesis and consists of the remaining four chapters.

Chapter 2: Towards a genealogy of depression and work, provides in its first two substantive sections an outline of a genealogical account of both work and of the diagnosis and treatment of depression through the 20th century. It concludes with an account of indicative approaches to understanding the connections between the two, drawing on literatures involving both medical and workplace human relations perspectives. Its orientation is primarily descriptive and chronological. It is implicitly Foucauldian in its perspective, seeking to provide an account of the two arenas under investigation in ways that will shed light on how things have come to be the way they are now. In particular, it seeks to illuminate what is perhaps the most striking and thought-provoking aspect of the study: the fact that, despite all the differences between the interviewees in terms of classic variables (age, gender, education, nature of employment, length of time employed, etc), they tell essentially the same story with respect to their understanding of the relation between their workplace experience and the diagnosis of depression.

Chapter 3: Rewriting the realist story: towards an analysis of the depressed worker self, introduces key elements of a body of theory which seeks to provide a more adequate way of accounting for the phenomenon of the depressed worker than the classic individualist approach assumed by contemporary approaches to the diagnosis of depression. Using the key poststructuralist tools of discourse and subjectivity, this chapter argues against the conceptual adequacy of current medical theorisations.

Specifically, it argues that depressed worker selves are far more complex than the taken-for granted selves of biomedical and psychological discourses, which maintain the notion of a single unitary self. This unitary self is theoretically dismantled by adopting a poststructuralist/ Foucauldian approach to provide an alternative way of thinking about the production of depressed worker selves, in terms of power, discourse and the subject. The chapter concludes with a set of theorisations of multiple selves drawing particularly on understandings of re/subjectification.

Part II: The Study, consists of three chapters as follows:

Chapter 4: Research design and methodology, details the research design and the methodology employed. It includes the rationale for an in-depth interview study, a discussion of interviewing as a research tool, the development of the set of semi-structured interviews utilised in the interviews, the recruitment of research participants, demographics of the research participants, reflections on the interviewing process and appropriate data management. Ethical decisions involved in the interview process were in conformity with my ethical responsibilities, both as a practising systemic family therapist, and as a doctoral researcher. The chapter concludes by laying out the mapping of stages of the transformation of the interviewees from 'worker selves' to 'depressed selves' which emerged from the stories told in the interviews. It is this mapping which constitutes the major theoretical contribution of the thesis to understanding workplace depression. These stages are set out in the table entitled 'Stages of resubjectification'. They form the framework for the detailed discussion of the interview data presented in Chapters 5 and 6.

Chapter 5: The process of resubjectification: workplace change as loss and distress, is the first of the two analysis chapters. It provides an analysis of accounts of workplace change in the narratives of workers' experiences. The focus here is on the first part of each story where interviewees discuss their experience of changes in their work and their workplaces, and the effects this had on them. In this first stage, interviewees identify the series of multiple losses they experienced in the workplace, together with the subsequent breaking down of a previously experienced coherent sense of self, a self experienced as a 'viable' worker. Further readings of the data identified a set of repetitive patternings. By moving from individual stories across the data set of twenty

interviews, a clearly identifiable pattern emerged of the beginning of the process that culminated in the production of the self as a depressed worker.

Chapter 6: Resubjectification as a depressed self: regaining a viable life, is the second analysis chapter. It maps the narrative process of resubjectification from the first stage, that of the production of the self as a non-viable worker, across the four remaining stages of the conceptual framework, to the final stage: the production of the self as a 'depressed worker self'. The chapter focuses primarily on an in-depth account of the process of one worker's narrative of resubjectification, through the progressive emergence of new forms of selfhood. These new forms of selfhood draw upon the pre-existing psychological self, that make it theoretically possible to construct in succession the internalised self, the somatised self, the medicalised self and the pharmaceutical self. From the recurring themes in the data, it is possible to see the discursive struggles that workers experience to make meaning out of workplace change, its effects on them and their diagnosis and treatment as depressed workers. The chapter concludes with a set of indicative quotations from the narratives of five other interviewees, making clear that the primary narrative of the chapter is in no way special but in fact maps the narrative process of resubjectification common to all.

Chapter 7, Conclusion, reviews the terrain traversed by the preceding chapters and opens some questions for future research, as well as for potential intervention in terms of the management and treatment of the phenomenon of worker depression. It draws on recent initiatives in systemically-focused organisational change, with a view to supplementing this emerging work with the insights gained from this study.

Chapter 2

A century of change: a genealogical perspective on depression and work in the 20th century

Introduction

The identification of worker depression as a significant and increasing phenomenon of the late 20th - early 21st centuries, and its consequent emergence as a significant site for policy, calls for some enquiry into the possible conditions of emergence of this phenomenon. This chapter provides an outline of such an account. Its most substantive focus is on changes in the diagnosis and treatment of depression, since this is the new phenomenon and the primary focus of this study. Changes in work, on the other hand, have characterised human history from the beginning of the journey of *homo sapiens* on earth. One could argue that it has been changes in human work practices that have constituted defining moments in human history – and that such changes have always involved large amounts of human misery.

The dislocation and displacement of people has been a regular consequence of the move from shifting cultivation to fixed agriculture: the practitioners of shifting cultivation are not necessarily transformed into farmers but are commonly displaced by them, as in the current transformation of vast areas of third world countries such as Indonesia, New Guinea and the countries of the Amazon basin into plantations to service world needs for food and fuel. The shift out of primarily agricultural societies into the urban and factory-based employment of the European Industrial Revolution was achieved at the cost of great misery and suffering to countless humans. Something of this cost for 19th century populations has been documented by novelists, such as Charles Dickens in England and Emile Zola in France, and by social commentators and analysts, most famously and controversially by Karl Marx. The pace and extent of such change has increased throughout the 20th century, particularly with the emergence of the globalised economy.

The changes currently in train in 'advanced' capitalist countries such as Australia and the United States involve another revolution in the nature of work: as the significance of

manufacturing declines, it is increasingly exported to 'developing' countries where labour costs are lower. The growing area of employment in 'developed' countries is in what are somewhat euphemistically known as 'service sectors'. More and more workers are finding that forms of work that once provided economic security and personal satisfaction are becoming unsustainable. Australian farmers, for example, are experiencing unprecedented pressure from changes to the key factors which make their work possible, weather and finance, even as markets are not necessarily declining. As weather becomes more unpredictable – or only predictably unfavourable, and the needs for ongoing affordable finance consequently more urgent but increasingly unavailable under current conditions of global financial instability, more and more farmers are finding that a personally satisfactory way of life that persisted for generations is disappearing. The suicide rate for farmers has been steadily increasing and can be expected to increase further.

Workers who spent a working life employed on manufacturing production-lines find their services no longer required as manufacturing moves off-shore. Familiar jobs are disappearing and the workers who performed those jobs are regarded as surplus to requirements: the skills they have are barely regarded as skills, certainly not seen as transferable, and they themselves are seen as too old – not only too old to retrain, but too old for a new modern age. New kinds of jobs are appearing, requiring new kinds of skills: sometimes requiring such a rapid turnover of skills that even those trained for a new workplace are having difficulty adjusting to the constant new demands. This is the context in which this study takes place: a time of major transition in the nature of work, bringing human distress inevitably in its wake. The remnants of the welfare age of the mid-20th century are still in place, so displaced workers (at least in Australia) will not starve. The misery and destitution of the 19th century in the wake of the Industrial Revolution is unlikely to be re-enacted in all its horror, despite increases in homelessness and youth alienation. However, unhappiness is widespread, not only among those no longer part of the productive workforce but on the part of those who still have a job. The conjunction of such unhappiness with major changes in the diagnosis and treatment of depression has produced a particular kind of outcome: the depressed worker. It is these histories of depression and work through the 20th century that are outlined below.

The chapter is organised with three major concerns: the first, and the most detailed because it is the new story, tells of significant moments in the 20th century story of depression; the second tells a 20th century version of a familiar story – a story of work change; the third tells of how these two stories are being brought together by those whose professional business it is to address the question of worker depression, principally doctors and employers or their representatives.

Where the opening chapter presented largely a series of 'facts' about the phenomenon of worker depression, the focus of this chapter is different. The concern in what follows is to look inside the boxes labelled 'depression' and 'work' and see these less as entities than as processes: depression and work at this point in time, in the context of this particular history. Such an approach is essentially genealogical, in Foucault's sense. It is fundamentally concerned with how things came to be the way they are. The chapter is nevertheless realist rather than overtly poststructuralist in its orientation, however. Telling the stories of depression and work in the 20th century as essentially realist accounts opens up a space for new questions about the relationship between depression and work. Chapter 3 will argue that pursuing such questions explicitly through the lens of poststructuralist theory will be necessary to provide a theoretically adequate framework for the analysis of the data of the study presented in Part II below. It will provide an account of the tools regarded as necessary. In the meantime, the work of this chapter is to pursue stories.

The big question that this chapter addresses follows on directly from the primary issue of Chapter 1: the emergence of worker depression as a new site of policy. In order for that to happen, depression had to have already emerged as a significant site of *medical* attention. A range of factors is recognised as relevant. Bell (2005, p. 7) for example, ascribes the 'impressive, noticeable increase in antidepressant usage in Australia today' to what she calls the 'co-operation' of three large but inherently unequal groups: the multinational drug companies; the physicians who write prescriptions; and the public who turn to medicine for answers. In what follows, this essentially realist account is told somewhat differently. Three somewhat broader factors are identified.

Historically, the first factor was the development from the late 19th century of psychiatry as a distinctive branch of medicine with its own traditions of diagnosis and treatment of specifically psychiatric forms of illness. Crucial to this process was the

progressive elaboration in the 20th century of taxonomies of psychiatric illness, most elaborately through the various iterations of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (*DSM-IV*, produced in 1995). The *DSM-V* is currently in preparation and it is anticipated that it will be available in May 2012 (American Psychiatric Association, 2009) Retrieved March 1, 2009 from http://www.psych.org/MainMenu/Research/DSMIV/DSMIVTR.aspx.

The second factor in the story of depression, as a significant site of medical attention, has been the development of an increasing range of pharmaceutical resources directed at amelioration or even cure of psychiatric illnesses, including depression. The widespread availability of such forms of medication, particularly the SSRI (selective serotonin reuptake inhibitor group of drugs) for the treatment of depression, has had an enormous impact, not only on psychiatric practices of treatment, but on understandings of the nature of psychiatric illness, i.e. on diagnosis itself. Depression has come to be widely understood as an effect of malfunctions of brain chemistry and hence treatable by pharmaceutical adjustment of that chemistry. Medical practice has been significantly locked into this approach to diagnosis and treatment in conjunction with the third factor in the production of depression as a significant medical object: the emergence of a society which is increasingly oriented to the calculability and hence control of levels of risk in all forms of behaviour affecting others. In the case of medicine, the specific manifestation of the 'risk society' is the practice of what has come to be known as 'defensive medicine', where medical decisions have to take into account the possibility of the most adverse outcome. Thus a doctor must act in such a way, in dealing with a patient who is anxious, low, unable to eat or sleep properly, as to cover him/herself against the risk of the most serious possible outcome: suicide. A diagnosis of depression, together with the prescription of anti-depressant medication, is highly predictable under these circumstances.

This chapter will first address these three factors by describing how depression became a significant site of medical attention. This is followed by two further sections which deal, respectively, with the kinds of change in work experienced by many in advanced industrial countries such as Australia and with how the issue of worker depression is currently understood and responded to from both medical and managerial perspectives. Unsurprisingly, the individualist orientation of 20th century perspectives on depression and work profoundly informs such responses. The chapter concludes by attending to the

tensions and contradictions in responses to worker depression, as stakeholders and researchers struggle to reconcile this individualist orientation with an increasing recognition that dealing with worker 'stress' as a major contributor to worker depression might require something more of a 'systems' orientation. Such questioning leads directly into new theoretical terrain, elaborated in Chapter 3, offering less individualist ways of understanding the self in relation to its environment, understandings that inform the exploration of the experience of worker depression in Part II.

2.1 The emergence of psychiatry as a distinctive branch of medicine

The modern institution of psychiatry emerged in the last decades of the 19th century, as part of the historical process which Foucault (1975) first explored in terms of the 18th century emergence of new knowledges concerning human life (biology, economics, linguistics). This terrain has subsequently been extensively explored by Nikolas Rose with specific reference to what he calls the 'psy-sciences' (psychology and psychiatry) and the increasing spread of their influence through the 20th century and into the 21st (Rose 1996a).

As psychiatry itself began to expand, a new grid of perception not only established general medicine and psychiatry as separate disciplines but expanded the potential terrain of the new discipline of psychiatry. As Rose sees it, 'Psychiatry was able to address itself to a range of new problems that were offered to it – not of madness but of social inefficiency and unhappiness…. 'The new imperatives were: investigate, assess, prescribe, treat' (Rose, 1996b, p. 11). In a move highly relevant to this thesis, Scull further sees psychiatry as undermining traditional ways of treating the sick and the non-productive (Scull, 1993).

Through the course of the 20th century, psychiatry moved decisively beyond the confines of the asylum, its original site of operation. It has come to play a particular role in the increasing medicalisation of society, 'making medicine and the labels "healthy" and "ill" *relevant* to an ever increasing part of human existence' (Zola, 1972, p. 487). Part of the work done by psychiatry in medicalising society has been through activities such as the participation of psychiatrists as expert witnesses in courtrooms. Here, the role of psychiatry as a mechanism for the governance of populations is more visible.

Rose sees such participation in terms of a larger set of claims for 'the significance of their science for the administration of the population as a whole in the interests of well being' (Rose, 1996b, p. 8).

From the 1920s to the 1970s, the dynamic model of psychiatry was the dominant basis within the psychoanalytical disciplines, and became best known through the work of Sigmund Freud. Dynamic psychiatry, based on a link between neurotic and normal behaviour and classifying both as variants of common developmental processes, revolutionised the classification of psychiatric symptoms (Horwitz, 2002 p. 7). The blurring of the normal and the abnormal, or pathological, allowed psychiatry to expand its domain to include innumerable neurotic behaviours (depression, anxiety, hysteria, etc) previously considered to be outside the realm of psychiatry. Dynamic psychiatry did not view symptoms such as depression, anxiety, or hysteria as direct indicators of underlying disorders but rather as symbolic clues to underlying psychological processes that could be understood in terms of psychoanalytic theories (Kirk & Kutchins, 1992, p. 77).

However, the limitation to dynamic psychiatry, according to Horwitz (2002 p. 16), is that 'the symbolic, verbal, private, and interior essence … is in many ways the exact opposite of the direct, objective, public and overt emphasis of classical scientific methods'. The result was that the legitimacy of dynamic psychiatry was eventually questioned and a diagnostic model became the dominant mode of operation. Several factors have contributed to the reorientation in the latter part of the 20th century. These include: the training of psychiatrists firstly as medical practitioners; the ongoing engagement of psychiatry with laboratory-based and experimental work (remember that Freud as a young man was an observer of Janet's demonstrations of hysterics in Paris); the rise of neuroscience and the insights it offers into brain function; the seduction of increasingly sophisticated pharmaceutical remedies; and the increasing practice of defensive medicine.

Blazer sums up his understanding of the current dominant psychiatric perspective on depression as follows:

> Today, biological explanations of the burden [of depression] predominate. Biological treatment is focused on the brain in the form of medications, and psychotherapy for depression emphasizes the need of the individual to adjust to the social environment. Psychiatrists rarely acknowledge that something is wrong with the social environment, and they encourage change in that

> environment even more rarely. In other words, despite the commonly accepted facts that major depression is prevalent in our society and that our social environment is rife with stressors that make us vulnerable, psychiatry does not link our melancholy with the society in which we live. Social psychiatry – the study of the social origins of psychiatric illness – has all but disappeared as a paradigm for investigating the origins of depression and, instead, has been replaced by biological explanations (Blazer, 2005, pp. 288-289).

His subsequent reference to the absence of articles 'investigating work-related stress as a predictor of psychiatric symptoms or disorder' (only one was found in a review of the two most widely read psychiatric journals in the US) bears out the general observation (Blazer, 2005 p. 169).

As biological explanations took precedence within psychiatry over other forms of depression causality, diagnosis became more complex and differentiated. Earlier in the century, the classic diagnostic differentiation for depression was between endogenous (internally caused) and reactive (response to adverse external circumstances). Prior to 1978, the term 'major depression' was rarely found in the psychiatric literature. This altered with the publication of the 'research diagnostic criteria' published in the revised third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III- R) (American Psychiatric Association, 1987).

By 1980, the vague symbolic system of dynamic psychiatry was replaced entirely by *DSM-III* (American Psychiatric Association, 1980) as a contemporary psychiatric touchstone describing depression and remains in use by health professionals of all disciplines. Its diagnostic categories have been cited for insurance, forensic and disability matters as well as for mental health. Since its first publication as a slim volume in 1952, the diagnostic criteria for depression have broadened dramatically. In that first edition, there were 106 'diagnostic entities' for depression; in the *DSM-II* this had risen to 180 categories; in the *DSM-III-R* of 1987 this had increased again to 292 categories requiring a manual of some 500 pages. In the latest edition, the *DSM-IV* published in 1995, a publication of over 900 pages excluding references, diagnostic categories had trebled from the first edition to 307 categories (Rose, 2001). A further revision is currently under way, no doubt involving a further expansion of diagnostic categories.

The diagnostic criteria for a 'major depressive episode' are identified in the following terms. At least five of the following symptoms have to be present during the same two-

week period, must represent a change from previous functioning and must include either depressed mood or loss of interest or pleasure:

- depressed mood most of the day
- markedly diminished interest or pleasure in all activities most of the day
- significant weight loss or gain
- psychomotor agitation or retardation
- fatigue or loss of energy nearly every day
- feelings of worthlessness or excessive or inappropriate guilt (which may be delusional)
- diminished ability to think or concentrate, or indecisiveness, nearly every day
- recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or suicide attempt or specific plan for committing suicide (adapted from the *DSM-III-R*, American Psychiatric Association, 1987, p. 222).

There is considerable scope for highly subjective interpretations of these categories. Moncrieff (1997) criticises these diagnostic criteria, arguing that 'variation in mood is a characteristically human way of responding to circumstances but unhappiness has become taboo in the late 20th century' (p. 3). Medicalisation disallows the 'legitimacy of grief and discontent' (p. 3) and responses to the vagaries of life and associated feelings are no longer tolerated, diverting attention away from the 'political and environmental factors' (p. 3) such as workplace change and the associated effects of those changes.

The *DSM* was intended as a guide for mental health professionals to provide some clarity in identifying mental health conditions. The proliferation of diagnostic categories, in the continued absence of any clear-cut diagnostic test for depression, means that diagnosis remains problematic. Medicine has usually distinguished symptoms and diseases. Glenmullen (2000), a clinical instructor in psychiatry at the Harvard Medical School, provides the following example of this distinction: fever is a symptom, not a disease, while arthritis is a disease, with inflamed and painful joints as symptoms of that disease identifiable by pathological tests. In the absence of pathology or physiology, a cluster of symptoms repeatedly observed in patients is usually called a syndrome, not a disease. What sets psychiatry apart from other medical specialties is that all of its diagnoses are basically syndromes *presumed* to be related to diseases.

Therefore, the *DSM-1V* uses the term 'disorder' for syndromes, as none are classified as diseases. As Bell points out: 'We have no routine blood tests or X-rays that will measure the subjective symptom we call "mood"' (Bell, 2005, p. 61).

Nevertheless, in the absence of any physiologically verifiable disease, over the past few decades psychopharmacology has constructed 'disease models' for psychiatric diagnosis. These are hypothetical suggestions of the possible underlying physiology, primarily a chemical (serotonin) imbalance. The rationale for drug companies' marketing strategies was that 'diseases' of psychiatry could be modelled on medications that could 'treat' them, claiming to be operating with what Bell calls 'the holy grail of scientific endeavour – smart-bomb accuracy' (Bell, 2005, p. 41).

Bell goes on to quote Candace B. Pert, co-discoverer of serotonin binding receptors, decisively rejecting such an interpretation in saying:

> I am alarmed at the monster that John Hopkins neuroscientist Solomon Snyder and I created when we discovered the simple binding assay for drug receptors … The public is being misinformed about the precision of these selective serotonin uptake inhibitors when the medical profession oversimplifies their action in the brain and ignores the body as if it merely exists to carry the head around! (op. cit.)

The novel *Prozac Nation* captures the oddness of the logic involved, as a young woman is treated for 'atypical' depression:

> It's not depression—it's atypical depression. Who would have thought they have a name to describe what is happening to me, and one that pinpoints my symptoms so precisely? … Enter Prozac and suddenly I have a diagnosis. It seems oddly illogical: rather than defining my disease as a way to lead us to fluoxetine, the invention of this drug has brought us to my disease (Wurtzel, 1994, p. 265).

Depression is often described as a common medical condition affecting physical health, mood and thoughts. In psychiatric and psychological texts, a variety of positions is taken regarding what constitutes depression. Different authors assign different primacy to the causes of depression such as biological, biomedical, genetic, physiological, hormonal, familial, situational, psychological and pharmaceutical. In the absence of any absolute diagnostic test for depression, the diagnosis of a 'depressive disorder' remains problematic (Thomas-MacLean, Stoppard, Baukje & Tatemichi, 2005). The *DSM –IV* (American Psychiatric Association, 1995) is used as a diagnostic tool but does not attempt a definitive causality of depression.

It is hardly surprising that, in the absence of definitive diagnostic tools and clear understandings of causality, the boundaries of what may be understood and treated as depression have widened. A range of what might otherwise have been regarded as normal responses to social stress, relationship problems, work difficulties or other problems of living, once accepted as integral to a person's lived experience, are now pathologised as medical problems indicating individual dysfunction, expressed and understood as depression.

This expansion of the boundaries of what is understood to constitute depression is coming to incorporate a range of 'dysthymic' emotional states, which lend themselves to intervention through 'professional help' of one kind or another. Busfield (2001 p. 27) cites Lyon's (1996, p. 61) view that Prozac is commonly prescribed for persons who do not in fact fit the criteria of depression, but who are labelled as 'dysthymic or even "sub-borderline", i.e. as demonstrating emotion "inappropriate" to the circumstances' (Busfield 2001, p. 22). In popular language usage, shifts towards the almost exclusive use of the term depression have now subsumed other terms such as sadness, unhappiness, grief, and feeling low. As outlined in Chapter 4, in the details of the research design, the population of workers selected for interview in this study had received a diagnosis of depression, had not previously been diagnosed as depressed, and were all managed along similar lines. No one in this population was diagnosed with major depression.

The dramatic increase in the rate of people being diagnosed as depressed detailed in Chapter 1 is paralleled by an increase in the scale of anti-depressant prescription. In 2004, twelve million prescriptions for this group of drugs were dispensed through the Australian Pharmaceutical Benefits Scheme (PBS), a figure that contains both newly initiated scripts and monthly repeats of established regimes and equates to well over a million annual users, in a population of less than 20 million. More people than ever before in the history of Australia are taking antidepressants. Five million PBS scripts in 1990, 8.2 million in 1998, 12 million in 2004, 250,000 of which were written for patients under twenty years old (Bell, 2005, p. 3).

How did we get from the 1930s, where medication was regarded as having a purely sedative role, not affecting the disease process itself, to the 1990s, with its vast expansion in the intensive marketing of SSRIs by the pharmaceutical companies, a

process that Healy suggests 'was to prove capable of leading to vast expansion in the apparent frequency of depressive disorders' (Healy, 2002, p. 309)? Is it a story of the availability of a new treatment leading to an increase in the recognition of disorders that might benefit from that treatment, a general principle in the history of pharmacology suggested by Healy (2002, p. 309)? These are some of the questions that need to be asked, in exploring the role of medication in relation to the diagnosis of depression. Rose (2006), reviewing the scope of expanding psychiatric diagnosis, argues that 'diagnosis leads to treatment, which usually entails the prescription of psychiatric drugs' (p. 466).

2.2 The expansion of pharmacology—the rise of the SSRIs

Since the birth of psychiatry, drugs have been used extensively for treatment. Prior to the 19th century, opiates and barbiturates were used to sedate people. According to the medical records of the Maudsley and Bethlem Hospitals in the UK in the 1930s, drugs were used to treat both inpatients and outpatients. However, drugs were rarely documented or discussed in actual notes and medication cards were kept separate from the medical file, as it was thought that drug treatments had no effect on the disease process (Moncrieff, 2002).

From the 1950s, drug treatment became important and glamorous, and new drugs came to be viewed as specific treatments for specific conditions. The pharmaceutical industry played an important role in establishing drug treatments as central to psychiatry. The first high-powered marketing campaign helped launch Chlorpromazine (under brand names Thorazine and Largactil) in western society in 1950 (Swazey, 1974), making $75 million for the pharmaceutical company, Smith Kline & French, in 1955 alone (Rose, 2004b, p. 91). Drugs with specific actions were seen as a scientific breakthrough: as new conditions were described, the specific drugs made the condition more believable. 'Designer' drugs are now prepared and marketed as having specific effects on certain psychiatric conditions, rather than just having sedative effects. The very successful marketing of chlorpromazine (Thorazine) to psychiatric hospitals in 1950 was quickly followed by the development of specific drugs used to treat 'depression', such as Tofranil in 1958, Amitriptyline in 1961, and other drugs such as Reserpine and Isoniazid, which would in time form the basis of the serotonin hypothesis of depression.

No universally accepted method for labelling drug therapies exists, however. Parker (2004) suggests that antidepressant drugs may be classified by their chemical characteristics, their function and the generation of the drug. He explains that:

> first-generation antidepressants emerged in the late 1950s and were extensively trialled in the 1960s. Second-generation antidepressants emerged in the late 1970s and early 1980s, while third-generation drugs have generally been available only since the 1990s (p. 89).

Parker further argues that the notion that all antidepressant drugs are of equal benefit is inaccurate, as some drugs have a different effect on different forms of depression. The equal-benefit hypothesis of antidepressants, he concludes, is based on data from drug trials where 'pure' cases of depression are rarely included (p. 89).

In spite of Parker's position, there appears to be little if any difference in terms of prescribing practices as noted in Shorter (1997, p. 319):

> the share of psychiatric patients receiving prescriptions increased from a quarter of all office visits in 1975 to fully one-half by 1990 (from 25.3 percent to 50.2 percent). With the benzodiazepines as the entering wedge, psychiatry became increasingly a speciality orientated to the provision of medication.

Rose compares the year 1960, when there were 130,000 inpatients in psychiatric hospitals in the UK, to 1980, when these numbers were halved through policies of deinstitutionalisation (Rose, 2001, p. 93). The major growth in tranquillisers, hypnotics, anxiolytics and antipsychotics, from around 6 million prescriptions to an estimated 24 million, is thought by Rose (2001) to be linked to beliefs about their specificity of action (p. 94).

Specificity refers to a drug's ability to target a chemical component of the body in order to treat a discrete condition. Specificity was claimed in the marketing of the SSRIs (selective serotonin reuptake inhibitors). The pharmaceutical giant, Eli Lilly marketed Prozac in the late 1980s as a new mood-altering drug that purportedly targeted serotonin, a naturally occurring chemical in the body that is responsible for controlling many of the regulatory hormones affecting multiple physiological processes. As Azmitia and Whitaker-Azmitia (1991, p. 4) report, 'the brain serotonin system is the single largest brain system known and can be characterised as a "giant" neuronal system'. The marketing of Prozac, Zoloft, and Praxil was based on the claim that serotonin targeted the brain exclusively. However, as Glenmullen (2000) argues, while

antidepressants have been marketed as 'selective', serotonin has been implicated in many other conditions such as insomnia, appetite fluctuations, learning functions, memory impairments and sexual dysfunction (pp. 16-17). This would seem to suggest that the SSRIs may have more global effects on the body.

Similarly, in 1993, the psychiatrist Peter Kramer (1993), in his influential book *Listening to Prozac*, made sensational claims that this new serotonergic agent not only treated depression but also a host of everyday 'maladies' like timidity, shyness, sensitivity, lack of confidence, perfectionism, fastidiousness, fear of rejection, low self-esteem, competitiveness, jealousy and fear of intimacy. Perhaps Kramer's most astonishing claim was that Prozac could transform people's personalities, coining the phrase 'cosmetic pharmacology'—Prozac made people better than well!

In contrast to Kramer, Bell (2005) questions the rise of the SSRIs as a panacea for all ills:

> After a ten-year love affair with "happy pills", we are beginning to see flaws in some of the hard science underpinning our beliefs about the safety of these drugs, and to recognise the disguised motives of those who bring the drugs to market. Researchers are questioning the wisdom of medicating 10 per cent of the population with potent molecules when (many argue) other, less encroaching strategies might work just as well (Bell, 2005, p. 4).

In citing the then prescription rate of twelve million prescriptions for antidepressants in an Australian population of less than twenty million, Bell graphically poses the question of whether '[t]he sun-bronzed Aussie optimist with his no-worries attitude to calamity might be an outdated caricature' (p. 4) or whether there is a need to look beyond diagnosis of individual dysfunction in order to understand patterns of anti-depressant prescription. She takes the latter perspective:

> [The] impressive, noticeable increase in antidepressant usage in Australia today has come about through the co-operation of three large but inherently unequal groups: the multinational drug companies; the physicians who write prescriptions; and the public who turn to medicine for answers (Bell, 2004, p. 7).

Turning to medicine for answers in the search for perpetual happiness is recognised by Busfield (2001, p. 29), who writes that, in the pursuit of the myths of 'happiness' and the 'good life', we have come to believe that anything less than perfection means that we are faulty or lacking some essential quality. The 'designer chemical self ' of the bio-

psychiatric era is produced through the pursuit of such myths that in turn lead us to the physician for a prescription to treat what we come to see as our 'symptoms' – our lack.

Rose notes a further dimension of the dramatic increase in antidepressant usage arising from the 'proliferation of psychotherapies and emergence of what one may term the therapeutic culture of the self' (Rose, 1999, p, 91). The 'desiring, relating, actualising self' is an invention of the latter half of the 20th century, Rose argues. The 'therapeutic culture of the self' seeks individual happiness and self-fulfilment. The focus of marketing anti-depressants becomes more comprehensible when read through Rose's idea of the 'therapeutic culture of the self' and in taking up Bell's (2005, p. 5) observation of the trend of seeking solutions in medicine.

Risk management of depression

The final factor that needs to be taken into account in understanding how worker depression became a site for policy in the late 20th century is the practice of defensive medicine as it developed as a professional response to risk management. Risk has become part of the vernacular of advanced industrial societies. However, it is not known how much more risk there is today compared to one hundred years ago. According to risk experts, every 'condition' now has some measure of risk attached to its management and its cost. Klawiter (2004, p. 2) sees the 'riskiness' of modern societies growing in direct proportion to:

> the conversion of looming dangers into precisely calculated possibilities and the translation of potential opportunities into quantified likelihoods … proliferation of risk is thus an expansion of knowledge, but it is knowledge of a quintessentially modern character, an intimate knowledge of uncertainty (Klawiter 2004, p. 2).

Risk is now part of every industry, workplace, health care and financial institution, domestic sphere, and education, transport, public health and medicine department. Riskification, the process aiming to avoid potential litigation by calculating how and when breaches are likely to occur, is an inclusion of most business practices. The bio-medical management of depression predominantly relies upon riskification because a diagnosis of depression is virtually a forgone conclusion when people report stress and unhappiness to their doctors. In addition to the scripting of pharmaceutical technologies and the routine ordering of psychological treatments, all are aimed at preventing 'depression' from escalating to suicide, which is nearly non-defensible if risk-

management procedures are not followed. Changes in medical regulatory practices have altered the way that knowledge is produced, medicine is practised, and patients are constructed as depressed.

Such practices are central to the practice of what has come to be known as 'defensive medicine'. Defensive medicine, according to The United States Department of Health Education and Welfare, is defined as:

> the conducting of a test or performance of a diagnostic or therapeutic procedure which is not medically justified but is carried out primarily (if not solely) to prevent or defend against the threat of medico-legal liability (Handcock, 1993, p. 6).

Handcock (1993) sees issues such as the increasing rates of medical malpractice litigation, rising levels of court awards and out-of-court settlements and rising rates of medical defense indemnity insurance premiums, both in Australia and overseas, as relevant to the practice of defensive medicine. While Australia (at the time of Handcock's research) was not regarded as having a malpractice crisis comparable with that of the United States, there are concerns in Australia that medical practices are becoming more defensive. Some of the background factors include:

- increasing specialisation, sophistication and mechanisation of medical care;
- greater public awareness, dissemination and discussion of medical knowledge;
- higher patient expectations of medical treatment outcomes;
- increased consumer demand for information about medical conditions and treatments;
- increasing numbers of doctors practicing in groups or in hospitals, or in 'entrepreneurial' medical clinics, contributing to changes in the traditional relationship between doctor and patient and lack of continuity in patient care;
- changes in the traditional relationship between the doctor towards more shared patient doctor decision-making toward more shared patient-doctor decision-making;
- increased pressures on medical practices from external and internal demands for cost-cutting and efficiency and a climate of criticism of medical care brought about by increased public awareness of medical litigation;
- media publicity about malpractice in North America and of the issues in Australia;

- complaint mechanisms in some states (Victoria, New South Wales and most recently Queensland), which may add to the public's awareness of medical practice mistakes, and high-profile medical negligence suits in Australia and overseas (Handcock, 1993, p. 3).

One of the difficulties Handcock encountered in her research was a lack of data on malpractice claims and reliable data on claims settled out of court. As cases often dealt with state medical boards and various medical defence organisations, this descriptive data is often confidential and subject to non-disclosure as a condition of settlement. Furthermore, members of the State Medical Boards and Medical Defence Organisations are 'provided with professional indemnity against any claims of medical negligence' (1993, p. 4). Additionally, there was no national or state database providing a breakdown of the types of categories of injuries, specialties, and/or damages awarded, or the number of cases settled out of court.

A decade later, research on defensive medicine conducted in the UK noted that few such studies had been conducted in the UK prior to the 1990s. One of their findings was that 'defensive practice is common even among general practitioners who are commonly regarded as being in a low-risk specialty, with 98% claiming to have made some practice changes as a result of the possibility of the patient complaining' (Passmore & Leung, 2002, p. 671).

Conversely, defensive medicine may also include improvements in the quality of the service, for example, more comprehensive explanations and better record keeping. In contrast, Anderson argues that 'physicians practice defensive medicine all the time. Some of us know it, acknowledge it, accept it. Others believe that it is quite untrue and find the concept unconscionable and reprehensible' (Anderson, 1999, p. 2399). Furthermore, he points out that defensive medicine as a concept is elusive, pervasive and widespread and that it may well go unrecognised, so much so that practising defensive medicine need not be a conscious undertaking by medical practitioners.

Despite the development of defensive medicine, Mant et al. (2004), drawing on Hickie's (2002) work, argue that GPs do not routinely prescribe anti-depressants when dealing with depression. They see the uptake of new drugs by doctors following a diagnosis of depression as a process 'mediated by a complex set of doctor, patient, regulatory and

commercial influences … the opinions and practices of colleagues, and the availability of the drugs on the PBS' (2004, par 2).

Indeed, the rapid increase in depression diagnosis is not uncontroversial within psychiatry. Parker's (2007) paper 'Is depression overdiagnosed? Yes' continues to raise concerns about the non-specificity that rules depression modelling and treatment. He acknowledges that 'depression will remain a non-specific "catchall" diagnosis until common sense prevails' (p. 328). Parker's view is based on his belief that the over-diagnosis of depression stems from a lack of a reliable diagnostic model together with the concurrent marketing of pharmaceuticals as an encompassing solution for the treatment of depression. Further, depression is widely viewed as a 'single disorder varying dimensionally' (Parker, 2003, p. 335). That is, depression has literally no exclusionary criteria and the meaning of a 'depressive disorder' (Parker, 2003, p. 335) is lost, so that everyone has the capacity to be diagnosed as depressed if no criteria exist that fall outside the ever-widening diagnostic categories as seen in the *DSM-IV*. Depression therefore is viewed as a 'disease that has nothing to do with … personality', but is caused by 'chemical brain changes, requiring … anti-depressants' (Parker, 2003, p. 335).

Despite the uptake of prescribing anti-depressant medication, a growing number of researchers are becoming very vocal in critiquing the seemingly magical properties of these drugs, alongside concerns about the validity of the research methods used by pharmaceutical companies. One of the most articulate critics of serotonin boosters is Sherwin Nuland, professor of surgery and historian of medicine at Yale University. His view is that the public is 'subjected to the arguments of seemingly authoritative physicians and scientists who propose views that don't stand up to the scrutiny of trained professional eyes' (cited in Glenmullen, 2000, p. 15). He goes on to say that the pop psychopharmacology accompanying the serotonin boosters is 'preposterous, unsubstantiated' and a 'psychopharmacological fantasy'. Noting that it 'remains anything but certain that clinical depression is, in fact, caused by a decrease in serotonin', he rejects the 'junk science of serotonin deficiencies and biochemical imbalances as uncertain groupings for proof of a fanciful theory' (Glenmullen, 2000, p. 15).

It is by no means the case that all those professionally concerned with the diagnosis and treatment of depression are unaware of the impact of the world beyond the biochemical. David Smail, (1993) a Professor of Clinical Psychology, argues that

> instead of looking inward to detect and eradicate within ourselves the products of "psychopathology" we need to direct our gaze out into the world to identify the sources of our pain and unhappiness. Instead of burdening ourselves with … the responsibility for symptoms of "illness", "neurotic fears", "unconscious complexes", "faulty cognitions" and other failures of development and understanding, we would do better to clarify what is wrong with the social world which gives rise to such forms of suffering (p. 1).

Smail is not arguing that people do not have psychological or emotional problems; rather, that in the beginning we are victims of social pathology, such as workplace change, rather than simply having some form of psychological pathology.

2.3 Work in the 20th century: from Fordism to new enterprising workers

The workplace is, of course, the locus of concern for this thesis and we now turn to this world. This section will not attempt a detailed account of the changes that the workplaces of the western world have undergone through the course of the 20th century. That work has been undertaken by a variety of researchers, including Rose, (1996a). At its most general level, the changes encompass a reorientation from manufacturing (the Fordist moment) to the 'knowledge economy' (Gee, Hull & Lankshear, 1996 p. 23), including especially the service (including financial) sectors, together with the increasing dominance of international companies with no roots or commitments to the nation states which provide them with temporary bases. Such a reorientation, in the case of Australia, is only partial because of Australia's significant role as a supplier of raw materials (such as coal, iron ore, alumina) in high demand internationally. The enmeshing of the Australian economy with what is increasingly a world economy proceeds nevertheless through this means, as well as through the increasing internationalisation of companies of all kinds.

The focus of this section is on a broad-brush account of the current state of play at three levels of generality: first, a macro level of globalisation and neo-liberalism and their effects on the global re-distribution of work and on how workers are viewed; second, an intermediate level concerned with social changes consequent on the reconceptualisation

and the reorganisation of work in countries like Australia; third, a micro level of actual workplace organisation impacting directly on the experienced well-being of workers, factors such as increases in working hours and levels of surveillance. In combination, such changes have had very considerable effects in terms of the preparation for work, in the experience of work and in relations between work and non-work. These changes, it is argued, are producing new kinds of selves: certainly new kinds of worker-selves but, beyond that, new kinds of selves in new kinds of relations with families and significant others and with fellow citizens (see for example the detailed arguments in such publications as Gee, Hull, & Lankshear, 1996; Holman, Wood, & Wall, 2005).

At the broadest level, the international take-up of globalization, in conjunction with the spread of neo-liberal principles and the ongoing introduction of new technologies, has had a variety of material effects on the stability of labour markets and on economic (including taxation) reform at national levels. Such effects, including reduced public spending by governments, ongoing major corporate restructuring by companies of all kinds and increasing casualisation of the workforce itself have created significant changes to people's lives, including, arguably, their mental health.

The international economic and political climate which provided the context for the increased incidence of depression outlined in Chapter 1, and for the instability and unceasing change experienced by the subjects of this study, is now itself in the process of further massive upheaval. The current global financial crisis is seeing direct government intervention in the economy on a scale not seen for many years. But the latter part of the 20th century was a time dominated by neo-liberalism, initially in its more local British ('Thatcherism') and American ('Reaganomics') versions, but ultimately as a global phenomenon. Internationally, neo-liberalism was imposed by powerful institutions, including the:

> World Trade Organisation (WTO) and the International Monetary Fund (IMF), in order to manage and transfer resources and wealth from the poor and less developed nations to the richest and most powerful nation states and to the wealthy corporate defenders of capitalism (Giroux, 2005, p. 6).

Increasingly corporations have designed the economic culture, shaping legislation that involves all levels of government, almost unopposed. The rich and the powerful benefit as corporate power infiltrates all layers of political processes, placing greater burden on

the middle and lower classes to carry the weight of tax reforms that focus on workers rather than the wealthy.

The deregulation of trade and labour market flexibility, and free labour mobility across countries, has been accompanied by the promotion of individual self-interest, and competition amongst individuals as well as amongst sectors in organisations. Competition was extended to individuals through the individualisation of the wage relationship, individual performance objects, individual performance evaluations, individual salary increases 'or granting of bonuses as a function of competence and of individual merit; and individualised career paths' (Bourdieu, 1998, par. 8). Simultaneously, individuals were held responsible for their sales, their products, their branch, their store, ensuring the 'involvement' and 'self control' by individuals, exacerbating the high-stress conditions.

The current globalised workplace and how it will be organised in the future raises serious concerns (van Wanrooy, 2007; Williams, 2008). Contemporary themes of uncertainty and change influenced by rapid environmental, technological, and social change, have produced many diverse visions of present and future work. The characteristics of the current global workplace include: the 'formalisation' of work with the loss of subsistence and unpaid exchange disappearing, a widespread increase in the effects of capitalism, increasing operations in a deregulated global market place, and increasing flexible work practices replacing mass production (Williams, 2008, p. 654).

The 'new' workplace in advanced industrial societies, has typically been designed to shape the nature of work and affect employees' behaviour. These changing working practices often create problems at all levels of organisations for employees. In a recent study (Davis & Blass, 2007), over 800 graduates of Master of Business Administration degrees described their current workplaces and reported their expectations of the nature of the globalisation of business in 10 years time. The current workplaces were described as 'challenging, … through a drive for innovation and entrepreneurialism' (p. 44) and marked with a lack of creativity, with future workplaces being viewed as shifting from expert roles and functional knowledge to being more distributed, technologically orientated, and information based. 'Uncertainty, confusion, unpredictability and unethical' (p. 44) were all terms used to describe current globalised workplaces.

In his discussion of the contemporary Australian workplace since 1975, Pusey (1998, p. 20) identifies the following range of shifts, providing a useful overview of the intermediate level of social and workplace change consequent upon globalisation and neo-liberalism:

- from the public to the private sector
- from the bottom 70% of wage and salary earners to the top 10%
- from wage and salary earners to corporations
- from small business to big business
- from the bush to the city
- from consumers to producers
- from households to markets

Such a list encompasses an extraordinarily wide range of dimensions of life, impacting in one way or another on the lives of all Australians. When one looks at such a list in conjunction with some of the specific features increasingly characteristic of the contemporary workplace, it is hardly surprising that many people feel that their whole world has changed.

In the context of greater global economies, and increasingly '24/7' societies, along with demographic changes, many organisations facing cost and quality competition depend on the skills, commitment and initiative of their workforce in order to remain viable in a competitive globalised marketplace. The intellectual property of the 21st century organisation is based more and more on ideas and concepts, rather than machines and processes. That is not to say that the industrial giants of the 'Golden Age' of the 1950s and 60s cannot be successful today, despite their success in a time that enjoyed unprecedented economic booms combined with low unemployment, low inflation and rapidly growing living standards. On the contrary, companies that have reinvented themselves as information age companies have shifted their view from regarding the individual worker as the cornerstone of the organisation, to the notion that people work in teams and communities of practice, while they manage knowledge, as van Wanrooy (2007 p. 71) points out. Knowledge management is about being able to share knowledge and work in teams collaboratively, while participatory management styles have become the standard, rather than the exception, at least in theory.

Global economic views of the changing workplace such as Aldisert's (2002) sound very encouraging for organisations and workers, yet there are many and varied effects on workers that are not quite so positive. For example, a recent ABC-TV Four Corners television program on the workplace (McDermott ABC, 2007) began with the statement: 'In an economy demanding constant change in the workplace, the anger and distress of those who have experienced a cultural shift is taking place in one of our biggest and most powerful companies' (2007, p. 1). The discussion on workplace change issues focused on staff in inbound call centres who 'are measured on dollars per logged-in hour, contracts, 3G handsets, average handling time, wrap time, and adherence' (2007, p. 4). One of the key performance measures for workers was average handling time. As one worker reports:

> There was also what we call a wrap, a time between one phone call and the next and you'd be typing up notes from the previous phone call, you had to keep that to a minimum. Adherence is a schedule. You have to be on time, you have to go on breaks where they have set a break for you and if you're on a phone call with a customer, that can affect your adherence adversely and you can be, you know, penalised at the end of the month for that, for having poor adherence (p. 4).

Such control of workers, together with the associated surveillance, is one of a number of factors widely implicated with increasing levels of stress in the workplace. These can be summarised from a variety of sources, including van Wanrooy (2007) and Buchanan (2007), as follows:

- constant restructuring of organisations;
- increased work hours (e.g. Australians' hours of work increased: 'both men's and women's average full-time hours have increased since the 1980's stabilising in the mid 1990's' – the main reason for the increase in hours is attributed to 'unpaid overtime' (van Wanrooy, 2007, pp. 1-2);
- increased work loads;
- increased levels of casualisation/outsourcing;
- increased and more effective surveillance and control.

On this latter question, as Buchanan (2007) notes:

> You have now extremely good technology, which allows you to monitor a worker's performance. You can track waiting times; you can track response times; you can listen in and

> track the quality of their activities; and under those conditions they are under immense pressure to perform to the absolute best of their ability (Buchanan, 2007, p. 5).

Bryant (1995) identifies the rising dominance of organisational surveillance over employees and the 'naturalisation of this trend through the rhetoric of the "imperatives" of globalisation and competitiveness' (p. 1). As Bryant argues, workplace monitoring is not new as a workplace practice; what has changed is the degree of highly detailed performance-related data gathered on each individual worker who may not know they are being monitored on a minute-by-minute basis (Bryant, 1995). The crux of the matter, as Zuboff (1988) reports, is that these electronic 'information panopticons' not only monitor workplace processes but workers:

> Once the system was in place, managers discovered that another parallel history was also being captured. This history was the history of human decisions at the data interface, this history of operators' attentional behaviour, the history of the operator problem solving, Managers had learnt to use the objective record as a means of deducting this behavioural history (Zuboff, 1988, p. 316).

These workplace changes are a far cry from a century ago when workers at the Ford motor company were measured by their 'unblemished' personal lives at home.

Workplace surveillance is justified as a way to protect the intellectual property of the organisation by restricting the possibility for workers to transfer company information to their competitors. Subsequently, many workers no longer feel that they have any privacy at all, as workplace monitoring is generally unregulated so the employer may listen, watch and read most of their workers' communications.

Some of the new methods that workers need to adopt are documented by the Organization for Economic Cooperation and Development (2001). This report explains that employees will be required to exhibit teamwork, 'an ability to cooperate in an unclear environment, problem-solving ability, the capacity to deal with non-routine processes, the ability to handle decisions and responsibilities, communication skills and the capacity to see workplace developments in a broader context' (OECD, 2001, p. 99). In Australia, three key areas for workplace reform (health, education and training, and work incentives) were identified by the Human Capital Reform Report (National Reform Initiative Working Group, 2005, p. 14). The Human Capital agenda requires workers to be a 'healthy, skilled and motivated population', which is important to both 'workforce participation and productivity' (p. 14). The valuing of employees in terms of

human capital is relevant to this work of this thesis because workplaces may need to carefully consider the rising number of 'depressed workers' as a multifaceted and complex issue that extends beyond a worker's 'absenteeism' or 'presenteeism'.

Employers increasingly expect 'multi-tasking' employees to have an understanding of more and more of the following aspects of a business: aspects of the workplace's financial situation, the importance of long-term customer relationships, community requirements with regard to shareholder value, equal employment opportunity, occupational health and safety, environmental requirements, globalisation factors such as increased international competition, global market activity, increasingly complex operating environments as a result of legislative and financial changes, innovative ideas for cost effectiveness or the creation of new products of services, flexible enterprise structures, and flatter more autonomous structures. Such unrealistic expectations have arguably intensified workers' stress, anxiety, and uncertainty, along with other changes including: unpredictable working hours, work overload, work underload, high uncertainty, fragmented work, career uncertainty, work of low social value, job insecurity or redundancy, downsizing, casualisation of working hours, time pressures and deadlines.

In contrast to credentialed workers, there is a growing demand for cheap, mobile, (often female) labour created by global capitalism, including factory workers, domestic service workers, sex workers, and child care workers (Walkerdine, Lucey, & Melody, 2001, p. 70). An increase in outsourcing and temporary work to meet the changing economy means that large corporations avoid the costs of insurance, occupational safety, or human amenities such as office supplies, tea rooms, furniture and decorating through the use of contract work. Where in-house jobs remain, a trend exists to use the temporary workforce on a needs-only basis when productivity increases. The more a workforce is outsourced or temporary, the more employers can avoid responsibility for the worker, up to and including health insurance and pensions.

As technology advances, a vision of borderless workplaces has been articulated, where more people will work from home, with limited visits to the organisation/ workplace. How this will be realised is unclear, but with the current trends towards downsizing, mergers and relocation, it is predicted that there will be fewer people at the actual

workplace and more workers will be independent contractors, or on short-term contracts.

Workplace management bodies often imply that innovations take place for the 'good of the workers', increasing for example, the intensity of surveillance in the workplace. However, worker monitoring is not a new practice. Throughout the history of industrialised production there has always been some regulation of workers' performance, such as on Ford's assembly line, where knowledge and planning were separated from their manual execution. What has changed is the nature of supervising and controlling workers. More than three-quarters (77.7%) of the major U.S. firms record and review employee communications and activities, as noted in the summary of key findings on Workplace Monitoring & Surveillance (American Management Association, 2001, p. 4). If activities such as reviewing phone logs or video-recording for security purposes were included, the overall figure for workplace surveillance would be 82%, an increase from 67%.

Emphasis on the individual is perpetuated through new styles of management, which include performance indicators, and benchmarking, or what Dean (1999, p. 169) calls technologies of performance, that are utilised from above as indirect means of regulating agencies, of transforming professionals into 'calculating individuals' with 'calculable spaces', subject to 'calculable regimes'. Power (1994, p. 11) captures the essence of this in *The Audit Explosion:* 'Audits are needed when accountability can no longer be sustained by informal relations of trust alone but must be formalised, made visible and subject to independent validation'. In the 1980s, major accounting firms began to grow dramatically, with young people being trained and socialised into the context of auditing. This produced a distinct mentality of administrative control that has resulted in a pervasive logic with specific associated practices.

The question of auditing as an alternative to trust provides one kind of focus on the extent to which workplaces are changing, highlighting a central tenet of neo-liberal thinking: the assumption that all humans are always motivated solely by rational self-interest. From such a perspective, constant auditing and surveillance make sense. And such practices will have effects, in the way that practices always do, on conceptions of what work is 'for' and what workers are 'for'. The early 21st century can be said,

however, to be still a time of transition between older conceptions of what work and workers are for and new, rationalist conceptions.

The perspective that informed Freud's view that the two most fundamental things in human life were work and love (Neff, 2006, p. 90) continues to inform attitudes and beliefs for many and is in significant tension with neo-liberal perspectives. It is significant to note that the neo-liberal perspective on the workplace, with its fundamental individualist perspective, may well be contributing to tensions and stresses for workers informed by other views and expectations. It is very much in harmony, however, with the rational scientific perspective informing contemporary approaches to the diagnosis and treatment of depression. There is little space from either perspective, management or medicine, to understand depression in any other terms than as personal inadequacy or failure. Thus, the response is likely to be largely in terms of identifying and 'managing' the problem of worker depression, rather than looking for causes – certainly 'causes' beyond the individual level. Such a view is borne out by the literature on worker depression, which this chapter now turns to.

2.4 Understanding worker depression: three approaches

In moving from an account of the current state of play with respect to depression and the workplace to their conjunction in 'worker depression', three preliminary observations are in order: first, as Heidel, Klachefsky, McDowell, Muldoon, Pendler & Scott (2007), observe, two different cultural universes are involved; second, the literature on workplace depression is sparse, though expanding, and much of it quite recent; third, in a policy context of attention to worker depression which brings together highly technical (with respect to depression) and economic (with respect to the workplace) frameworks, much of the commentary and response is concerned with managing the phenomenon rather than researching it. And 'research' frequently stops with the collection of organisationally-oriented data (particularly concerning incidence and cost) rather than developing any interpretative framework for understanding why the phenomena described are occurring, much less exploring the experience of those suffering depression. This has meant that neither a focus on cause-and-effect relations between the workplace of the late 20th century and depression, nor actual critique of the workplace and recommendations for change, has featured highly on the list of concerns. As 'managing' comes to incorporate better understandings of precisely what aspects of

the workplace are contributing to depression and anxiety, this is starting to change. And major research studies, particularly those with a longitudinal orientation such the Dutch study by Plaisier et al. (2007), are contributing to the development of new kinds of thinking about what, at the moment, might more accurately be named 'depression-in-the-workplace' or 'workplace depression' than 'worker depression'.

This chapter will conclude by commenting on three significant recent bodies of work, originating in three countries, and oriented rather differently. First, the 2008 special issue of the American *Journal of Occupational and Environmental Medicine* devoted to workplace depression contains a range of papers from medical, managerial, and occupational health perspectives. It perhaps can be said to present a mainstream state-of-the-art perspective, concerned primarily with returning workers diagnosed with depression to work. The *Journal of Occupational and Environmental Medicine* (Volume 50, Number 4) consists of 15 articles, contextualised by the editors as follows:

> [D]epression in the workplace is a common, chronic and often recurrent disorder with consequences spanning a continuum from mild to barely perceptible subclinical effects to disabling symptoms affecting employees at all levels of enterprise structure, in its various forms. … [A]ll authors support the notion that depression is a costly and disabling condition from any perspective (Caruso and Myette, 2008, p. 2).

Of the 15 articles, four papers define the problem of workplace depression and established the extent of the problem as 'a disabling and costly disorder'. These papers outline the scope and prevalence of worker depression with attention to epidemiology, etiology, diagnosis, associated costs of depression, social factors, and the occupational consequences (Kessler, Merikangas and Wang 2008; Langlieb & DePaulo, 2008; Khan, 2008; Lerner & Henke, 2008).

Four papers relating to the management of workplace depression address concerns about the limitations of current treatments and describe newer care models. Details of primary and secondary prevention of the disorder include reviews of current treatments for workplace stress (Couser, 2008). These treatments include pharmacotherapy (Nierenberg, Ostacher, Huffman, Ametrano, Fava and Pertis, 2008) and psychotherapy (Markowitz, 2008). Lerner and Henke (2008) assess the occupational consequences of workplace depression from three perspectives: first, the magnitude of depression's impact on individual performance and the productivity of paid work; second, aspects of job performance and work productivity adversely affected by depression; and third, the

importance of the severity of illness in explaining variations in performance and productivity. The concepts of impairment and disability of depressive illness are analysed (Williams and Schouten, 2008) and the implications of accurate assessment in relation to work function, diagnosis, and ethical issues for the occupational medical provider are highlighted.

The final seven papers address gaps in existing services for quality treatment of workplace depression and propose population-care based approaches. Seelig and Katon (2008a) examine factors including providers, clinical practice and organisations, health care plans, employers and patients, with a view to identifying barriers to the improvement to services for people with depression. A second article by the same authors (Seelig and Katon, 2008b) asserts the necessity of two key conceptual changes: adoption of the chronic care approach and the collaborative, stepped care model of management. Wang, Simon and Kessler (2008) propose the involvement of increased employer and payer involvement in identification and management of affected workers. Burton and Conti (2008) take the position the corporate medical director needs to be involved at each step in the management process of worker depression and recommend a set of managerial practices aimed at returning people to work as soon as possible. A clinical and consulting occupational medical perspective is presented by Caruso (2008), who suggests some potential roles that focus on improving current practice, while Myette (2008) proposes an integrated approach that involves many currently disparate service providers in the management of worker depression. Lastly, Caruso (2008) explores potential solutions to challenges encountered in clinical management of worker depression and suggests that there are many opportunities to improve the current management of worker depression.

This special issue of the *JOEM* clearly focuses on the economic and health concerns arising from worker depression in organisations. Many authors present a range of ideas about the multiple and complex causes of depression, that include molecular contributions, temperament, life story, genetic variations, gender, life stressors, cognitive interpretations of events, work stress, and lack of social supports in the workplace. While no one approach clearly established a causative mechanism, the prevailing theme this journal identified is the substantial cost of worker depression and that depression disease management programmes can have a positive return-on-investment from an employer prospective, based on best practice.

A different approach to worker depression is offered in the second body of work, a major longitudinal research study conducted in Holland by Plaisier, de Bruigin, de Graaf, ten Have, Beekman and Penninx (2007). This study involved 2,646 men and women and examined the impact of working conditions on the production of depressed workers. Plaisier et al. (2007, p. 402) point out that, despite various studies exploring the relationship between poor working conditions and poor mental health, 'the relationship between working conditions and depressive and anxiety disorders remains unclear'. This was certainly the conclusion arrived at by Wilhelm, Kovess, Rios-Seidel and Finch (2004) (cited in Plaisier et al. 2007, p. 402).

Three kinds of psychological demands are identified in this study. The first kind of demand is basically negative, involving being required to work fast, work hard, but having insufficient time to do the work, as well as being given excessive work, and with conflicting demands. The second kind of demand requires choices and creativity about how to perform work, how to plan tasks, when to take a break, choosing work tempo. It involves learning new things, developing skills, task variety, creativity.

Finally, the third kind of demand leads to anxiety. Central here are 'job security' issues, including the possibility of future layoff and the prospects for steady work (Plaisier et al. 2007, p. 409). The major difference between this study and the papers in the *JOEM* issue is that Plaisier's study reports on the effects of working conditions on workers, rather than the identification, occupational therapy and economic management of worker depression as a problem for organisations.

The third body of work was conducted in Australia, and consists of a research report carried out for the Health Department of the Victorian State Government, *Workplace Stress in Victoria: developing a systems approach* (LaMontagne, Louie, & Ostry, 2006), together with a follow-up publication by members of the original research team (LaMontagne, Keegel, Louie, Ostry & Landsbergis, 2007). It is this work which is in closest sympathy with the emerging perspective of this thesis, though not from within the same theoretical framework.

The original study (LaMontagne et al. 2006) utilised a complex, system-wide approach, drawing on 'individually-focussed understandings of the problem as well as individually-focused interventions'(p. vii). The research conducted in-depth interviews that included employers, employer groups, trade unions, worker advocates, researchers

and the Victorian Workcover Authority, all of whom operate within the context shaped by Occupational Health and Safety, with a focus on controlling risk in the workplace. This risk management includes risk to the psychological or mental health of the workers. The interviews regarding job stress were conducted to evaluate the effectiveness of a systems approach (defined as intervention that was both organisationally and individually focused) over other approaches. It assessed 'patterns of job stress exposure among Victorians' and estimated 'the contribution of job stress to ill health among working Victorians' (p. vi). The study concludes that a systems approach to job stress yields the best outcome for both individual (better health) and organisational health (lower absenteeism). However, there is only 'limited leadership' on systems approaches to support movement in this direction (p. vii).

The work of La Montagne et al. distinguishes between primary, secondary and tertiary interventions necessary to a systems approach. Primary interventions or 'stress prevention' (LaMontagne et al. 2007, p. 152), including, for example, 'job redesign, changes in work pacing, enhancement of social support', may be directed at both the organisation and the individual. Ameliorative secondary interventions seek to modify individuals' responses to stressors (p. 268), whereas tertiary interventions, such as counselling, and rehabilitation programs, seek to minimise the 'the effects of stress-related problems once they have occurred' (p. 269). The earlier (2006) report had noted that the largest actual intervention within organisational systems studied was at a tertiary level of intervention, namely at 'individually focused understanding[s] of the problem, as well as individually focused interventions' (p. vii). The subsequent paper recommended that a systems approach needs to draw on all levels: primary, secondary and tertiary interventions.

While the focus of this work was on worker stress, and not on worker depression as such, its orientation to the importance of a systems-based approach is of particular interest. What this orientation does is to allow attention to the processes within organisations, including, potentially, narratives of workers' experiences of workplace stress. Such an orientation is essentially in harmony with an approach informed by my history as a family therapist, an approach which opens up a space for thinking about organizations in terms parallel to the processes of families. Such an approach would seek to understand the difficulties experienced by individuals, whether in a family or in a workplace, as connected with the actions, behaviour and values of other members of

that social system. And just as individual difficulties are part of the system, so healing has to be part of it. This approach to depression in the workplace will be opened up further in the concluding chapter.

Chapter 3

Rewriting the realist story: towards an analysis of the depressed worker self

Introduction

The first two chapters of this thesis have focused on presenting essentially a 'realist' account (Lather 1991) of the phenomenon of depression in the workplace. By this is meant an account that is framed within the descriptive terms of scientific, empirical research, with an emphasis on what is directly observable and hence measurable or countable. Such a perspective, involving contributions from economic, sociological, bio-medical, psychological and occupational health perspectives, is crucial to understanding the breadth and scope of the problem of worker depression in post-industrial societies at the beginning of the 21st century. The focus of this third chapter of Part I of the thesis shifts away from such a realist perspective, however, because of its conceptual limitations with respect to the specific focus of this research: the lived experience of workers diagnosed and treated for depression.

The realist account is predicated on a set of assumptions concerning the self as stable, as coherent, as unitary and as existing in some sense autonomously in, but not of, its environment. Such an implicit conception of the depressed worker self lies at the heart of these literatures, manifested variously in the individualist focus of both diagnosis and treatment, including the strong orientation towards management of the individual in the workplace. It leaves the workplace itself conceptually untouched. From the perspective of a family therapist, the workplace, no less than the family, needs to be considered in relational terms. It is by understanding the situatedness of individuals in the network of relations – not just of people but also of obligations and expectations – that change can be effectively negotiated. Such relations need to be understood as they are experienced, however: from the 'inside', not merely from the 'outside'.

From the diagnosis of depression to its medical management in the realist literature, there appears to be no exploration of the worker's perspective on worker depression, including the effects of workplace change in the lived experience of a population of depressed workers. It is hardly surprising, then, that no single theory has emerged to account for the unprecedented increase in worker depression since the taken-for-granted

biomedical discourses of depression locate the problem, 'the depression', within the individual. Such a perspective offers no vantage point for addressing the question of why there should be so many more of these kinds of individuals – those vulnerable to depression – at this point in time. The dominance of a bio-medical approach means, however, that only certain aspects of the individual's experience are attended to – essentially those that can be 'counted' towards a diagnosis of illness.

Thus, what is experienced in the body can be accounted for as 'symptoms' (see more detail under the term 'somatisation' in Chapter 6). What is experienced in terms of lowering of mood and loss of capacity to experience pleasure can also be attended to, according to the rubric for identifying depression elaborated in the *DSM-IV*. Forms of distress associated with the workplace itself, however, are more likely to seen as 'noise in the system' – contributing to but outside the depression itself. The adoption of perspectives drawn from poststructuralist theory in this chapter opens a space for considering the experience of depression rather differently than simply as an interruption to the ongoing story of the individual, restored to its 'real self' by appropriate diagnosis and treatment. The story of the experience of worker depression, as this thesis will demonstrate, is better understood in terms of more complex understandings of the self. It is the task of this chapter to lay out the conceptual framework on which such understandings rely.

Three terms are central to the perspective being developed: power, discourse and subjectivity. Each will be elaborated below. These theoretical categories are not separate entities and the order in which they have been addressed is based on the idea that it is the technologies of power that produce discourses which, in turn, produce or 'call forth' subjectivities, or forms of self. This chapter scaffolds the theoretical framing for the analysis of the data in Chapters 5 and 6.

Power is central to an understanding of the ways in which human beings are made into selves or subjects: they do not simply pre-exist in some essential way – they are *made* into who they are by the operations of power. This understanding of power, as productive (of persons), not simply as repressive, is central to the thinking of Foucault. His stated aim was 'to create a history of the different modes by which, in our culture, human beings are made subjects' (Dreyfus & Rabinow, 1983, pp. 209-8). The operations of power are central to this aim. Foucault's exploration of what he called

'technologies of power', in particular those of the panopticon, surveillance and technologies of performance (audits) are of particular relevance to this study.

These practices, or technologies, of power are relevant to the ways in which depressed workers' bodies are regulated, disciplined and produced through specific macro- and micro-economic reforms, which impact on the workplace and workers. Together they constitute part of a discursive regime attempting to produce contemporary workers as particular kinds of selves – the kinds of new selves variously referred to as the 'new worker self' (Billett, Fenwick, & Somerville, 2007, p. 14; Rose, 1996), the 'neo-liberal' or 'enterprising' worker.

The conception of discourse elaborated below is, again, Foucauldian in origin. It refers to the complex of ways in which 'truths' are generated and distributed in particular places, at particular points in time by how people learn to act in particular ways and by how they talk and write about what they do and who they are. From this process, of examining the historically and culturally specific rules regulating the ways people gain access to the truth and how truth is distributed throughout the social body, one can come to a better understanding of how reality is 'constituted by all that was said in all that the statements that named it, divided it up, described it, explained it … and possibly give it speech by articulating, in its name, discourses that were to be taken as its own' (Foucault, 1973, p. 32).

The final theoretical framing focuses on subjectivity in terms of technologies of the self and the assemblages of selves. As well as drawing on Foucault, the perspective developed below makes use of aspects of the work of Judith Butler and Nikolas Rose. Rose's theorisation of a set of contemporary 'selves', or subject positions, he names the *psychological self*, the *internalised self*, the *somatised self*, the *medicalised self* and the *neurochemical/pharmaceutical self* (1985; 1996; 2001; 2004; 2007) are of particular relevance to this study. The study is, of course, mindful that the categorisations of theory are themselves discursive practices 'calling forth' particular forms of subjectivity. As Sarup (1996, p. 86) writes, '[T]he self is not an objective reality to be described by our theories but a subjective notion that is actually constituted by them'. Hence, one's form of subjectivity changes in the telling and retelling of stories about the different forms of self called forth.

The new worker self is not an ideal or permanent category; rather, the new worker belongs in a particular time and place. Rose (1996, p. 137) and Gee et al. (1996, p. 17) share the notion that workplaces and workers changed after both world wars. Rose uses a poststructuralist/psychological lens to describe the changes to workers. He agrees that after World War I, 'the subjectivity of the worker was to be opened up to knowledge and regulation … the worker was to be individualised in terms of his or her particular psychological makeup and the idiosyncrasies and the job analysed in terms of its demands upon the worker'. Gee et al. (1996), in contrast, take a more managerial approach, distinguishing between two categories of worker 'produced' by the economic climate: 'low-level workers hired "from the neck down" to engage in allegedly mindless, repetitive, and meaningless pieces of tasks, the wholes of which they did not need to understand and certainly had no control over' and 'middle managers', who were mostly trained in business schools and were allegedly the 'professional brains' of the organisation (p. 17).

Of central importance to this study is the notion of 'resubjectification'. By this is meant the process of being reconstituted as a subject. It is derived from Butler's work (Butler, 1997, p. 11), addressing Foucault's ideas of the self or subject constituted in discourse. Since individuals as functioning social beings simultaneously participate in multiple discourses, which are themselves changing constantly, the process of being formed as subjects is necessarily not only multiple but also changing. This is particularly relevant to a study of depressed workers in rapidly changing workplaces. As the interview study of Chapters 5 and 6 will elaborate, the experience of depression for these workers can be productively understood in terms of an ongoing process of re-formation of identity or subjectivity: first, involving the loss of a coherent sense of self, followed by progressive forms of resubjectification into a new self. Chapter 4 will lay out the schematic template that was arrived at by reading the interview data through the lens of the idea of resubjectification. This template identifies five stages in the process of resubjectification, as workers move from the initial stage of loss of a coherent sense of self, eventually being resubjectified as a new kind of (provisionally) viable, coherent subject: the depressed worker. The regaining of a viable life as a depressed worker, albeit one that is fragile and transitional, is not merely signified by accepting the name 'depressed worker'. Rather the naming brings this person into existence as such by the productive power of discourse, which produces what it names. The depressed worker

subject can be said to be 'hailed' into existence (Hacking, 1995). Once so hailed, depressed workers are then countable statistically as part of the 'epidemic of worker depression' published as a 'fact' of the 21st century.

3.1 Technologies of power

This section gives an essentially Foucauldian account of three key means by which power is realised: surveillance, the panopticon and technologies of performance. It is not the purpose of this chapter to give an exhaustive account of Foucault's understanding of the complex interrelationship of power, discourse and subjectivity but rather to make productive use of certain of his ideas in relation to an area he himself did not explore: the contemporary workplace. These particular technologies of power are the focus of attention here because they are of immediate relevance to the contemporary workplace and hence to an understanding of how worker subjectivities are formed.

Foucault analyses power 'not as a negation of the vitality and capacities of individuals but as the creation, shaping and utilisation of human beings as subjects'(Rose, 1996, p. 151), arguing that individuals are an effect of power. All knowledge arises out of a power complex: regimes of power define what counts as meaningful utterances, what topics are to be investigated, how facts are to be produced, and so forth. Bevir (1999, p. 66) clarifies in the following terms: '[A]ll regimes of power are constituted by discursive formations: regimes of knowledge define who does and who does not have the intellectual authority to decide issues, how information should be gathered about who and by who [sic]'. Foucault 's *Discipline and Punish* was an attempt to analyse the way that power works on the body through external controls in the contemporary form of (workplace) surveillance and surveillance of the self in the formation of worker subjectivities:

> Discourses are not once and for all subservient to power or raised up against it, any more than silences are. We must make allowances for the complex and unstable process whereby discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling block, a point of resistance and a starting point for an opposing strategy. Discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it (Foucault, 1978, pp. 100-101).

Surveillance and panopticon

Surveillance has become a key apparatus in the contemporary workplace for managing and disciplining workers. Foucault's discussion of the panopticon, Jeremy Bentham's prison-complex design, enabling surveillance of prisoners by guards without the watcher being observed by the watched, is of particular relevance. Foucault notes that:

> Bentham was surprised that panoptic institutions could be so light: there were no more bars, no more chains, no more heavy locks; all that was needed was that the separations should be clear and the opening well arranged; [moreover] he who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself … he becomes the principle of his own subjection (Foucault, 1975, p. 202).

Contemporary workspaces have reconstituted the panopticon for workplace surveillance, visibly and invisibly. Open-plan offices, video cameras, keystroke monitoring and performance appraisals are introduced by management as good workplace practices, resulting in workers and managers being under constant surveillance. The gaze is not only directed toward workers but it also becomes internalised as ways of looking at their own behaviours and actions. Workers consciously or unconsciously come to monitor their own bodies, feelings, and actions, even meting out their own punishment if they find themselves lacking.

The technologies of the workplace panopticon, supplemented by those of the audit and technologies of performance, mean that workers' performance is no longer externally regulated by standards of conduct set by management. In the past, workplace audits were introduced only when trust has broken down (Power, 1994, p. 13). It can be said that, ironically, the implementation of the contemporary workplace audit creates the very 'mistrust' it is intended to address, as can be seen in the section to follow on technologies of performance. 'Technologies of performance' here basically entail economic checks and balances in the workplace and for the workers. They are primarily based on what Foucault termed the 'technologies of the self' (1988) that are a series of techniques that allow people to do work on themselves by regulating their bodies, their thoughts and their conduct:

> which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct and way of being so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection or immortality (Foucault, 1988, p. 18).

Foucault identified three main technologies of the self for achieving subjectivity in Western culture. The first, or Senecan, involved a series of techniques that allowed people to examine how their thoughts tie in with the rules of society. The second technology, what he calls early Christian hermeneutics, was concerned with inner thoughts and inner purity. The third technology was the Cartesian mode, which examined the extent to which thoughts correspond with reality. The main tenet of these technologies of the self emphasised the need to verbalise thought as a way of examining and knowing ourselves. Today, psychology and psychiatry still encourage people to talk to professionals as a way of finding the truth about themselves (Danaher, Schirato, & Webb, 2000, pp. 128-129). All the same, these technologies of the self are governed by what Foucault calls a 'game of truth, relations of power, and forms of relation to oneself and to others' (Foucault, 1988, p. 17).

Technologies of performance

Technologies of performance are concerned with the evaluation or the monitoring of workers' performance and the ways that organisations, both public and private, attempt to shape and direct the conduct of (individual) workers. The conduct of those who impose these measures on workers (management) is also governed in accordance with workplace reforms. The widespread use of workplace audits that demand changes to workers' subjectivity is one such technology of performance. Such audits require workers to become self-managing and self-regulating in accordance with workplace governance (Power, 1994; Shore & Wright, 2000; Dean, 1999, p. 169). The new vocabularies of such audits, including terms such as 'transparency', 'efficiency', 'benchmarking', 'quality assurance', function as discursive tools of power, bringing into existence new kinds of relations of workers to work – and to one another. The audited subject is recast as a personalised unit of economic resource whose productivity and performance must constantly be measured and enhanced.

In this study, technologies of performance can be taken up, not as government in terms of 'the State', but rather in the ways that workplace management techniques are formulated and implemented in an endeavour to shape, guide, and direct the conduct of others, irrespective of the type, size, shape and purpose of the organisation. As Rose (1996, p. 12) asserts, technologies (of performance) are about the formation and regulation of the 'conduct of conduct' – in this instance, of the workers' performance in

relation to organisational goals and the refashioning of the ways in which they perceive themselves in relation to their work.

Four examples of technologies of performance have been taken from the research interviews to portray the numerous ways in which technologies of performance occur in the workplace, to show how workers' performance is measured against the goals of the organisation and the expectation that workers will become more self-regulating and self-managing. The relevance of these different forms of technologies of performance in this study is to show the ways that new workplaces now have the expectation that '[a]ll vectors included in the organisation's strategic plan should be properly aligned with the ultimate goals of the organisation as they are defined in its vision mission' (Armstrong, 1988, p. 7).

The first example is provided by a senior mathematics and science teacher regarding the HSC:

> *We had a new syllabus imposed on us which is totally different, for a lot of us it's brand new material for which there's been no training, for which there's been virtually no real support, yet far more demands and discipline—disciplinary action is threatened if we don't get certain results with the kids.' While the type of disciplinary action that could be imposed on this teacher is not specified in this account, it is clear that this teacher's performance is linked to either a negative or positive outcome based on his performance.*

A second example is provided by a technician from an international computer company:

> *We used to have teams in every state and in other states and they were all just getting cut back, cut back, people going out all over the place, just to improve the margin and get rid of those overheads.' Here we can see the relation between reduction in the amount of staff (economic resource) that is required to achieve the economic goals of this workplace.*

The third example is provided by a journalist employed at a large Sydney university, who says:

> *We have an annual review of basically what we've done for the previous twelve months, what we want to do for the next twelve months and the expectations of what we'll do for the next twelve months is always attached to this curve or a gradient—you've got to do better.*

The fourth example is provided by a woman who was originally employed to teach computing software and was moved into sales when there was a merger in her place of work. Following the merger, the performance technologies were primarily based on sales targets that had to be met each month. She recounts:

> *I came back into the office and found that everything had changed; everybody was sitting with their heads down, the laughing and joking had stopped and everybody was working flat out, and I was told that if you don't perform, you're out—those are the words that I got from my manager.*

These examples of technologies of performance will be used as a means to analyse the workers' narratives to show the effects of these technologies of performance and to highlight the ways in which different regulatory regimes are constructed in workplaces. The difficulties that these workers report in these accounts do not appear to be a resistance to the technologies of performance as an instrument as such; rather, it is the demands to do better without sufficient staff or sufficient training, which could be construed as economic rationalisation (by the workplace) that directly influences the 'performance' problems of the workers. Imbued in these narratives is the lack of time available for these workers, who have to meet greater demands with the same amount of remunerated hours. One way that many workers adapt to being 'time poor' is to work longer hours in an attempt to meet their respective goals and those of the organisations, which are under constant review as their economic targets increase. In support of this hypothesis, Blair-Loy writes that '[the] relationship between employer and manager, in which the manager's allegiance will be rewarded with upward mobility, financial security, a positive sense of identity, and recognition from peers … these responsibilities may require longer hours and closer involvement with colleagues' (Blair-Loy, 2003, p. 21). These extra demands on workers are not always made explicit, as the fourth example above shows.

3.2 Discourse

This section explores the term discourse, within a Foucauldian framework. The particular perspective adopted is captured well in McHoul and Grace's account of discourse:

> In any historical period we can write, speak of, think about a given social object or practice (madness, for example) only in specific ways and not others. A discourse then would be

> whatever constrains but also enables writing, speaking and thinking within such specific limits (McHoul, 1993, p. 31).

The first part of this section will outline a Foucauldian approach to discourse analysis; the second will provide an overview of power, knowledge and regimes of truth; and the last part will specifically address the discursive construction of depressed workers' subjectivities.

Foucauldian discourse analysis

For Foucault, discourses are statements that set up relationships with other statements. They share a space and establish contexts, and may disappear and be replaced by other statements. According to Danaher, Schirato, & Webb (2000, p. 35) statements are essentially rare. As a discourse can potentially take up unspecified numbers of statements, usually only a limited number actually constitute any discourse and are reused repeatedly.

An example of this is depression discourse, which has a limited set of statements, including *feeling blue, feeling down, feeling sad, feeling out of sorts, feeling unhappy, not coping*, which establish a condition of truth upon which this discourse is judged and enacted by bio-medical institutions. On the strength of a set of limited statements, an individual can receive a diagnosis, be referred for treatment, and eventually take up the position of a depressed worker.

Nikolas Rose posits the notion (originally Foucault's) that people do not have a pre-existing self, which is then available to be studied by psychologists and psychiatrists – the 'psy' disciplines; generally it is these institutions that help establish a particular version of what a certain kind of person is. Hence individuals do not exist prior to history (or discourse) but are a product of history. From this perspective, depressed workers are knowledge objects produced by discourses.

Foucault believed in looking for the rules of exclusion, or prohibitions, for how one person's action is assigned to 'reason' and another to 'folly'. In *The Archaeology of Knowledge*, Foucault attempts to show how 'epistemes' (or notions of a period of history) 'speak themselves' through the production of 'discursive formations' or 'orders of discourse', and how speech is used to organise ideas and concepts and produce 'knowledge objects'. Foucault cautions against interpreting discourses purely at a

descriptive level, as such interpretations readily lend themselves to being understood as 'truth' or 'reality'. As he states:

> I would like to show that discourse is not a slender surface of contact, or confrontation, between a reality and a language (langue), the intrication of a lexicon and an experience: I would like to show with precise examples that in analyzing discourses themselves one sees the loosening of the embrace, apparently so tight, of words and things, and the emergence of a group of rules proper to discursive practice. These rules define not the dumb existence of a reality, nor the canonical use of a vocabulary, but the ordering of objects … A task that consists of not – of no longer treating discourses as groups of signs (signifying elements referring to contents and representations) but as practices that systematically form objects of which they speak (Foucault, 1972, pp. 48-49).

Discourse analysis from such a perspective makes very clear that meaning is not fixed and unitary but is multiple and shifting, depending on what context is involved, who is talking and who is interpreting what is said. As Foucault stated, '[T]he individual is carefully fabricated' into the social order (1975, p. 217). People are woven into and out of discourse (MacLure, 2003, p. 176). As a result, discourses are used by people to make sense of the world, and to learn to behave in specific and appropriate ways through discursive frameworks. Foucault notes:

> [I]n every society the production of discourse is at once controlled, selected, organised and redistributed according to certain numbers of procedures whose role is to avert its powers and its dangers, to cope with chance events, to evade its ponderous, awesome materiality (Foucault, 1971, p. 8).

Foucauldian discourse analysis refers to the 'macro-level' of structural orders of discourse (Foucault, 1971). These are broad historical systems of meaning and include any meaningful political practices (referred to as 'discursive practices'), which are relatively stable over considerable periods of time. However, as Foucauldian discourse analysis emphasises, identity is not only constructed in the context of relations of meaning but also within institutionalised relations of power. Discourses of national identity, sexuality, gender or race are not autonomous systems but operate in the context of the institutional supports and practices upon which they rely (Mottier, 2000).

Power, knowledge and discourse as regimes of truth

Power, discourse and subjectivity are interrelated concepts, not separate entities. The 'depressed worker self' posited in this thesis is hence necessarily discursively complex

and in this section the aim is to examine how technologies of power and knowledge function in the production of a diagnosis of depression of an individual worker that is then taken as a regime of truth or made to function in the workplace and society as true. The discourses circulating within an institution (in this case the medical institution) work by 'producing meaning, forming subjects, and regulating conduct within particular societies and institutions' (MacLure, 2003, p. 175). These sets of statements are accessible through the talk and written language and prescribe what is deemed 'normal' or appropriate for the subjects organised by the institution.

Foucault (1980a) realised that knowledge is a basis for power, rather than something to be owned or possessed, and demonstrated that the force of power is not static. In his genealogical work, Foucault developed a theory of power and knowledge whereby power does not belong to different agents, such as individuals or the state, or a group with particular interests; rather, power is spread across different social practices. Power is not exclusively oppressive, but productive, and constitutes discourse, knowledge bodies and subjectivities:

> What makes power hold good, and what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression (Gordon, 1977, p. 119).

These conceptualisations can be used to explore the ways in which particular kinds of knowledge and discourse structure individuals' own self-understanding and practice, including their own desires and aspirations, and will become connected with wider governmental objectives and aims (Burchell, Gordon & Miller 1991). Practices such as self-inspection of thoughts and behaviours enable people to transform their thoughts in particular ways, thereby becoming self-conscious, responsible, classifiable, self-regulating and self-determining. Rose (1996) suggests that these practices of the self and psychological discourse and knowledge are a cornerstone of the ways that authorities seek to govern individuals and how individuals understand and act upon themselves.

Regimes of truth are important for understanding the construction of worker depression, as this is how workers take up the social rules of the workplace, as evidenced by the discourses that they use to make meanings of workplace change and take up as truth.

Regimes of truth construct the measures of how people should act, feel and understand their world, and are commonly reflected in the discourses that they mobilise:

> Each society has its regime of truth, or 'general politics' of truth—that is, the types of discourse it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements; the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; and the status of those who are charged with saying what counts as true (Foucault, 1980a, p. 131).

3.3 Subjectivity

This section addresses the third of the three terms which are the focus of this chapter: subjectivity. Again, it does not attempt to give a comprehensive account of even Foucault's thinking on this topic, much less the larger body of available theory. Rather, it attends to two specific issues of particular relevance to this study: first, technologies of the self, concerned with how the self makes itself as distinct from being made by forces outside itself; and second, multiple subjectivity or multiple selves – the condition of experience for all persons living in complex societies who need to negotiate a multiplicity of contexts, together with the discourses operative in those contexts, in order to function as viable persons. The perspectives adopted draw on the work of Foucault, together with particular insights from Judith Butler and Nikolas Rose, as having particular resonance with the work of Billett, Fenwick and Somerville (2007), whose poststructuralist notions of worker subjectivity, workplace change and the production of new workers provide productive ways of reading the depressed workers' accounts in this study.

The realist account of the 'depressed worker self' relies on taken-for-granted biomedical, psychological and neurochemical discourses that locate the problem of 'the depression' within the individual and maintain the notion of an individual singular unitary self, as outlined in the introduction to this chapter. In contrast to this singular, essentialised and 'damaged' conception of the 'depressed worker self', this section works to put in place a more complex understanding of the process of the forming and re-forming of new (interim) selves which eventually give rise to the formation of a depressed worker self. This self can certainly be understood as an interim form of subjectivity, as all subjectivities are. It is not to be understood, however, as merely a 'damaged' form of some essential and enduring self, much less as the restoration of an

originary essential self. These are not the truths that realist accounts of this terrain represent them as being but fictions, chimera even.

Technologies of the self

The question of subjectivity was central to Foucault's project, which he formulated as follows, rejecting centuries-old assumptions:

> To study the constitution of the subject as an object for himself: the formation of procedures by which the subject is led to observe himself, analyze himself, interpret himself, recognise himself as a domain of possible knowledge. In short, this concerns the history of "subjectivity", if what is meant by that term is the way in which the subject experiences himself in the game of truth where he relates to himself (Foucault 1998, cited in Hall, 2004, p. 92).

'Technologies of the self' are the processes by which people become objects of knowledge to themselves and, through revealing their deepest personal truths, become controlled and can control themselves. In doing this, they constrain themselves in the way they construct themselves during their discursive relationships with others. For Foucault, the term refers to ways which permit individuals to effect, by their own means or with the help of others, a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality (Foucault, 1988, p. 18).

This emphasis on the role of the self in the formation of its own subjectivity involves a somewhat different take from everyday 'common-sense' thinking. From that perspective, the self is acted upon by forces outside itself, which seek to influence (read 'distort') its direction and nature. From a Foucauldian perspective, the self is conceived more fluidly in its interactions with what is outside itself: in fact, its very existence as a particular kind of self is built on the basis of those interactions. Henriques, Hollway, Urwin, Venn and Walkerdine (1998) speak of subjects as being 'dynamic and multiple, always positioned in relation to particular discourses and practices and produced by these – the condition of being subject' (1998, p. 3).

This understanding of subjectivity is expanded upon by Rose (1989) who proposes that subjectivity:

> has taken shape through the proliferation of a complex and heterogeneous assemblage of technologies. These have acted as relays, bringing the varied ambitions of political, scientific,

> philanthropic, and professional authorities into alignment with the ideals and aspirations of individuals, with the selves each of us want to be (p. 217).

Butler posits a more radical version of this perspective by proposing that personal identity or the 'self' is an illusion, that the 'self' is an ever changing discursive construction (Butler, 1990). Taking up Butler's theorisation of the self, it could be hypothesised that 'depressed workers' are socially constructed and perform the work of neo-neoliberal workplace discourses. As workers desire to attain these 'illusionary notions of self', multiple and contradictory discourses are created in the production of the self and the most accessible contemporary dominant discourse is that of medicalisation or depression which is accepted by workers. Further, as Butler suggests, 'no subject emerges without a passionate attachment to those on whom he or she is fundamentally dependant' (1997, p. 7). There is an inextricable link between subjection and dependency on discourses that are not of our choosing, paradoxically producing and sustaining workers' agency (1997, pp. 1-2).

In this study, workers' passionate attachments to their past and present discourses of the self were frequently mobilised in terms of uncertainty, frustration and reinstituted past/present workplace binaries. The loss of past stable workplace structures was a key feature identified by workers in this study. New forms of a self (the depressed worker self) post-diagnosis may be interpreted with relief that the worker is not going mad; however, one of the material effects of medicalisation is that medical governance will now determine the ways in which workers conduct their lives, both in the personal choices they make and in the workplace. As Rose states, '[I]ndividuals play their own part in the spread of the diagnosis of depression and the shaping of conceptions of the self' (2007, p. 154).

Since subjectivities are socially constructed, they can be imposed, assumed, resisted, or changed through discursive practices. Technologies of the self are relevant in understanding how individuals are simultaneously positioned by, and choose to position and to understand themselves in terms of, their subjectivisation (Foucault, 1988b). Instead of being pre-determined by biology, a person's '… subjectivity is made possible through the discourses s/he has access to, through a life history of being in the world' (Davies, 1994, p. 3). A poststructuralist approach recognises that persons take on subject positions by positioning themselves and being positioned, minute by minute,

through the discourses that are mobilised and in which they participate. Davies describes it thus:

> … while not negating the power of the conscious and unconscious minds to store and use the multiple layers of knowing that accumulate in anyone's life, each person is, nevertheless, also in an important sense, constituted afresh in each new context, each new set of relations and positioning within the discourses and storylines (Davies 1994, p. 4).

In the context of this study, the depressed worker is best understood, not as bringing that subject-position, already formed, to the process of diagnosis and treatment, but as being constituted as such through those processes. Their own acceptance of such positioning is, of course, essential to the effectiveness of the process: they have, in some sense, to recognise and acknowledge themselves in the terms made available. They have to come to know themselves as depressed workers. In seeking to answer the fundamental question, what 'discursive work' is involved in making themselves into depressed workers, the ground for such discursive work has already been well prepared by the spread of particular conceptions and practices of the self through the 20th century. It is to Nikolas Rose's account of these discourses that this chapter now turns.

Building on the work of Foucault, Rose (1996a) problematises contemporary regimes of the self by addressing the processes through which current regulative ideals have been invented. His project is to expand the limits of what is currently thinkable, to extend those limits and to enhance the contestability of what appear to be natural ways of relating to our selves. The focus of the essays in his volume, *Inventing Ourselves: power, psychology and personhood*, are the psychosciences and disciplines—psychology, psychiatry and their cognates, which he collectively refers to as the 'psy' sciences. These, he argues, have 'brought into existence a variety of new ways in which human beings have come to understand themselves and do things to themselves' (p. 2).

This 'critical' history focuses on the vocabularies, explanations and techniques of psy in relation to '"making up" the kinds of persons that we take ourselves to be' (p. 10). Rose (1996a) poses further questions such as: 'What means have been invented to govern the human being, to shape or fashion conduct in desired directions' (p. 26)? How have programs such as 'asylum management, medical treatment of women, advisable regimes of child rearing, new ideas in workplace management, improving one's self esteem' sought to clarify the problems and simultaneously make them manageable (p. 26)? Part of the answer to this question is taken up by Rose, drawing on the work of

Deleuze and Guattari (1988), who suggest that 'subjects … might better be seen as "assemblages" that metamorphose or change their properties as they expand their connections, [and] that [they] "are" nothing more or less than the changing connections into which they are associated' (Rose, 1996a, p. 172).

Part II of the thesis provides an account of the effects of workplace change on the worker subjectivities that are called into being when workers experience a lack of fit between workplace change and a previously experienced sense of self. It will be argued that the workplace is a technology that shapes workers' conduct and directs them to behave in particular ways. Work is understood as 'an individual's engagement in goal-directed activities that usually emanate from social and cultural purposes' (Billett, Fenwick, & Somerville, 2007 p. 4). Work can be seen as a range of visible activities and interactions with others. However, work's enactment is basically realised through the deployment of human subjectivities that shape how the work is conceptualised, engaged with and conducted (Billett 2003). The significance of subjectivity to the work of this study from a poststructuralist perspective is that workers' subjectivities comprise a set of conceptions, procedures, values and dispositions that are largely unconscious but become conscious when something that the worker experiences does not fit with their world view of how things were or should be in the workplace.

Other considerations of work place change involve new flexible working arrangements which are, as Billett, Fenwick and Somerville (2007) suggest, more for portfolio workers, as many elements of traditional work remain in other sectors such as farming, factories, mines and aged care. The problem with trying to bridge the gap between older work traditions and new working arrangements is that change in the work context appears to be in the type of subjectivities 'called forth' in each of these workplaces. Fenwick (2007) suggests that 'almost all of the workplaces from the traditional to the fluid work situation are characterised by changing discourses of subjectivity' (p. 249).

Changing subjectivities are evidenced when a worker experiences workplace change as overwhelming and relentless. This is the time when workers revert to somatised discourses that are readily available to be mobilised in an attempt to convey distress to others, who include fellow workers, family and friends and eventually their doctors, by using 'I' statements: *I could not sleep, I could not eat, I could not concentrate*. These not only 'change the connections into which they (the workers) are associated' but also

engage the workers in a process that resubjectifies them(selves) as depressed workers. Detailing how this process of (multiple) resubjectification occurs is, of course, the work of Chapters 5 and 6.

Multiple selves

In this section, I again draw on Rose's work to explain the ways that the 'psy' sciences have 'brought into existence a variety of ways that human beings have come to understand themselves and do things to themselves' in relation to 'making up the kinds of persons we take ourselves to be' (Rose 1996a, p. 3). The specific set of forms of subjectivity identified by Rose are: the psychological self, the internalised self, the somatised self, the medicalised or the resubjectified self, the pharmacological/ neurochemical self and the enterprising self or the new worker self. A brief account of each of these forms of subjectivity will be given below, as a prelude to the work to be done in Chapter 4, which will actively use this set of available positions to develop a grid for mapping the processes of resubjectification undergone by the depressed workers interviewed for this study.

Programs for the liberal government of society operating from the 19th century opened up the space for psychological practices to play an increasingly key role that enabled human subjectivity to be translated into government, schools, the workplace and the economy in providing the language for speaking about intelligence, development, mental health and so forth. The problematisation of abnormality occurred prior to the knowledge of normality, which developed later and led psychology to feed into social and political thought. Rose (1996, p. 17) claims that, in the 19th century, psychology invented the 'normal' individual, the significance of which was a discipline of the social person:

> [H]uman beings have come to see themselves as being inhabited by a deep-interior psychological self. A person can now inspect oneself, account for oneself, and work on one's self to gain happiness and exercise personal choice (Rose, 1996a, p. 17).

Freedom has come to mean the realisation of what Rose calls the *psychological self*, which can be organised according to the ethic of autonomous selfhood. Psychology has thus participated in reshaping the practice of those who exercise authority over others, such as human resource departments, workplace managers, teachers, social workers and

so forth, so that they nurture and direct these individual strivings in the most appropriate and productive fashion (Rose, 1996, p. 151).

The second of new selves Rose identifies is the *internalised self*. The psychological self is the theoretical forerunner to this self. According to Epson (1993), the most politically powerful discourses in modern society divide us from each other and invite us to treat our bodies as problematic objects. Discourses that support this process are named 'internalising' discourses or 'inner dialogues', and interpret and colour events (Epson, 1993). In the workers' narratives in this study, internalising discourse is powerfully evidenced when they discursively shift from externalised forms referring to workplace issues in terms of 'they' or 'them' to referring to 'I' or 'me', or even parts of their own bodies, as problematic objects.

Rose's third 'psy' self is the *somatised self*, the self who experiences itself in terms of various bodily symptoms and emotional sensations. For the interviewees in this study, such experiences were articulated in such terms as *I was in a fog, There is a hole inside of me, I can't see*. Foucault notes that 'the symptom plays more or less the role of language in action' (1973, p. 32). Somatisation is common in everyday discourses, yet it resists medical explanation. However, it is taken up as a psychiatric discourse.

Hacking (1995, p. 68) maintains that expert knowledge in psychiatry 'effects the way in which human individuals come to conceive of themselves'. Novas & Rose (2000, p. 489) contend that, increasingly over the last half of the 20th century, clinical medicine has constituted the patient as an 'active' subject – one who must play a part in the game of cure. Medical practice requires the patient to offer up their voice in the diagnostic process in order to permit the disease to be identified and to commit themselves to the cure as part of the therapeutic alliance. The patient is to become skilled, prudent and an active ally of the doctor (Novas & Rose, 2000, p. 489). As indicated earlier in this chapter workers in the study had an array of reactions to being diagnosed as depressed, yet they too committed themselves to cure as part of the 'therapeutic alliance'.

Rose's fourth self is the *medicalised self*. Foucault (1980a) suggests that medicalisation operates as social control at the 'capillary level', not from above or below but from all social relationships, constraining individual bodies and governing individual actions and attitudes through discourses. Rose (2007) reports, that 'since at least the 18th century in

developed countries, medicine played a constitutive part in "making up people"' (p. 700), as individuals came to describe themselves in the language of health and illness:

> Medicalisation of sadness can only occur within a political economy of subjectification, a public habitat of images of the good life for identification, a plurality of pedagogies of everyday existence, which display, in meticulous if banal detail, the ways of conducting oneself that make possible a life that is personally pleasurable and socially acceptable … individuals play their own part in the spread of the diagnosis of depression and shaping new conceptions of the self (Rose, 2007, p. 701).

In a narrower sense, medicalisation refers to human decision (both personal, national and international), as described in policy documents highlighted in Chapter 1. The medicalisation of workplace stress from a poststructuralist perspective provides a way for unhappy workers to be resubjectified as depressed workers by visiting a doctor, who will reinterpret their internalising and somatising discourses and provide them with a diagnosis of depression. Thus, medicalising is a workplace matter. This form of medicalisation could also be understood as concealing problems in organisations, which are taken up by the worker, who becomes an 'active' agent and must play a part in 'curing the workplace', if only by presenting numerical evidence that workplace depression has been globally noticed and reported as an economic issue for workplaces.

The fifth self is the *neurochemical or pharmaceutical self* and is a relatively new concept that has been discursively produced from what Rose (2004) terms the 'pharmacological societies'(p. 2). These are 'societies where the modification of thought, mood and conduct by pharmacological means has become more or less routine' (p. 2). The modern era of pharmaceutical therapies began in the 1950s at the point where drugs were produced not only for sedative purposes but supposedly had 'specific effects on particular symptoms of certain psychiatric conditions'(pp. 2-3). The SSRI family of antidepressants, as discussed in Chapter 2, was crucial in the construction of the neurochemical/pharmaceutical self for depressed workers. Depressed workers are flexible and can be reconfigured in ways that blur the boundaries between cure, normalisation and the enhancement of capacities. Pharmaceuticals promise 'a power to reshape life pharmaceutically that extends way beyond what we previously understood as illness'(Rose, 2004, p. 27).

The last category of multiple selves is the *new worker self*, which emerged as a possible way to name the phenomena that materialised towards the end of the 1980s, where

workers were expected to take on more responsibility – not just managers, from the top down, as used to be the case in workplaces of the past. As organisational hierarchies flattened out, increased responsibility could now come from any sector of the organisational network. On this theme of new worker selves, Rose writes that 'the new citizen is required to engage in a ceaseless work of training and retraining, skilling and reskilling, enhancement of credentials and preparation for a life of incessant job seeking: life is to become a ceaseless capitalisation of the self" (Rose, 1999b, p. 161). Fenwick and Somerville (2007) supplement and augment Rose's argument by suggesting that one of the most significant changes in work contexts appears to be in the form of worker subjectivities 'called forth':

> The predominant change in the work context appears to be in the type of subjectivities "called forth" in each of these workplaces. Almost all of the workplaces, from the more traditional to the more fluid and contemporary work situations, are characterised by changing discourses of subjectivity … what counts as knowledge has changed, how workers learn has changed, and acquiring new or modified subjectivities requires processes of learning (Fenwick & Somerville, 2007, p. 249).

What this study has shown is that, not only are new forms of worker subjectivities 'called forth', but that these workers have pre-existing psychological selves readily available to be mobilised in response to the degree of 'ceaseless capitalisation of the self' (Rose, 1999b, p. 161). The critical thing about this array of subject positions available in the late 20th and early 21st centuries is that these are not alternative forms of subjectivity, identifying different kinds of persons, but rather an assemblage of possibilities, all equally available over time to the same person, as the interview study detailed in Part II below will amply demonstrate.

Conclusion

The pervading assumption of realist accounts of persons is that the self has one true nature or set of characteristics waiting to be discovered and described (Billett, Fenwick, & Somerville, 2007, p 39). A poststructuralist account of persons as subjects renders them both more complex and constantly in flux, to the extent that they participate in multiple institutions and the multiple discourses that circulate in those institutions. The 'depressed worker self', then, is far more discursively complex than the realist versions of worker depression depicted by the media, published in health and organisational policy and deployed in bio-medical, psychological and pharmaceutical discourses.

The eventual elaboration of a five-stage narrative resubjectification table on the basis of the interview data demonstrates the stages through which workers discursively engage in order to become progressively resubjectified into provisionally viable coherent depressed worker subjects. The regaining of a viable life as a depressed worker, albeit in a fragile and transitional way, means that they have in fact been 'hailed' into a new form of existence (Hacking, 1995). Once hailed into existence, these depressed workers contribute statistically to the 'epidemic of worker depression' published as a 'fact' of the 21st century. However, it will be argued that being resubjectified as a depressed worker is not a solution; it is a chimera – a figment of hope – rather than just another discursive positioning that may present as a changing form of agency, yet does little to re-engage the worker as a productive unit in the workforce. Just as Foucault portrayed the [depressed worker] subject as a product of regimes of power/knowledge, these workers are contemporarily produced by the economic and biomedical discourses of this historical moment.

Chapter 4

Research design and methodology

Introduction

This chapter gives an account of the origins and conduct of the research study detailed in Chapters 5 and 6. The Prologue has already given a narrative account of events that gave rise to this thesis: my professional experience of the researcher as a therapist, as I gradually became aware of the significant interrelationship between the workplace and depression. The research subsequently became an exploration of the effects of workplace change in the lived experience of a population of depressed workers and the way workplace change is construed and managed. It specifically addresses a gap in the available literature: the lack of accounts, from the perspective of workers, of the experience of workplace change and their subsequent medical treatment for depression.

The decision to embark on an interview study exploring the experience of this interrelationship for a number of depressed workers was made at an early stage in the research process. That decision could be described as an almost inevitable outcome of my prior professional training and experience as a therapist. Knowing how to get people to talk about their experience is learned as a necessary therapeutic skill in order to understand what is going wrong in people's lives. Understanding how the telling of lives – the process of narrative – functions is central to this therapeutic work. It is not a large step to seeing such telling as opening up a potentially valuable research space. This chapter tells of the practical steps taken in the evolution of this project. It also gives an account of the process I underwent as a novice researcher in learning to read the stories told by the interviewees in the study as researcher, rather than therapist.

The chapter is organised in four sections. The first section gives an account of the rationale for designing an interview study in terms of key elements of Systemic Family Therapy and Narrative Therapy. The second section describes the research process, explains the recruitment of participants and their demographic characteristics, describes how the research interviews were conducted and concludes with some researcher reflections on the interviews. The third section gives an account of the data treatment and analysis process, detailing the two reading strategies progressively adopted in interpreting the data. The chapter concludes with a summary account of the stages of

change undergone by the interviewees in moving towards a new identity as depressed workers.

The story of how the interview transcripts were read and reread, informed progressively by the bodies of theory outlined in Part I of this thesis, is a story in part of the power of theory to inform understandings of the world – specifically, by learning to listen differently to what people say about their experience. An initial reading of the interview data as 'case studies' – what is referred to below as the 'vertical' reading – attended more to what was individual about the stories. Subsequent readings *across* the body of data (the 'horizontal' reading) opened up patterns in common between the stories. Indeed, an understanding gradually emerged that, despite all the differences of detail between the tellers and their stories, they were in certain profound respects telling the same story. Those understandings will be elaborated in Chapters 5 and 6, which provide detailed accounts, respectively, of the horizontal reading of the body of data which was eventually developed and of a detailed vertical reading of one interview, framed by the preceding horizontal reading.

The data collection stage of the research was framed basically in terms of practices and understandings drawn from extensive therapeutic experience, and the knowledges informing such practice, principally Systemic Family Therapy. The analyses drew primarily on poststructuralist frameworks, particularly the work of Foucault and Rose as outlined in Chapter 3. As will be seen, these frameworks proved to be usefully complementary.

4.1 Conceptualising an interview study

Systemic Family Therapy (SFT) provides the fundamental framework within which other kinds of knowledge are deployed in this thesis, always with an orientation to practice (Campbell, Draper, & Crutchley, 1991; Flaskas, 2005; Jenkins & Asen, 1992; Minuchin, 1974; Shumway, Kimball, Korinek, & Arrendo, 2007) As Flaskas notes: 'Family therapy is, of course, a practice discipline, and the context and nature of practice disciplines shape the way in which knowledge is generated' (pp. 190-191). Family systemic therapists are interested in the belief systems, behavioural patterns and the contextual settings from which problems arise. The fundamental premise of a family therapist is that 'all behaviour has meaning in the context of certain relationships at a

given moment and the family is the expert about itself' (Campbell, Draper, & Crutchley, 1991, p. 339). Unlike psychodynamic therapists, systemic therapists:

> are interventive or 'leading' enquirers, attempting to introduce new ideas and ways of looking at familiar concerns, rather than waiting for the client to 'say anything that comes to mind' and then responding to this emerging 'material' (Jenkins & Asen, 1992, p. 3).

As interventive inquirers, SFT practitioners interrogate the context, rather than solely focusing on the individual as the one who is or has the problem. Narrative therapy, as a tool of SFT, views personal stories or narratives as different versions of the self. Clients have 'a problem saturated narrative' (Boston, 2000, p. 452) that has over a period of time become their dominant self-description or dominant discourse. The dominant discourse is maintained through a series of connections to other internalised stories. Therapists are particularly interested in the client's description of the presenting problem. Once described, the therapist externalises the problem, that is: 'the linguistic structure of a therapist's questions imply that the problem is something other than the client's core identity' (Boston, 2000, p. 452). Narrative Therapy plays a particular role in the repertoire of interpretive strategies used by Systemic Family Therapists (Parker, 1999; Payne, 2000; Sween, 1998; White & Epston, 1990). Boston (2005), when writing on deconstruction in Narrative Therapy, cites White (1992) who argues that 'therapy is primarily a linguistic endeavour' and 'the practice of deconstruction … [is used] as a means of offering alternatives to problem-saturated self-narratives and unhelpful dominant cultural discourses' (p. 272). Therefore, as all 'behaviour has meaning' to family therapists, what is of equal importance is the ways that people construct their narratives and the meanings that they derive from the fluidity of those constructions that are always changing, contradictory and partial.

Interviewing in clinical practice is integral to SFT and Narrative Therapy. As an experienced practitioner using these frameworks, I was already a skilled interviewer. As Burck (2005) points out, therapists are 'almost always extremely skilled interviewers, trained to follow feedback and unpack meanings, able to entertain and elicit multiple and contradictory perspectives' (p. 241). In addition, they are able to keep the interview focused, as well as monitoring themselves as interviewers. One of the hallmarks of family therapy education and training is live supervision, meaning that supervisors and an observing team of up to eight people may, from behind a one-way mirror, observe what is transpiring in the therapy room. Initially live supervision is daunting as, at any

time, a team member may interrupt the conversation and suggest that the therapist return to do further work on something said earlier. Such close monitoring works to develop skills of integrating close attention to local detail into the larger picture of the systems within which individual experience, and stories of that experience, must be located. People 'represent only the tip of the ice berg of a system that is nested within other systems… and made up of individuals who themselves can be seen as systems' (McCollum & Trepper, 2001, p. 21). The specific interview skills involved in such practice correspond in many respects to those required for the researcher 'semi-structured interview'.

A therapeutically-informed interview is certainly concerned to retrieve 'old' stories, that is, stories which have come to be solidified through previous tellings into 'true' stories. It is also designed to open up spaces for the construction of new stories, which can lead to new insights on the part of the interviewee. This is particularly the case, given the focus of the family therapist, not on returning the interviewee continuously back to the contents of the problem, but rather on the patterning of the problem. Refocusing attention in this way can be understood as attending to the dominant discourses informing the presenting problem. These strategies deployed in a research context will, and are intended to, give rise to new insights for both interviewer and interviewee. Such an approach is very much in accord with the perspective of Holstein and Gubrium (1995) who suggest that:

> Both parties to the interview are necessarily and unavoidably *active*. Each is involved in the meaning-making work. Meaning is not merely elicited by apt questioning nor simply transported through respondent replies; it is actively and communicatively assembled in the interview encounter (p. 4).

4.2 The research process

This section discusses the procedural and ethical aspects of the design and conduct of this study. It details the recruitment process, including demographic characteristics of the interviewees, ethical considerations, the process of conducting the research interviews and concludes with some reflections on the interview process.

The recruitment process

The recruitment process occurred somewhat serendipitously as a consequence of being sought for an interview on worker depression by a journalist from a local Sydney

newspaper, *The Sun Herald*, pursuing the question of why so many people in the workplace were becoming depressed. Following the interview, the subsequent published article (O'Rourke, 2003) referred to my research project and provided an email address for readers to contact me should they be interested in participating in an interview study.

Eighty emails from people interested in participating were received. Criteria for selection for interview were that interviewees were full time workers and had been given a diagnosis of depression. Those respondents receiving workers' compensation were excluded, as workers with compensation claims frequently focus on the outcomes of their diagnosis rather than on their experiences of being diagnosed with depression. Workers receiving compensation are governed by complex policies, and the outcomes of their disputes, and those emphases may not have been the most useful for my proposed research. Thirty people met the research criteria and were contacted via email.

Twenty participants were finally interviewed for this study, ten men and ten women. The gender split was designed to explore if there were similarities or marked differences in the effects of workplace change based on gender. As this was not a quantitative study, I was not looking for scientific evidence based on gender differences but rather any emerging patterns of response. However, gender differences did not prove to be relevant to the particular focus of the analysis, as both male and female research participants underwent largely similar processes of resubjectification, from being unhappy workers to being depressed workers. This should not be understood as suggesting that gender is not important in the experience of work-related depression, merely that it was not of significance for the focus of this study,

The twenty participants represented a range of demographic characteristics, including levels of education. Their ages ranged from 23 to 60 years. Four were single and living alone and sixteen had a variety of living-together arrangements. All interviewees lived in the Sydney metropolitan area. Participation in the study relied on the fact that workers had access to a computer and could use email to respond to the email address published in *The Sun-Herald*. These email responses revealed the workers' excellent literacy skills, provided a clear description of their construction of depression and why they believed their workplace had contributed to their depression.

Demographics of research participants

Name (Pseudonyms)	Occupation	Age group	Education level
Amber	Journalist	20's	Tertiary
Anne	Work Cover inspector	30's	Secondary
Ashley	Accounts payable clerk	50's	Secondary
Barden	Electrical engineer	30's	Tertiary
Cleo	Call centre worker	40's	Secondary
Daniel	Flight attendant	30's	Secondary
Graham	I.T. manager	50's	Secondary
Heather	Teacher administrator	40's	Tertiary
Isobel	Social worker	30's	Tertiary
James	Systems analyst / auditor	60's	Secondary
Ken	Head teacher - administrator	50's	Tertiary
Len	I.T. manager	50's	Secondary
Mark	Police inspector	50's	Secondary
Mary	Computer software salesperson	40's	Secondary
Megan	H.R. manager	20's	Tertiary
Molly	Recruitment consultant	20's	Secondary
Paul	Psychologist	50's	Tertiary
Peter	Chemical engineer	40's	Tertiary
Stefan	Podiatrist / musician	40's	Tertiary
Sue	Lawyer	20's	Tertiary

The diversity of the participants' workplaces included the following: a law firm, an international bank, an international airline, a telemarketing company, a podiatry practice, telecommunications IT division, a specialised paint company, an employment and recruitment agency and an insurance company. One participant worked from home, as he required flexible working hours to meet his family's childcare needs.

Nine participants were on antidepressant medication at the time of the interview, and the remaining eleven had tried pharmaceutical intervention at some time but had chosen not to continue. Nineteen of the research participants had been officially diagnosed as clinically depressed, some for only a matter of months and others for the past two years. One person self diagnosed via *beyondblue's* Kessler (1994) Psychological Distress Scale (K10) questionnaire on the internet (see Appendix 4). This was only disclosed

during the interview. Interviewees were all employed at the time of the interviews and all except one worker had remained in the same workplace.

All interviewees wanted an opportunity to tell their stories. They expressed the hope that their workplace change and depressed worker stories would be heard in a wider arena and that in the long term this study would benefit other workers in similar situations. These self-referred interviewees felt that worker depression was widespread and that there had been little opportunity, for 'their side of the story' to go beyond their workplace, social contacts and family. They believed that most of the information on worker depression came from depression statistics gathered and collated by private and public institutions, giving no description of what it actually felt like to live through such an experience. Most clients I have seen therapeutically do not express concerns about others in similar circumstances, nor do they consider that their personal concerns and experiences could make a difference in the wider social context. Perhaps this 'difference' could be assigned to the interviewees' understanding that a 'research project' will occupy a public space, whereas individuals seeking 'therapy' seek private spaces.

Ethical considerations

The usual formal ethics procedures required by the university were conformed with. Prior to interviews, letters outlining the nature and purpose of the study, together with a confidentiality agreement, were sent to participants, providing them with further opportunity to ask questions. Signatures were secured before conducting interviews. At the time of the interviews, I explained that personal details would be de-identified by the use of coding of both audiotapes and data and that pseudonyms would be used in the thesis. Audiotapes, in keeping with ethics requirements, have been secured in a locked space, where they will remain for the mandatory seven years. Transcripts have been de-identified before being made available to supervisors, and the coding for de-identification kept in password-protected computer storage.

The nature of the study raised a set of ethical considerations going well beyond these formal requirements, however. These considerations had implications both for the design of the interview schedule itself and for the conduct of the interviews. The first issue was the possible emotional vulnerability of the research participants who had received a diagnosis of depression. Within my therapy training, the provision of care

and consideration to clients is mandated. Privacy and confidentiality in research, as in therapy, involves the development of trust between the therapeutic provider and the receiver.

Decisions about the broad structure of the interview were guided by the research requirement to determine how these people were experiencing their workplace, while my therapist positioning required me to begin with a relatively low-risk question to avoid depression discourses (in the SFT sense of the term) that may cause undue harm in the early parts of the interview. I therefore began by asking the workers to tell me about their experiences of workplace change and the effects of those changes on themselves, prior to asking them about their depression and its diagnosis. My therapeutic responsibility towards the research participants was to provide a safe place to talk about their experiences, while containing and managing the interview's internal psychodynamics. My duty of care regarding the risk of psychological trauma to the research participants during the interview was to tell them that the interview could be terminated at any time, that they did not have to answer any question that they may find upsetting and that, following the interview, they could contact me for a referral to a therapist should the interview raise any concerns or cause any distress that they would like to explore further.

During the process of obtaining formal approval for this research study by the UTS Human Research Ethics committee, and the conduct of the interviews themselves, I remained fully cognizant of what Elliott (2005) refers to when she highlights the importance of researchers understanding that 'once narrative is understood as not simply descriptive but constitutive of the self, the potential of research to be a significant transformative experience must also be recognised' (pp. 140-141). This ethical knowledge of an interview as 'constitution of the self' was recognised through out the interviewing process, from the time that informed consent was gained, prior to the interview by allowing time for any concerns that the participants may have about the interview, during the interview by allowing minimal interruption to their story, at the conclusion of the interview when the participants were offered a debriefing time regarding their experience of the interview, and following the interview with a commitment to feedback.

Ethical considerations continued to be ongoing and integral as the rights, needs and desires of the participants continue to be respected (Elliott, 2005; Kvale, 1996). Ethical considerations arise throughout the research process, and while this may be most evident in the data collection stages of research as the researcher comes into direct contact with the research subject, Elliott argues that 'this relationship continues throughout the analysis and dissemination stages of the research' (p. 135). Finch (1984) also argues that interviews carried out in an informal setting, such as an interviewee's home, easily take on the character of an intimate conversation between friends and suggests that this type of interview can leave [participants] open to exploitation:

> I [have] the feeling that my interviewees need to know how to protect themselves from people like me. They have often revealed very private parts of their lives in return for what must be, in the last resort, very flimsy guarantees of confidentiality (p. 50).

Participants were given the option of being interviewed at their place of work, at my home, or any other place of their choosing. Those who chose to be interviewed in my home were in fact shown into my consulting room that is set up in professional décor in keeping with standards of professional practice and appropriate ethical requirements.

Conducting the research interviews

Interviewing the research participants for this study was undertaken with the same amount of respect and confidentiality offered to clients in clinical practice. Special consideration for the emotional safety of the participants was accorded, as all the research participants had to have had a diagnosis of depression in order to participate in the study. Posavac and Carey's (1997) perception that interviewees are to be 'protected from harm' informed my decisions for interviewees to choose where they would prefer to be interviewed and to begin the interviews with questions concerned with workplace change.

Before asking the interview questions, I told the participants that there would be roughly an equal amount of time devoted to their experiences of workplace change and their experience of depression. The participants all articulated their experiences of workplace change clearly. However, they needed encouragement to talk about the process of being diagnosed with depression. At some points during interviews, probing questions were used to encourage research participants to expand on or clarify their responses to these broad questions. Despite the interview protocol (see Appendix 1 for

detailed interview protocol), priority was given to material the research participants suggested was the most important aspect of their story. The first three questions related to workplace change, specific changes to their jobs, and the effects of these changes. The following two questions were about the onset of their stress, and the relevance of that stress to work. They were then asked what they had done about the stress, and about the process of being diagnosed with depression. The next questions were focused on treatment and the effects of those treatments. The final set of questions were reflexive questions: was there ever a time when you did not feel stressed at work? If you could change one thing about workplace change and the increase in worker depression, what would that be? All the questions were open ended and, as previously mentioned, probes and prompts were used to encourage them to expand the stories of their experiences. When the stories seemed unclear, or needing to be unpacked, clarification was sought by asking questions such as: could you tell me a little bit more about that?

As the interviews progressed, all interviewees seemed to be comfortable moving between discussing their experience of workplace change and their experience of being diagnosed with depression. It was only when I began to ask more specific (open-ended questions) about how they had been diagnosed that they became significantly less articulate. However, none showed evidence of 'emotional harm' that I could identify.

Establishing rapport, including building a sense that the interview process was not a one-way street with all control invested in the interviewer, involved a number of elements. Initial decisions about participation and about the time and place of the interview had been made by the participants. They were asked to give an account of what it was about this research topic that had interested them. They were alerted that the recording could be turned off at any time, guaranteeing confidentiality, if they did not want some of their experiences recorded. And they were further alerted that they could decline to answer any questions that were too emotionally provocative.

As an opening question, I asked the research participants to 'tell me about their work and the changes in the workplace'. My rationale for this choice was to provide an opportunity for participants to speak about their work at the outset, providing a subject area that would sustain their agency, prior to moving on to questions related to their experience of being diagnosed with depression. This kind of opening question is in keeping with therapeutic practice. Opening with emotionally laden questions could have

necessitated the termination of the interview prematurely, had the research participants become emotionally overwhelmed when recounting their experiences of depression.

Most of the answers around workplace change were linear accounts of time, place and effects, while the questions on depression were answered primarily in symptomatic terms. The most difficult question for people to answer was: 'Given that depression used to be strongly associated with mental illness and was rarely discussed in public, do you have any hunches as to how "depression" has become such a household word today?'

When conducting the interviews, I assumed that the depressed workers were people who believed that they had a condition that they were ultimately responsible for managing. Their positioning of themselves as individuals who were pathologised and medicalised with a minimum of resistance was borne out in the interviews. This appears to be important, as it probably indicates that they responded to the questions retrospectively, that is, from the position of the 'now' depressed worker, not the 'then' position of the stressed worker.

There were certain points in the stories which I chose to expand or develop to demonstrate an alternative view for myself and the person interviewed. For example, I attempted to move away from the dominant bio-medical discourse when exploring different stories. As I selected specific points upon which to focus, I was aware that a similar process would occur when I selected data for analysis. This process represented a number of alternative ways of thinking about the condition known as depression that would inevitably change me and my perceptions, writings and understandings of the construction of depressed subjectivities.

During the interviews, I felt that I was able to behave much more as 'myself' than with other parts of the research project. I enjoy interviewing and I take pleasure in the focus that an interview involves, allowing participants an opportunity to speak of their experiences and myself to hear their accounts in an unhurried way. In daily life there are not many opportunities for people to tell their stories in a narrative mode with minimal interruption and without judgment. Interviewees saw the experience of putting thoughts and feelings into words within the silence of a room as something special and, without exception, all participants said it had been a positive experience. Additionally, I felt that it was important to debrief the person following the interview so that they were not left

with the feeling that I was just taking their story for research purposes with little consideration of their negative experience of workplace change and depression.

In the interviews, I attempted to make it clear to the participants that there were no right or wrong answers. What I sought to elucidate was their experience of workplace change and their understanding of how they came to be depressed. I wanted to hear their stories and gain an understanding of how things had come to be the way they were. The list of questions for the interview was used as a guide only.

Some reflections on the interview process

Reflecting back on the conduct of the interviews for this study, I am struck by two things: on the one hand, by the differences between the research interviews and the therapeutic work I was familiar with; and on the other, the changes in my thinking about myself as an 'interviewing self'. The work of the research interview is primarily to facilitate narrative flow, whereas the therapeutic interview is concerned more to facilitate self-understanding, using a whole range of interventions on the part of the therapist to 'deconstruct' the client's problem-saturated stories. The time factor is important here, as well as the purpose of the interview. The time available for the research interview influences the researcher's ideas about what is relevant to explore and what can usefully be pursued within the set time frame. In my study there was very little time to deconstruct meanings within the interview. What I was able to do, however, was to ask the participants to expand on an idea from time to time, in an attempt to make sure that I had their construction of a problem as clear as possible.

What became clear early in the interviews was that, irrespective of the process through which they had been diagnosed as depressed, the participants regarded the workplace as the main contributing factor to this diagnosis. This view was a significant revelation, as it was in direct contrast to the views of the people with whom I had worked in the Anxiety and Depression (A & D) group, who initially perceived their workplace issues as secondary to their diagnosis and treatment of depression (see Prologue).

At the beginning of that group process, the hospital group members attributed their depression to unknown causes or as originating from familial inheritance, chemical brain imbalance, financial or relationship issues. However, as group discussions progressed, it became clearer that workplace change and workplace uncertainty were of major importance in the construction of their depression. In time, group participants

came to understand the ways in which their subjectivity was mobilised around being unhappy and discontented workers who became ill and required admission to hospital to take time out in a space away from work. The similarities between the post-discharge group and the research participants in this study was that, irrespective of the setting, both groups of people had been resubjectified along very similar lines as depressed persons or as depressed workers. Their different representations of the problem can be attributed significantly to the context of the interviews: the research interviewees were oriented from the beginning to the relationship between work and depression while the hospital group, by virtue of being located in a hospital setting, were oriented to the depression rather than the workplace.

The one-off nature of the research interview is also a factor: interviews conducted at a different time may well have given rise to somewhat different tellings of the stories. It is as true of the research interviewee as of the researcher, as Scheurich (1997) notes, that s/he 'has multiple intentions and desires, some of which are consciously known and some of which are not' (p. 62).

The issue here is that any interview can never be duplicated, even a week later, as the meaning allocated to the question by the researcher will change over time, as will the meaning that the interviewee ascribes to the question. As Scheurich notes, what occurs in a specific interview is contingent on the specificities of individuals, place and time. A realist approach to data wants to read it in terms of the accuracy of its representation rather than understanding it as 'a creative interaction between the conscious/unconscious researcher and the decontextalised data, which is assumed to represent the reality of the interviewee' (p. 62).

At the time of the interviews, I was unaware of my multiple intentions and unconscious desires as a researcher. I also believed that the interviewee was providing an accurate – 'realist' – account of their reality. It was only during the data analysis process that I began to understand that the accounts provided by the participants in the early readings were inevitably being read by me as a family therapist, trained in SFT and narrative therapy. As Scheurich (1997, p. 74) argues:

> [t]hat the written result, the final interpretation, of the interview interaction is overloaded with the researcher's interpretive baggage is, therefore, inevitable. In a very important sense this written representation is largely, though not completely, but a mirror image of the researcher and his/her baggage.

Since conducting these interviews, many changes have taken place, including changes regarding my previous notions of self. My pre-research worker self and even my professional practices have come under scrutiny, under the influence of the later 'baggage' of poststructuralism I came to employ. At the time of writing these reflections, I now question some of my therapeutic practices, as well as my original ideas about what constitutes an interview. But that is a story for another time and place.

4.3 Research analysis

This section discusses how the particular analytic framework deployed in Chapters 5 and 6 was developed. There were many ways in which the data of this research could have been analysed drawing on a range of views. In setting up the research design, my initial choice of ten men and ten women was to see if there were any visible or observable differences in their respective experiences. There is a case to be made for feminist literatures as discussed in Chapter one, however a feminist perspective was not a primary concern of this study.

In this particular study, the concern was to notice the commonalities and repetitive patternings across the data set that captured the effects of workplace change and the subsequent diagnosis of depression There are insights from feminist literature that offer important ways to advance this research, although it is beyond the scope of this study, exploring the possible influences of gendered workplace practices on worker depression could be an extremely valuable area for future research.

The first readings of data were concerned with the individual stories of the research participants and were termed 'diagnostic' readings because they came out of a therapeutic context and 'vertical' as they focused on single 'cases'. The second step was in bringing these twenty narratives together, first to identify and then to work with the commonalities and patterns across the narratives. This second reading is referred to as the 'horizontal' reading: it is a reading which attends to the commonalities between the stories, rather than the differences, by paying attention to the discursive regularities.

The significance of these formative groupings is that they provide a way to see what Rose alludes to, when he presents the argument that the 'psy' sciences have 'brought into existence a variety of new ways in which human beings have come to understand

themselves and do things to themselves' (p. 2), or as Rose, citing Hacking suggests, '"making up" the kinds of persons that we take ourselves to be' (1996, p. 10).

These groupings were subsequently reformulated and tabularised, drawing on Rose's categories, as five recognisable stages of resubjectification that workers progress through in their narrative journey from worker to depressed worker. This table is included as the last element of this chapter.

Vertical (diagnostic) readings

The process of engaging with data is graphically captured by St Pierre (2004) who describes it as:

> leaping into the abyss of discomfort and uncertainty that surely accompanies every study but is seldom described in the literature and working that confusion as rigorously as our imaginations allow (p. 325).

I began with what was most familiar to me, drawing on my professional experience: the diagnostic reading – reading the individual stories as individual case studies. This led to sorting the data into pathways. Three major pathways taken by interviewees were identified: (i) agrees to be pathologised and treated, (ii) agrees to be pathologised and resists treatment, (iii) agrees to diagnosis but is ambivalent about treatment. The overall outcome of these three pathways was an acceptance of the diagnosis of depression, although there may have been some misgivings as to the benefits and the side effects of the SSRIs, where these were prescribed. At this stage, I was reading the stories as case histories and primarily looking for the effects of the workers being diagnosed with depression.

The next stage focused on the description of depression in the workers' narratives. The reasoning behind this orientation was that the condition of depression has such a broad symptomatology that the origins remain strongly contested by 'knowledge experts'. Possible causes include: biological, psychological, genetic, environmental, familial, physiological and more recently neurophysiological (depression as a disorder caused by a chemical imbalance in the brain). Hence, treatment for depression is operationalised via the process of the diagnosis, followed by pharmaceutical and/or psychological treatment. While no one cause is universally accepted, the umbrella term depression is taken up as a 'truth'. Literatures on the causation of depression vary greatly. On most websites reporting on depression, however, there is a marked tendency to minimise the

origins or aetiology of depression and move readers quickly on to the vast range of symptoms and pharmaceutical treatments (Rose, 2007, pp. 142-143).

Workers in the study used descriptions such as: *getting run down physically and mentally; health problems associated with personal and work related stress; killing yourself; a stigmatised thing; can't see, can't think, can't concentrate; want to hide want to become invisible; can't sleep, can't eat.* These medicalised 'symptoms' of depression appeared to be strongly associated with personal malfunction, something lacking in the person, a something that requires fixing, improving, or in some way demands medical intervention to restore the person to a former level of functioning.

What emerged from this reading of the narratives was two distinct time frames, past and present, depicting two kinds of worker experience: a workplace in the past that provided workers with stability, safety and security, compared with the uncertainty and instability of the current workplace. From this reading, a 'work in progress' table was constructed reflecting comparisons between old workers/workplaces and new workers/workplaces. This comparative device was generated out of workers' descriptions of their past experiences of being a part of the team. They identified character, loyalty, the tenure they experienced, the value they found in the sociality and support of work and their sense of the workplace as being like a family or a team. This was contrasted to their perceptions of themselves as new workers, where they experienced rapid workplace change and a focus on what they did as individual workers with all the attributes of autonomy, mobility, flexibility, rights and freedoms. This 'freedom', however, involved the increased use of surveillance technology that facilitated a non-stop work ethic. With these changes, came loss of certainty, loss of autonomy, more work with fewer staff yet the same workload, and so on. As more and more repetitions of 'past and present comparisons' became evident in all of the workers' narratives, the discursive analytic tool of contrastive rhetoric was applied to the data. Contrastive rhetoric is evident when the workers in this study repeatedly drew on past working conditions as a way of positioning themselves as they tried to cope with their experiences of the ever-changing conditions in the present workplace (Delamont, Atkinson & Parry, 1998, 157-173).

Horizontal (discursive) readings

What appeared to be missing in the vertical 'diagnostic' readings was that the workers did not discursively demonstrate what actually happened in the process of being

diagnosed and treated as depressed, nor did they illustrate the effects of workplace change on workers and the connections between those changes and being diagnosed as a depressed worker. In order to address this problem, a decision was made to read horizontally rather than vertically. This decision quickly revealed that there were a series of repetitions and patternings across the whole data set.

By reading the accounts horizontally, new 'relationships with other statements' (Danaher, Schirato & Webb, 2000, p. 35) in the workers' stories began to appear. The data were then subjected to further analysis, which was a slow, complex, iterative process that involved multiple readings of the transcribed material, looking for dominant and subjugated meanings, in keeping with the focus of discourse analysis (White & Epston, 1990, pp. 27-28). In order to make meaning from the narratives, close attention was paid to the language that research participants used to give an account of themselves, and the ways that they managed their different senses of self. From the multiple readings of the data set, a selection of text fragments was grouped together based on their similarities/commonalities. The text was then re-examined to notice the ways that language was used to 'construct' representations.

By changing from vertical to horizontal readings, similarities across all the participants' accounts began to emerge. The first commonality to emerge involved stories of major loss, which emerged in every participant's story: the loss of a 'golden past' when everyone worked as a team, the loss of agency and the loss of former selves who knew who they were. The main implication of this 'loss' theme across the whole data set was that workers seemed to have had a different sense of themselves prior to the experience of workplace change. The beginnings of the process by means of which 'the individual is carefully fabricated into the social order' (Rose, 1975, p. 217) were now in place. The process of analysis was now carried further by returning to Rose's work on multiple selves, subjectivity, and resubjectification, his categories providing the tools for mapping the stages in the narrative process articulated by the interviewees, to be read as stages in the progressive (re)subjectification of the interviewees through their tellings.

The narratives themselves can be read as consisting of five narrative processes: psychologising, internalising, somatising, medicalising and pharmacologising. These correspond to five stages in the progression of the narratives, as well as to five kinds of self in the progressive (re)subjectification of the depressed workers, starting out from

Rose's category of the *psychological self*, arising from the impact of the 'psy' sciences on people's understandings of themselves and the accompanying process of normalisation of a deep-interior psychological self (Rose, 1996a, p. 17). The psychological self is succeeded in the narrative accounts by the *internalised self*, extending Rose's notion of the psychological self by detailing the processes by which people interpret and colour the events that have occurred. This work incorporates Epson's (1993) notion of internalising, a process of treating one's self as problematic object. The *somatised self* follows, the workers' subjective reporting of bodily symptoms as identified by Rose and Novas (2000). The next stage is the *medicalised self*, which, in Rose's account (2007), draws on the changing phenomena by which individuals describe themselves using health and illness discourses. Again, I drew on Rose (2004) when naming the fifth and final stage as the *pharmacological self*, a self who accepts the centrality of pharmaceutical products to the management and normalisation of one's health.

As a concrete example of the methodology used, one of the repetitions and repeated patternings in the data involved the ways that workers shifted from the third person to the first person when they were attempting to draw a distinction between the workplace and workplace management in relation to themselves – selves who were having problems in coping with the demands of workplace change. Drilling down further into the data to look for the 'exact specificity of [the data's] occurrence; [to] determine its conditions of existence' (Foucault, 1972, pp. 27-28), what I noticed was the shift from externalising to internalising discourses. This discovery led to the creation of a separate stage called internalising. This stage addresses the 'unsustainability' of the internal gaze of workers, as they begin to internalise their uncertainties and work-related stresses. Workers' language changed from referring to the workplace in the third person as 'it', to referring to themselves in the first person singular as 'I'. These kinds of vernacular interchanges between the workplace, 'it', and the self, 'I', highlight the workers' entrée into somatising discourses and the formation of the third category.

The internalising category was then expanded to include the workers' embodied language, as workers self-labelled their bodily symptoms. This grouping of similar discourses was later called somatising. Examples included: *I was super stressed and frustrated and having problems sleeping (Amber); My mood just went absolutely downhill… with a result that … I was in tears before I came into the office. I was … so*

withdrawn from absolutely everything (Mary). The discursive shift to workers' description of bodily symptoms became the signal that prompted workers to seek medical attention.

The circumstances that brought workers to a doctor were collected into a further set of groupings. This new set of groupings detailed the process of the workers going to their doctors, as they were concerned about their physical problems. This grouping was later known as medicalising. For example:

> *I couldn't concentrate properly. I was overly anxious, I lost a lot of confidence I was finding it increasing difficult to work for seven hours, even though I might have been in the office for ten or twelve hours. I had constant headache. So I went and saw my Doctor and he diagnosed my depression and put me on Zoloft, and gave me a certificate for sick leave for three week (Sue).*

The doctor's diagnosis of depression was noted as common. Following the diagnosis of depression, these workers were routinely offered a prescription for antidepressant medication. This category became known as the reinterpreting and medicalising category. The final set of data groupings arose out of the workers' stories providing accounts of their experience with therapies. A range of treatment therapeutic options was offered to patients; these included referrals to psychiatrists; pharmacotherapies, mainly SSRIs; sick leave; counselling; and alternative therapies/activities. Because of the prevalence and significance of pharmacotherapies, this narrative stage is referred to as pharmacologising.

The five-stage worker resubjectification narrative process table which follows (Table 4.1), summarises this final methodological section of Chapter 4. This framework will be used in Chapter 5 to detail the process of worker resubjectification across a number of interviews, and again in Chapter 6 to analyse one in-depth interview.

Table 4.1 The five stage worker resubjectification narrative process table

STAGE 1 Psychologising	The data will show how initially the workers have a strong sense of agency prior to workplace change. Loss of a golden past Loss of agency Loss of a team Loss of sociality	The psychological self
STAGE 2 Internalising	Workers teetering can be identified when the workers switch between describing the workplace in the third person, *'they'* and *'them'* to describing the workplace using the first person singular, '*I*' *I felt totally naked.* *I felt humiliated.* *I felt embarrassed.* *I felt degraded.*	The internalised self
STAGE 3 Somatising	After internalising workplace stress, the participants draw on bodily symptoms. *I have a headache.* *I can't concentrate.* *I can't sleep.* *I can't eat.* *I developed a rash all over my body.* *I think I am going mad.*	The somatised self
STAGE 4 Medicalising	There is no data to show what is said in the doctor's office. However, the *DSM IV* is the key reference tool for all mental health conditions. Hence, the diagnosis of depression is made according to: • *DSM IV* • Medical governance • Defensive medicine/footnotes.	The medicalised self
STAGE 5 Treatment	Participants were routinely prescribed anti-depressant medication. Most of them regarded such pharmaceutical management as 'normal'.	The pharmacological self

Chapter 5

The process of resubjectification: workplace change as loss and distress

Introduction

This chapter focuses on the accounts of workplace change given in interviews with the twenty workers selected for this study. The chapter provides an account of the major narrative, or discursive, regularities across the data set with respect to the experience of change. It is, then, a 'horizontal' reading in the sense outlined in the previous chapter, looking across the stories told by all the interviewees. It forms a pair with Chapter 6, which provides 'vertical' readings, primarily of the story of one interviewee. This vertical reading is not to be understood as the 'case study' reading of the early stages of the research, however. Its goal is to follow the narrative account of a single subject through the painful process of progressive resubjectification, the transformation of the self into a depressed worker self. The vertical reading of Chapter 6 is intended as an exemplary instance of the process of resubjectification. Its exemplary status is underscored by the chapter's conclusion with summary accounts of this process, as experienced by a further five workers.

The data on which this chapter is primarily based consist of the set of responses to the opening interview question: 'Could you tell me about your experiences of work and the changes that have occurred over the past couple of years?' All of the research participants gave very detailed and energetic accounts of changes in their workplace and the subsequent effects of these changes on them as workers. Their workplace change stories generally took up the greater part of the interview. These were stories that the workers were eager to tell, perhaps as part of a quest for a coherent, continuous, stable, agentic subject position. Such a position was being inhabited in the face of the disruption and increasing uncertainty brought about by workplace change, prior to the interviewees seeking medical assistance.

The quest for a coherent, continuous, stable, agentic subject position is built, of course, on a fantasy. Subjectivity of its very nature is constantly in process, especially in a changing world. Experiencing it as fixed and stable can only be a product of discourse itself – of the ways we learn to act and speak, to be acted upon and spoken to, in the

places and at the times where we live our lives. This implies that the achievement of subjectivity is, in essential ways, always retrospective: we learn who we are by listening to what we say and to what others say to us and by observing what we do and what others do to us. A study such as this must always be mindful of the retrospective nature of the construction of subjectivity, since it is based on retrospective accounts. Nevertheless, the strength of the investment in the emotional truth of these accounts provides some kind of warrant for reading them as accounts of subjectivity in process, despite the strong desires of the tellers that it were otherwise. That investment is manifested discursively in such ways as the eagerness to tell, the time spent on these accounts of workplace change and the energy of the telling. What it is possible to discern in the material of this chapter is the process undergone by these workers in transforming themselves and being transformed. The lineaments of this process become clearer through a detailed examination of the discursive regularities which pervade the accounts.

There are a number of such discursive regularities, operating at both macro and micro levels. At the macro level, two regularities stand out. The first of these, unsurprisingly, focuses on time: the contrast between two different time-frames, then and now. This contrast rhetorically structures the accounts, employing a contrastive rhetoric where the terms of the contrast are strongly evaluated as ‘good’ and ‘bad’. Within this evaluative logic, past = good and present = bad. The time contrast will be used as an organising frame for this chapter, to reflect its fundamental place in the interviewee accounts.

The second major discursive regularity depends on the first and its evaluative framework. It is concerned with the overall emotional stance taken towards past and present. Inevitably, since this stance is being reported from the perspective of the present, it carries the negative evaluation attached to the present. From the perspective of the present, the ‘good’ past can only be represented in terms of loss, calling for mourning, and the present in terms of distress, necessitating suffering.

The accounts provided in this chapter spell out in detail what workers valued of a past that has been lost. Broadly, they mourn the loss of the stability and sociality of the workplace of the past, both of which are seen as having been lost under changed conditions of work. They mourn the loss of familiar work practices they took pride in and, through these, the loss of a familiar and valued self. This self is understood to have

been of worth and to have had agency. The workers' sense of an agentic self across all the interviews seemed to have been incrementally eroded, as changes in the workplace appeared no longer to be invested in or have the values that they deemed to be important to their sense of agency or coherence. Stories of the present are replete with accounts of the loss of value and of agency – perhaps none more poignantly than that of former police inspector, Mark, whose story is told in Chapter 6. His rank was the only thing that was not lost in a changed workplace; and in the end that too was lost as he agreed to accept medical retirement.

The loss of the 'good' past, and the self that inhabited it, is undoubtedly a source of distress in itself for the workers in this study. But the 'bad' present is the source of ongoing distress. Distress arises from a variety of factors. Beyond grief for the loss of the past itself is the distress arising from the contradictory new workplace logics of 'more' (hours of work, expectations for productivity, responsibility) coupled with 'less' (training, direction, personnel, resources) experienced by the interviewees. 'Distress', the term chosen here to contrast with the loss of the past, can of course be readily translated into the 'stress' of medical discourse. Its use here makes a far more appropriate contrast with 'loss', however, since both terms give due weight to the emotional dimension of the representations of experience being constructed.

The interviews reveal one further twist to the story of the present as a source of distress. This is the recognition that, despite the pervasive sense of the loss of agency, not everything in the new workplace involves the agency of others. Some changes require new kinds of agency on the part of those who primarily experience themselves as subject to the agency of others. These new kinds of agency, however, particularly those requiring workers to do more with less, prove to be distressing rather than empowering.

As a strategy for making sense of the world, the combination of loss and distress would seem to lead inexorably from stage one of the resubjectification process to the further stages, leading straight (via the negative experiences of loss and suffering) into the internalising self of Stage 2. The discursive production of a series of multiple losses troubling a previously experienced coherent sense of self is the critical first step in destabilising and breaking down former selves, leading eventually to the formation of a new 'depressed worker' self. Those further stages will not be reviewed here, however, since the trajectory through them forms the substance of Chapter 6 to follow.

This chapter is organised first, in terms of two major sections reflecting the fundamental contrast of past with present. Within each of these major sections, there are two sub-sections addressing two major themes. For the section focusing on the past, these subsections are the two major sites of perceived loss: the loss of an apparently 'golden' past and the loss of a coherent self. For the section focusing on the present, the sub-sections focus on the locus of agency and the equally painful consequences of both in the new workplace with respect to the agency of others (what was done to us) and the agency of self (what we did to ourselves). Each subsection consists of several specific foci for loss and/or suffering, presented as an ongoing series of extracts from the data with relevant commentary.

5.1 Looking back: change and loss

This section explores the ways in which research participants construct workplace change by drawing on narratives of the past and the present. It should be noted that the past of past narratives may be the quite recent past – perhaps only weeks or months ago, not necessarily years. What all narratives of the past have in common is that they are refer to a time when the workplace is represented as offering a greater semblance of structure, stability and certainty than that currently experienced.

The two subsections deal with the two major focuses of loss: a more 'objective' one focusing on the workplace itself, its procedures and its relationships and a more 'subjective' focusing on the felt experience of the speaker. The former is referred to as the loss of a golden past and the latter as the loss of coherent self.

Loss of a golden past

As these workers struggle with the complexities and contradictions of shifting workplace requirements, it is understandable that their representations of the past constitute it as a 'golden past'. The choice of this term is intended to underline the fantasy or mythic perspective involved. These 'golden past' constructions allow the workers to mobilise discourses, not only of the more structured workplace, but also of themselves as once having been agentic workers.

The use of the binary past/present workplace is also available to be read as one of the ways in which these workers attempt to manage their uncertainties, since the diagnosis of depression would suggest that these workers have been unable to effectively

constitute themselves as agentic new workers. Their loss of agency has involved no workplace intervention to date, other than for the workers themselves to be medicalised as depressed. This has the effect of individualising responsibility for such a diagnosis.

Each of the four following accounts describes a significant shift in a worker's history. These are, respectively, the shift from: the public to the private sector, from casual to permanent work, from one Government department to another, and returning from maternity leave. In each case these changes were initiated by the worker who at the time of the change believed that they would be advantageous. At the time of interview, however, all their accounts contrasted a golden past with their distress in the present workplace.

From the private to the public sector

Amber worked as a journalist at a metropolitan university in Sydney. Her former place of work as a journalist was in the private sector and she noted that after a three-year period overseas: *there had been a change in the private sector in terms of new forms of journalism.* As an interim measure, she took a temporary position in the public sector, replacing a staff member who was on extended leave.

Amber described her present workplace as involving long and often unpaid hours of overtime and working predominantly on her own, other than at compulsory workplace meetings. She recalled a previous workplace of some two years before in the following terms:

> *Everyone worked together as a team—we socialised together after work, we all became friends, and everyone, you know, got stuck in and got the job done. We worked together as a team and it was beautiful. I loved it.*

Amber here is mobilising a discourse that constructs a time gone by, when the workplace provided her with a social identity, which is closely aligned with the notion that work is central to a person's sense of self and social role. In this account, Amber's sense of agency appeared relatively intact and provided her with a stable sense of who she was, in comparison with who she now is. In this excerpt, she took the position that the workers back then worked as a team, socialised together and all became friends. This could indicate that not only was the worksite produced as stable and certain, but also that the workers were different kinds of selves, who highly valued mateship and collegiality.

Amber went on to describe the ways that these past workplace values appear to be receding, as workers are now required to bring more of their worker selves to the workplace and social spaces have been subsumed by the workplace exerting higher expectations in terms of productivity and measurable outcomes. What may be problematic for Amber in the present workplace is that she now has sole responsibility, with minimal avenues for help and support. As Shore and Wright (2000) point out, 'failure' is not an option, so there is increasing pressure on 'new workers to conform to the audit culture' and be responsible for self-management. Amber valued being included and reliant on others in the team, as opposed to the present workplace that requires workers to be self-regulating individuals more accountable and capable of self-management. In her account, Amber constructs a story that legitimates her reluctance to engage in new worker discourses and redefine her agentic self in their terms.

From one department to another

Anne had worked for a government department for several years and had initiated a shift to another department in order to take up the opportunity for promotion in her new job. In her account, she constructed that past workplace in very positive terms:

> *It was very different, like in terms of family-oriented, like everybody helped each other. Everybody was always looking out for each other and we'd have social activities.*

She constructs her present workplace as lonely and alienating:

> *It's all entrenched these people have all been here for years it obviously takes years to get accepted. Management didn't want to know, their objective was to reduce numbers of employees they didn't care what was happening to people.*

The contrast between the degree of workplace collegiality Anne experienced in her previous workplace – collegiality and connectedness that she really valued – and her present experience is represented very much as the loss of a golden past. On the one hand she had been given a significant promotion, while on the other hand she experienced the shift on terms of a management not caring *what was happening to people.*

From casual to permanent work

Ashley had worked in a casual position in the financial sector for many years. Following a downward shift in her financial circumstances, she made a decision that she needed to have permanent work, as it offered more financial security.

At the time of the interview, she had changed to permanent work some ten months ago. In her prior place of work she was very happy and now she is very unhappy with both her new employers and her fellow workers. She said that she was experiencing a total culture shock, as in her past place of work things had been very different:

> *We went out for drinks on Friday nights, we all had lunch together, we all compared, you know, what our kids do. We talked and we socialised and it was just a great atmosphere to work in, and for me this was just a total culture shock. I thought it was going to be like one big happy family and everyone gets in and helps one another and goes out of their way to be friendly.*

The family theme is repeated here and expands to include the activities of the workers' children. When Ashley recounts this experience of being included in social and work activities, she appears to be happy. She represents her former workplace as being 'better', therefore creating a contrast not only between past and present but also between them and us, in her attempt to find meaning as to what is making the difference in her current place of work. The time-space in which this past workplace narrative is located is relatively short, just a matter of months, compared with other workers such as Len, who has been employed by the same government department for the past twenty years. However, what is similar in all of these accounts is that Ashley's and others' sense of past agency seems to come from seeing themselves as being part of a system in which they have certainty: they know their role in that system.

Returning from maternity leave: the workplace has changed

One of the benefits afforded parents in some workplaces is the opportunity to take maternity leave knowing they will have a job to return to. This provides a sense of stability and certainty. Often people returning to work, whether consciously or unconsciously, expect to find the workplace much the same as they left it. Their reasons for taking leave often supersede their concerns about how the workplace will be when they return.

Isobel works as a part-time social worker for a non-government agency. She said that, prior to going on maternity leave, she was very happy with her work and wanted to return to her current position. While she was away, the organisation underwent major restructuring and had a high turnover of staff, as new positions, new managers and new roles were devised to meet the goals of the restructuring. In her account of returning to work, Isobel explained the effects of these changes in the organisation as producing a number of stressed workers, including herself. She told of the differences between the workplace she left and the workplace she returned to, drawing attention to the definition of roles:

> *Yes, it was quite different in terms of—when I left, the organisation was growing but people seemed to be fairly settled in their roles—you know, people had well-defined roles.*

The space between leaving work to go on maternity leave and returning to work was an important time for Isobel. At the time, her departure from work and her first foray into motherhood appear to have had far greater priority than the impending restructuring of the organisation. In Isobel's story, people were settled in their roles and had well-defined roles. However, there was a degree of contradiction in what she said. *Well-defined roles* implies a sense of certainty about what is expected of workers. At the same time, she was aware that the organisation was growing, implying organisational change, with its implications for change in workers' roles and job descriptions.

The loss of a golden past in this narrative may be less transparent than the other examples. What is similar is that Isobel's agency is constructed by having a well-defined role in the system. Therefore, loss of agency is caused by changes in roles and the system as a whole.

The workplace changes that workers need to address are multiple, complex and contradictory. Workers draw upon stories of loss in an attempt to make sense of these changes. Such 'golden pasts' enable these workers not only to mobilise discourses that are in contrast to the present workplaces, but also to assist them to position themselves as more agentic workers than the type of workers they are experiencing themselves to be in the present.

It would seem that the more bounded and stable working conditions in workplaces of the past created the conditions of possibility for particular kinds of agency. As

retrospectively constructed, such agency was seen as productive but also benign and embedded in social practices. Those past sets of conditions have changed profoundly. New workers are required to engage in workplace practices that require workers to be self-managing and self-sufficient. New workers need to take on individual responsibility for becoming agentic, as a challenge. In the workplaces of the golden past, agency was a by-product of the system itself: an invitation to participate.

Loss of a coherent self

If the workplace as a source of sociality and of agency within that sociality are represented as being increasingly lost, so too is the workers' sense that, as *workers*, they knew who they were. In the following four examples, what is evident is how a worker's sense of self is related to past stable structures and job descriptions. What is also evident, however, is their uncertainty about how to cope with the shifting matrices of the current workplaces.

A worker's sense of self is of great importance, as the form of self that had been created along the way and that constitutes their truth and most profound reality. A key component of these workers' discursive engagement seems to be their willingness to imply that things had not always been the way that they were now. That is, in the past they had classified themselves as a certain type of (self) who knew who they were.

These workers seem to experience great difficulty as they attempt to manage the tensions between a previously known coherent sense of self that appears to be disappearing in the face of the current challenge and the need to invent another worker self. The new worker self can no longer rely upon past stable structures to try and sustain a coherent sense of self. The space between the known and the unknown provides the conditions for workers to become increasingly aware of a profound loss of a coherent sense of self. The loss of past stabilities was a key feature identified by workers in this study.

The first significant event that appears to contribute to a worker's loss of a coherent sense of self is the shifting of responsibilities from the workplace to individual workers, who are now expected to self-manage in a variety of ways. For example, workers are now expected to make decisions about what work has to be done, for how many hours, and by whom, with minimal direction from management. In Ashley's account, a major issue is not knowing when the working day is over. Such unpaid overtime, which occurs

on a regular basis, exemplifies one of the ways that a new worker is expected to be responsible for her work, and be responsible enough to know when to go home, even if the scheduled amount of work exceeds a 'normal working day'. Ashley saw this shift in responsibility as manipulative: *they put you on salary as a way around things*.

In excerpt two, James identifies the loss of stable structures that provided him with a sense of direction in his work whereas now he no longer knows who he is or what is expected of him. Sue, in the third account, is responsible for meeting the automated billable hours as set by the firm. This change in the reporting structure is understood by Sue as no longer being valued as an ethically 'good worker'. In this example, the shift to electronically produced billable hours could have a number of interpretations, but Sue sees no alternative to a view of herself as lacking. For Graham, in excerpt four, shifts in responsibilities are experienced as loss of leadership and direction.

In the past, a workplace employer's responsibility included care of the employee. In one sense such care may be understood as involving the exercise of power, since employers carried out most of the decision making. Changes in workplace practices have destabilised the ways that workers once constructed their sense of agency through being cared for in the workplace. Workplaces typically now require workers to be responsible for themselves, without necessarily explicitly stating this. As Peters (2001, p 151) notes: 'Neoliberalism promotes the notion that individuals be free in order to govern, as self-government emphasises the "responsibilisation" of individuals as moral agents … often with unspoken directives'.

These examples will be expanded on later in this section to show how responsibility for the well-being of the worker has substantially shifted from the employer to the employee, who often seems to be unaware of these shifts in responsibility. As Graham asks: … *you say God help me—what does all this mean?*

The study demonstrates that boundaries between work and home, work and family, health and ill health are becoming less distinguishable, as workers' accounts of workplace change suggest that they are now expected to bring more of themselves to the workplace. The impact of taking more of themselves to work, working longer hours, taking on more responsibilities and having fewer employees do the same amount of work has induced increasing uncertainty. Such uncertainty is spoken of in terms of not knowing if they will be able to keep going in the same job, if they will have to change

jobs and accept a lower salary, or make other decisions about their economic status and life style.

They put you on a salary as a way around things

In the past, many workers in both government and non-government sectors were directly employed under award conditions or employed under an agreement based on a particular award (ACTU 2006). The benefit of these awards is that many workers knew their hours of work, their rate of pay, when they were 'doing overtime', and so forth. In contrast, Ashley was not always sure what she was expected to achieve in the same amount of allocated hours. In the private sector, these uncertainties regarding when the work day begins and ends are more or less left to the worker to decide, as most workers are put on a 'salary', which is generally formulated by the employer. Hence, being on a 'salary' provided Ashley with a higher hourly rate compared to government workers, but what goes unstated is the number of hours Ashley needed to work to reach her required outcomes.

Ashley had recently changed jobs from doing casual work, with unpredictable hours, in the financial sector to a full-time permanent position with another firm. When first employed full time, she had believed that the permanent position would provide better financial stability. What she had not foreseen was that, as a salaried worker, she no longer knew how many hours her work would take each day. The ongoing daily unpredictability of when her work finished proved to be very stressful:

> *They put you on salary so and it's a way around things. You do whatever hours it takes. It doesn't matter how many hours you work, you just get paid this much salary and that's it. So whether you do eight hours a day or whether you do twelve hours a day, it's just all part and parcel of your job.*

For Ashley, being salaried means that she is expected to get the job done, irrespective of the number of unpaid hours of labour. Although the bringing of more and more of herself to work was not articulated specifically, this issue could be read as contributing to her loss of boundaries between home and work. Being unsure of when her work was to be completed, it is as if she has resigned herself to the way that things are. It could be argued that the workplace has imposed regulatory practices that benefit the workplace and not the worker. Ashley may well assume that, if she fails to fulfil her responsibilities as a salaried worker, she may lose her job. Since *it doesn't matter how*

many hours you work, you just get paid this much salary and that's it, Ashley must stay at work, despite the number of hours it takes, or risk losing her job.

Loss of knowing who I am or what is expected of me

Loss of knowing who a person is or what is expected of them can be read as another aspect of the problem outlined above concerning workers' uncertainty about how many hours are required to complete a task. In the following account, the emphasis is not on hours of work as such, but the issue here is of equal importance in terms of James gaining clarity about his role as a worker.

James has a dual work role. He is a Senior Systems Analyst, and an Information Technology Auditor for a merchant bank. His immediate difficulty is that he no longer has the appropriate staff to cover the current workload. As the structure of the financial systems in the bank kept changing, so did James' roles. James explained the constant change in his work role as *a loss of knowing who he is or what is expected of him*. Additionally, James was concerned that workplace transitions never seem to arrive at a new stable state. James believed that workplace changes are now a permanent condition of workers' lives and that the word 'change' is misleading, as it implies that there will come a time when workers will experience a sense of certainty and balance.

With reference to what aspects of his work to retain and what to let go, James says.

> *Because obviously the work that one person's doing still needs to be continued, and if that person's being employed full-time on that particular job, then there's obviously gotta be something he's gotta let go and still be someone to take it up…it was a case of trying to work out what was to be let go.*

James' dilemma focused on multiple issues such as what part of his dual role needed to be maintained, what part could be let go, and who would be available to take up other parts of the work that he could no longer do. However, the problem was not only the changes imposed by the workplace: James was working reduced hours because of his depression. On the days that he was not at work, no worker was allocated to his responsibilities, yet he felt responsible for getting the work done. And he felt that his manager treated him differently following his diagnosis.

This different treatment was the lack of a meaningful working engagement with James, not covering the days that he was off sick and not employing another worker to take on

additional auditing duties that were required following another workplace merger. James was frustrated with his manager's attitude and lack of decision-making:

> *I would go to him and ask him for some guidance on a particular issue …I'm still waiting for a response two and a half years down the track. He won't make a decision in front of me, so I got to a point where I couldn't go and speak to him at all.*

James' experience of his manager's lack of decisive action contributed to his sense of not knowing who he was. When he sought guidance from his manager and it was not forthcoming, James 'wrote off' his manager as unhelpful and simply stopped speaking to him. James' choice of action to dissociate from his boss could be seen as rational and reasonable from one point of view, in that he no longer had to deal with the frustration involved in trying to negotiate. The downside, of course, was that James had to deal with the stress brought about by no more workers being hired, since he no longer had any channel of negotiation to bring this about.

James' choice to stop speaking to his boss provided him at one level with a sense of agency, in the sense that he, at least, was making a decision. But it was not a productive decision: nothing could be done about his need for more staff under the conditions of such a stand-off. James was in effect refusing to participate in the relevant discourses. In such a situation, James could only see himself as powerless, as non-agentic.

Disabling worker/manager discourses not only interrupt the flow of communication in the workplace; they also enable the worker to allocate blame to others for not getting their workplace needs met. Thus by engaging in disabling practices, James is 'enabling' himself to be the kind of worker that he would prefer not to be. In the following excerpt, James shows concern about his shifting intolerance towards co-workers, as his responsibilities and workload increased:

> *I'm not a person who normally is a short [tempered] person with my attitude to other people. I was intolerant. But I also found my own performance was down, I wasn't getting through my work, I wasn't enjoying my work, I was becoming frustrated with my work.*

James' account of himself as not normally being short-tempered with others could be taken as a rational, objective way of making sense of the work-changes: the amount of

work, the lack of appropriately trained staff, and changes in management to which he has been exposed for the past three years.

James could also be speaking of management's 'unspoken directives' that require James to take up more self-direction, self-motivation, self-regulation and self-management. Here, the ideas of Mills (1997) and Peters (2001) segue with Rose's construction of the 'New Worker', whom he describes as an individual who has 'rights and freedoms' and is free to have more autonomy, flexibility and mobility.

The final disappointment for James was in terms of skills development:

> *I was not getting any mentoring or cross-skilling or up-skilling other than attending a one-day workshop to do with auditing, but I'd go in and do an audit and I was on my own.*

Expectations about how new skills were developed would seem to have changed. James' past experience was with management that was more directive, co-operative and transparent, providing him with staged mentoring, cross skilling or upskilling. What seems to have been on offer was a framework within which he was expected to further develop his own resources: the classic demand of the neoliberal workplace for the responsible, mobile, flexible and autonomous worker. The problem with such expectations would seem to be that they assume that such autonomy is understood and that the means to achieve it are available. James clearly did not see himself as in such a position; he no longer saw himself as having a viable position to occupy.

Change in the reporting structure of work.

Automated client billing systems are now widespread in professional practice. The purpose is to monitor the time worked on each client's account and the total time worked by each employee. Sue is a senior associate in a medium-sized law firm, where she has worked for eight years. Her major concern at the time of interview was the ways in which she was expected to account electronically for every six minutes of her working day. Sue said that this automated accountability of billable hours is linked to the way you *are judged and appraised on a yearly basis*. One of the effects of workplace change for Sue was related to her sense of self, of not knowing who she was, as seen through the lenses of her work ethic and her personality.

> *I definitely think that my work ethic was probably quite unbalanced for a number of years, and I think that's partly because of my personality, the way I am, but also I think it's to do with the way my work is structured, and the fact that in order to, to achieve, and to be seen as being productive and being successful is, being able to do fantastic budgetary performance, for example, and doing more than your seven billable hours a day and all those sorts of things.*

Sue's account identifies several factors she sees as relevant to her loss of a coherent self. These include her work ethic, something she and her working contemporaries value highly. She acknowledges that her work ethic may have been unbalanced for a number of years. Any problems arising from this have been exacerbated, however, because the 'rules of the game' in the law firm that she works for have changed. She did not appear too distressed by the seven billable hours a day, but when the *bar was raised higher and higher* and she was expected to do more, with increased workplace surveillance in the form of automated accountability, her coherent sense of herself as a hard worker was compromised.

As Clegg (in Holman, Wood, & Wall (2005) points out, workers are employed for their embodied and cognitive capacities that the employer seeks to use. Sue is a new worker who, via the 'rules of the game', is encouraged to retain discretion in what she does and how she does it, as an autonomous worker. The paradox in this situation is that Sue embodies a series of self-regulatory practices understood in terms of her high work ethic, yet over time she discovers that she cannot sustain her internalised surveillance, and the introduction of the automated accountability as an external auditing device is identified as 'the problem'. Without the discursive resources to articulate the effects of the automation, she draws upon psychological discourses in an effort to make sense of the distress she is experiencing: *it's partly my personality—that is the way that I am*. Although she glides over her construction of 'that's the way that I am' as the interview progresses, she articulates her confusion through her loss of coping skills and worker competencies, which may also be construed as a loss of her previous self.

Loss of leadership and direction – God help me…

'New workers' are now expected to 'aspire to autonomy … to strive for personal fulfilment … to interpret reality and destiny as a matter of individual responsibility' (Rose 1996a, p. 151). However, these intrinsic requirements go largely unarticulated by management and workers. These are new values in the workplace such that workers

need to be more self regulating, self directing and responsible for their work. These changing values are not a 'secret' as such; rather, they are merely not made clear in workers' performance agreements or job descriptions. As a result, many workers no longer experience receiving the leadership that they did in the past.

Graham is an Information Technology manager, who has worked his way up through the ranks of a global communications organisation over the past fifteen years. He said that he had enjoyed his initial work as a tradesperson and the stable workplace conditions. During the past ten years, the organisation has undergone multiple relocations, restructurings, mergers and massive organisational changes. It was during this ten-year period that Graham was promoted first to team leader, then to manager. His new role involved the assessment of workers and worksites prior to staff being offered redundancies, redeployment, retrenchments or early retirement. Graham sees the cumulative effect of these changes in the following terms:

> *There is no leadership any more. No one tells you how to do your job or show you what is expected of you; they just say this is your job, you sit there and off you go ... and you say, "God help me. What does this all mean?"*

Graham is uncertain and floundering, as the management infrastructure as he knew it has disappeared. He appears no longer to know what is expected of him or who he is. *What does this all mean?* is an indication of a significant loss of his capacity to see his work as making sense. It is a very clear indication of his loss of a coherent agentic sense of self, which he had possessed as a tradesperson when the workplace was more stable.

Graham's production of himself as a certain kind of worker, who once knew what was expected of him and the ways he valued being directed by management, provided him with a strong sense of agency. His present self is represented as a different, a less confident kind of worker self. He finds it difficult to discern structure in his new workplace, and sees himself as a floundering worker trying to meet the challenges produced by a workplace that requires him to be autonomous and more self-directed. The problematic nature of such loss of self is articulated by Foucault, who sees the subject as 'either divided inside himself or divided from others' (Foucault, 1982 p. 208).

5.2 Work now: responsibility and agency

This section looks at workers' constructions of their experiences of workplace change. It is broadly organised according to two foci; what the workplace appeared to do to the workers and in turn what the workers did to themselves. The first set of excerpts details the interviewees' accounts being taken advantage of in the workplace; that they had to deal with increased work expectations with fewer resources to achieve the expectations, they struggled with the loss of familiarity with workplace products with insufficient time to grapple with these changes, the difficulty in juggling their independence within the confines of company regulations and finally the loss of certainty regarding their job security. The second set details what the workers believe they had to do to themselves as a result of new conditions and workplace practices; taking on more work, and responsibility, a sense that were giving to the company as much as they were able and receiving very little in return, in turn these workers believed that they had to do more in order to remain operational within the company, with a diminishing sense of agency, requiring the taking up of new/different forms of worker subjectivity.

Feel like I am being taken advantage of

Appearances can be deceptive, as Molly's story attests. Molly's story provides an account of her five years of work in a large recruitment agency in central Sydney. During this period, many workers sought employment with her firm. As she said, *they believed it to be a glamorous* job, as well as having philanthropic properties. When new appointees discovered that they were required to work excessive hours of unpaid overtime, they commonly left the job, only to be replaced by another person who had similar aspirations and ended up similarly disappointed. The daily grind of interviewing people soon lost its anticipated gloss: matching people to available contracted work and cold calling soon become monotonous. On top of the interviews are the one hundred and fifty-odd CV's that she receives each week from within Australia and from overseas from people looking for work. Molly reports:

> *I've gone from, you know, sort of having three or four staff to having, you know, just me, to then having two extra staff, and, you know, so it's a constant sort of change and then I sort of, something feels like I'm being taken advantage of because, you know, like, they'll just think, 'Oh, she'll manage.'*

In Molly's narrative she emphasises her distress, brought about not only by the fluctuations in staffing, which cause her sustained and constant uncertainty, but also by the frustration created by management, which assumes that she will manage. She constructs these events as *being taken advantage of*. Underpinning this narrative are notions of loyalty to the company, a key element of past workplace discourses. Other workers who came and went were new workers who made the decision that the conditions of this workplace were untenable and so resigned. In contrast, Molly is putting up with the perpetual uncertainty of changing staff numbers. Later in the interview she positions herself as knowledgeable about the recruitment 'game' and says that, as it is all she knows, *it is better to be with the devil you know than the devil you don't.*

Molly has become very familiar with constant changes in workplace operations and their effects on the workforce. Seeing people every day for the past five years who have been sacked, retrenched, have taken early retirement or who only want to do temporary work, as it offers them a more flexible lifestyle, has resulted in her having very few illusions as the effects of workplace change on workers of all ages and differing levels of competence and skill. Workplace tenure is slippery, as Molly articulates after listening to people, many of whom are desperate to find work. Unfortunately, many people who have worked in the same place for many years only know old systems and have to spend weeks or months upskilling and bearing the high financial costs of re-education.

In terms of her own construction of tenure and living with the uncertainty of staffing levels, Molly could be understood as embracing both past and present workplace discourses: while she is not happy with being taken advantage of in her place of work she has made a decision to stay with *the devil you know*.

Loss of familiarity with the new product

Many workers argue that the speed of technology has multiple benefits. However, many workers also complain that there is little time to learn about new products to a level where they feel safe and competent in working with them. In Ken's account, the new 'product' is constantly changing high school curriculum. Ken is a high school administrator, who speaks in this excerpt about the rapid and ever-changing introduction of new high school curriculum for years ten and twelve students:

> *Now, of course, most of the stress is a rapid implementation of the last, well, forever I suppose, but in the last few years it's just been horrendous and it seems to be getting even worse—it just doesn't seem to let up.*

Ken mobilises discourses of past changes that have occurred so quickly that he speaks of them as *horrendous*, with no foreseeable end in sight. Ken's narrative includes multiple reasons for difficulties in the implementation of these changes, such as students who don't want to attend school, students who are kept at school because they are too young to enter the job market, and students who have multiple social, economic and learning difficulties. He recalls a time thirty years ago when students did not have as many social problems or, if they did, they did not bring them to school for him to solve.

This 'golden past' workplace represented a time when Ken enjoyed teaching as it was, whereas now his workplace has become complicated, over-regulated, overly managed, overly litigious, and teachers are now held responsible if students do not pass exams. The weight of the changes and tensions within the school is further complicated by the Department of Education, which appears to Ken to be determined to keep changing curricula and at the same time *offers no support or teaching of how to implement these changes.*

In Ken's story, there is tension between his desire to teach students without the complications engendered by increasingly prevalent social problems and the pressures imposed by administration, such as the requirement that teachers take responsibility for students reaching a certain standard prior to leaving school. The teachers of the present, in Ken's construction of events, are expected to take much more responsibility both individually and collectively in terms of accountability, audits, performance appraisals and so forth than teachers in the past, who had a greater sense of certainty about why they were there, what they could achieve and who they were.

Ken's loss of certainty also means the loss of a stable position that he once relied upon to position himself as an agentic worker self. The problem with his current workplace change is that he does not envisage any possibilities whereby he might reconstitute himself as an agentic self who has the kind of support necessary for even coping with workplace change, much less embracing it proactively as the kind of autonomous, flexible, mobile and self-directed worker new discourses are calling for.

More autonomy yet less control

The concept of autonomy is very attractive to many workers, as it suggests less surveillance in the workplace and more trust: being able to make independent choices about when and where work is done as long as the work gets done. The downside of having more autonomy is not without consequences, however, as the following excerpt shows.

Barden is a 30-year-old engineer who has worked in a number of workplaces. He has found it challenging and exciting to create new designs, even though this is an isolating task. In his opinion, all organisations are *culturally dependent*; so for example, in his previous place of work, the culture was to *push people around*, with minimal regard as to how they were going to meet their respective targets. If the worker could not reach the strategic target, there was a managerial view that *if it is too hot, get out of the kitchen.*

> *I think I do actually think it's good in some ways, in that I do believe working in a variety of workplaces helps in your own development. Yeah, it's interesting and I understand I think in ways workers have more autonomy these days in that organisations tend to be less hierarchical. More autonomy in how we decide to do the job, but we don't have more control.*

Barden seems to be taking up multiple and contradictory subject positions. He speaks of how a change of workplace can help in a person's development and the associated benefits of worker autonomy are that organisations are tending to be less hierarchical. So on the one hand, more worker autonomy is perceived as good. On the other hand, if workers cannot meet their workplace targets, management is less supportive than it would have been in the past. A further complexity is how workers simultaneously manage the requirement to be both autonomous (independent and self-governing) and controlled (carefully measured and regulated).

This juxtaposing of multiple and slippery subject positions reflects the unintended effects of power in the new workplace discourses. Although Barden seems to have internalised the agentic benefits of the 'enterprising new worker', the external technological constraints imposed upon him suggest that there is a discursive dissonance between 'how things should be and the way that things are'. These

dissonances could well contribute to the fluidity of his subject position and the fine cracks appearing in the coherence of his sense of a worker self:

> *We're enslaved by technology; technology is starting to control us. While the distribution of information is almost instantaneous, through email and so on, and the worker may have more autonomy in how he decides to do the job, he doesn't necessarily have greater control, as the external pressures are greater.*

In Barden's account, the values gained by having a sense of autonomy appear to be outweighed by his sense that technology is starting to control him and that the relentlessness of new information involves far greater pressure on him as a worker. At the time of interview, he did not see any way out of the current situation, as all workplaces operate with similar conditions when a person is employed as an engineer.

Loss of certainty – loss of a job for life

Today, as Barden attests, *working in a variety of workplaces helps in your own development*. Recruitment personnel no longer view people working in one place for many years as being as advantageous as it was once seen. Changing jobs every few years is now understood in terms of upward mobility, along with increased remuneration, ongoing learning, and changes in the level of responsibility. A worker can now change jobs in less than a year without being discredited as a suitable candidate to be considered for a new job.

No longer having a job for life has created multiple stressors and uncertainties as the next two accounts demonstrate. Mary tells a story of working for a private organisation that provided training programs and sold software. After a merger with a new company, she had been moved from a teaching position to a sales position, which she found distressing for a number of reasons. The first was that she found *small talk* (engaging the new clients) and working on the phones for eight hours difficult, due to her hearing loss. Recently she had been interviewed by her manager and given her first warning about her reduced productivity in the previous three months. Her comment is revealing about changed values and practices:

> *I was brought up in the belief that once you find a good job, if you do your best, you will be there until the end of your working days. Well, that is no longer a reality. That sort of permanence of jobs is no longer.*

Mary's story involves multiple changes to her work trajectory. Prior to working for this current organisation, she had been an English teacher in South Africa and had changed from teaching English to teaching computer programs. Both kinds of work involved face-to-face teaching and engaging with people in a different capacity. She was then moved to cold calling, selling computer software over the telephone for thirty-eight hours a week. Her story of her loss of workplace permanence can certainly be read within a workplace narrative of the loss of a golden past, in this case a past where some workers had a job for life. When the workplace required her to take on a different role, she drew upon this discourse in producing an account of a past workplace that had tenure, safety and security built into its storyline.

In this second extract, Graham expresses his concern about loss of certainty in terms of the issues of stable employment and lack of worker motivation. In this excerpt, he is speaking about the preceding eighteen months of workplace uncertainty, when staff at both informal and formal levels discussed ongoing rumours of workplace mergers and downsizing. Since no actual decisions were being made, there was no resolution to questions of what staff would have to go and who would remain. Nor were new initiatives possible, as existing infrastructure was based on the current number of employees.

> *With all these changes people just didn't know whether they had a job or didn't have a job. No one had much motivation because they did not know if we were going to be taken over and retrenched, or restructured, or not taken over and go back to the old ways.*

Security and certainty about work provides many workers with a base from which they make decisions not only about their work but their social lives as well. Graham shifts between talking about the others, their concern as to *whether they had a job or didn't have a job* and including himself. Interestingly, his inclusion of himself comes as part of a move which begins by referring to others: *they did not know if we were going to be taken over and retrenched or* …. The discursive selection of *them* and then *we*, as if he is moving away from other workers, then closer to them, is one indication of Graham's ambivalence about the whole scenario. His anxiety about the instability of the workplace and the effects of these changes provides a range of mixed loyalties, as part of the past worker discourses, when loyalty to the workplace and to other workers was highly valued.

What I have illustrated in this section is that accounts of present workplaces are not possible without an understanding that these workers have been crafted through both past and present workplace practices. These workers have experienced workplace redundancy, restructuring, relocations and downsizing that are not simply metaphors for changes to existing workplaces and worker selves, but are the site for the production of a prior, lost, coherent sense of self, in their struggle to sustain the unsustainable.

New workplace networks and power formations are not as stable as the networks formed at a time when people knew their position and what was expected of them. New workplace matrices, as depicted in the data, are not stable, but are constantly shifting. Attempts are being made by the workplace to recruit new agentic workers to take up new subject positions if they can sustain a worker self that readily mobilises neoliberal or 'new worker' discourses. These discourses of autonomy, flexibility and mobility are ones which disavow the social but salute the individual. The workers in this study are all attempting to tell agentic stories, but they are not yet coherent, competent, agentic stories. There appear to be varying degrees of dissonance between workers' experiences of increasing uncertainty, multiple losses and a set of previously known clear, predictable and stable workplace structures and becoming a new worker.

Taking on the work: coping with our own decisions

The focus here will be practices that the workers themselves initiated, such as taking on more responsibility, giving everything and getting nothing back, and functioning with fewer resources. These workers attempted to take up new forms of subjectivity through a complex range of activities. An inability to sustain these new work practices contributes to the workers' failure to achieve their goals of becoming self-managing workers.

The argument that underlies this section is that, while new workplace discourses purported to be offering workers greater flexibility, mobility and autonomy, the rise of technologies of audit and accountability in the workplace produce workers as instruments or commodities of workplace governance and power. The widespread use of workplace audits demands changes to workers' subjectivity, as workers now have to become self-managing and self-regulating in accordance with workplace governance (Power, 1994; Shore and Wright, 2000; Dean, 1999, p. 169, as discussed in Chapter 3). Hence, as workers do not have a choice about taking on self-managing practices, the

lack of choice is a discursive contradiction in terms of new workers with 'individual rights and freedoms', as outlined by Rose (1996a) who refers to '… the enterprising self … no longer as subjects with duties and obligations but as individuals with rights and freedoms' (p. 151).

In order to highlight this discursive contradiction regarding new workers' supposed 'freedom' on the one hand and lack of choice on the other, this section includes a number of examples involving a distinction between past and present workplace experience as speakers attempted to hold onto prior subjectivities that appear to be more stable. Prior subjectivities inferred more stability and predictability, in contrast to the instability of new subjectivities as the workers initiated more practices in their efforts to cope with the deteriorating effects of their respective workplace changes. New discourses tend to become 'normative' with increasing exposure, of course, and to have effects on the conduct of the worker.

The objective of disciplinary techniques is normalisation, the creation of routines, and predictability (Mills, 1997). Thus, as workplaces exercise 'economic rationalism' in the form of not replacing workers who go on extended leave, or resign, or go off on sick leave, or whose work requires more hours than are allocated, other workers take up more responsibility to fill the gaps left by absent workers in an effort to maintain the discursive currency of neo-liberal manifestations that is embodied by many new workers.

Taking on more responsibility

Taking on more responsibility without recompense is a familiar trend in the workers' accounts of their experiences of workplace change in this study. As Ashley said, for example, *they put you on salary as a way around things*. Such 'things' would clearly include taking on more responsibility in the absence of staff who have not been replaced or when staffing numbers have been reduced (downsized) as part of a process of economic rationalization.

Isobel, recounting her return to work part-time following maternity leave, told how she had to deal with the effects of a major restructuring, where the previously well-defined roles of workers had all but disappeared:

> *It was a very overwhelming experience, you know, having managers resigning. I felt I had to take on their responsibilities for the program.*

The managerial responsibility Isobel spoke about was for a carers' program that was state wide and involved support for staff working in both metropolitan and remote areas. Over time, other workers in the organisation saw her not as 'acting' in the position but as 'being' the manager. Her additional duties and responsibilities were soon 'normalised' by other staff (Mills, 1997, p. 8). In the absence of redefined roles, she became overwhelmed.

Isobel's experience, interpreted as a 'worker-initiated practice' of taking on more responsibility, meant that Isobel had become what Rose (1996, 151) terms an 'enterprising self' … [that] finds meaning in existence by shaping its life through acts of choice' as her experience was that she had no choice but to take on more responsibility if the program were to stay up and running. The workplace provided the conditions where Isobel discursively 'internalised the panoptic gaze' of other workers and staff in her attempts to take on the managerial role on a part-time basis. Being both a new mother and having additional responsibilities at work, Isobel's attempts at coping with her changing subjectivity soon began to break down to the point where she went off on extended sick leave.

Giving everything and getting nothing back

In the extract in this section, Amber, like Isobel, tells how she finds herself *giving more* in an environment of a lack of a defined role. Workers who work outside of 'office hours' and/or are not visible in the workplace by fellow workers during regular working hours frequently express their concerns that the extra unpaid hours spent outside the office for the most part go unacknowledged, irrespective of their job title.

> *I find I'm on call more often … the other day I had a media release out and my first phone call was at a quarter past six in the morning and the last was at ten o'clock at night. Then at other times you can't just sort of drop everything walk out the door and just breath a big sigh and say that's it it's all over for the day you do tend to take things home with you. I've always got to monitor what's going on in the news so you know where I'd love to sit down and just watch a movie I've got to keep an eye out on what's going on in the world because that directly affects my job I can't sort of completely switch off. I give everything and management gives nothing back I am sick of it.*

In this extract, Amber describes what is a normal part of her working life, leading to many hours of unpaid overtime. When a newsworthy story breaks, her task is to track down an appropriate person, interview them and have the story written ready to be released as soon as possible. The release of the news story is frequently required by the media in a matter of a day's notice, if not hours. Amber construes this as unfairness in relation to the ways that she was *giving all of herself to her work and management gave nothing back*, both in terms of the lack of acknowledgement and lack of remuneration.

The perspective of the new workplace, on the other hand is focussed on 'the audited subject' becoming a 'unit of economic resource' with the 'audit technologies' requiring that people adjust how they think about themselves in relation to others and the workplace (Shore & Wright, 2000, p. 62).

Workers' performance is no longer externally regulated by standards of conduct set by management, as in past workplaces. Power's account of audits (1994, p. 13) is in terms of them being introduced when trust has broken down; the spread of the audit has, however, created the very 'mistrust' it was meant to address. The individual audited subject has been recast and workers are now expected to judge themselves by the targets they set for themselves. These self-imposed targets are measured via technologies of governance such as annual or bi-annual worker performance appraisals, or by requiring workers to apply similar auditing procedures to themselves, if they wish to aspire to taking on new workplace agentic selves. Amber's experience of working many hours of unpaid overtime and not being acknowledged by her co-workers suggests that, in this particular workplace, working unpaid overtime has become discursively 'normalised' by other staff members. And as yet, Amber has not recast herself as a worker who is expected to judge herself, and set targets for herself as Power (1994, p. 13) suggests. This undoubtedly has increased her sense of being taken for granted.

Bringing more and more of ourselves to work

One final recurrent theme in these stories is the way in which many workers were expected to bring more and more of themselves to work. This is articulated in a variety of ways, for example workers talking about *taking on more responsibility* and *giving everything and getting nothing back* as outlined in the account above. A further story broadens the scope of this issue.

Heather's extra giving of herself arose from her responsibility for having the required number of teachers in the classroom each school day. She told how:

> *On one day I had 34 staff away for various things out of 76 teachers because many of the teachers were off on stress leave. I had to get in there at 7am in the morning and have it all done by the time the staff started arriving at 8.15am, so I had to ring all the people who were coming in for relief, I had to get their timetables ready—sometimes I'd get there at 6am if I knew it was going to be a busy day. There was no one to help me.*

Heather gives an account of the variety of pressures on her, beginning with the time she needed to arrive at school, which could be two and a half or three hours before the students started their classes. She would replay the message bank to ascertain how many teachers were off sick. This was followed by a succession of phone calls to find relief teachers, then creating timetables for the relief teachers.

While these tasks are not inappropriate for the work of a school administrator, what is striking in Heather's story is her account of the relentlessness of the need to fill in for the expanding numbers of staff who were not at school. Heather does not articulate 'unfairness' as Amber did, but provides a good account of the way she not only did more work, in an attempt to fill the staffing gaps, the needs of the students, the school, the parents, the community, the authorities that govern the education system but that she kept on *functioning with less resources* than her predecessor, who had worked in a period that could be constructed as workplace of the past that was more stable and predictable.

Since Heather was the only person in this position at the school, she tells how she often experienced being the recipient of other teachers' anger and distress when their personal and professional needs were not being met. At times she was positioned as a 'saviour' and at others as an interloper: an *academic who should go back to the* [Education] *Department*. The implied expectations were that she not only had to self-manage but that she would deliver staff support as part of the increasing load of replacing absent staff. Heather's story of the ever-increasing hours of unacknowledged and unpaid work is a very clear instance of 'internalising the panoptic gaze' of the school in her attempts to manage her changing roles from 'an academic' to a member of a secondary school staff, coping with an untenable working problem.

Some parallels can be drawn here between the coercive audits described by Shore and Wright (2000), who say that individuals are now required to self-audit and change the ways that they see themselves in relation to work (i.e. to learn new ways to self-manage), and that of the coercive nature of the panopticon. Foucault (1977) gives an account of how it made possible constant surveillance of the prison cells' inmates, while staying invisible to the prison officers. Significantly in a contemporary workplace, managers and people managing themselves as new workers both invoke the image of self-contained workers, who must be coherent, autonomous and flexible.

What is not so clear is the way in which power operates in the new workplace, where extra work is coupled with increasing uncertainty about employment, relocation, devolution, and so forth. In response to these changes, workers take on more work in an attempt to cope. One of the unintended effects of such new workplace practices for the participants in this study is that they have destabilised their subjectivities as agentic workers to workers who cannot cope with the constantly changing workplace. The inability to cope produces the conditions of emergence for the formation of internalising discourses as a precursor to somatic symptoms that can be diagnosed by a medical doctor as depression.

In terms of the staging of these narratives, the easy narrative flow seen early in the accounts provided in the interview process became progressively broken up, with varying degrees of hesitancy, as speakers appeared to be searching for the words to adequately describe their experience. This hesitancy was read as a form of 'teetering': in their stories, speakers moved backward and forward between past and present workplaces and between positioning themselves as once having been agentic workers in contrast to workers who were now breaking down. This notion of the discursively teetering worker became noticeable as the workers took up more and more 'I' statements to describe their experience. This shift became a major point of attention in the analysis as speakers moved away from talking about their external workplace experience. They gradually came to refocus on the internal conditions that became significant in the reconstitution of themselves as workers who then became engaged in the process of being resubjectified as depressed workers.

Conclusion

This chapter has described narratives of loss, set within the context of major workplace change. The workers' accounts of workplace change through their experiences have operated strongly in terms of a contrastive rhetoric marking a distinction between workplaces of the past (even if the past is only a matter of weeks ago, in a different workplace) and the present. It would appear that such a contrastive strategy provided a way to capture or illustrate their experience of how stressful the present workplace is.

The focus of this chapter has been on the first of the five narrative or discursive stages identified from the interview data and formalized in the five-stage resubjectification framework presented in Chapter 4. Its working method has been a horizontal analysis, in the sense elaborated in Chapter 4, working across the body of data. The next chapter will work through the remaining stages using a vertical analysis, focusing primarily on one worker's story. It begins with his story of workplace change, shows how he mobilised pre-existing internalised psychological discourses as precursor to somatising his workplace stress. Once somatic discourses were deployed, being diagnosed with depression automatically followed.

Chapter 6

Resubjectification as a depressed worker self: regaining a viable life

Introduction

This chapter continues to explore the process of narrative re-subjectification through examining in detail one account, Mark's story. The selection of his story was essentially arbitrary: any other of the research participants' accounts could equally have been used. This point will be clearly illustrated by the concluding section of the chapter, which consists of extracts from the narratives of worker resubjectification from five further research participants, organized to exemplify the five stages of narrativisation. These interviewees, too, were essentially chosen arbitrarily; the pattern was ubiquitous across the corpus.

The purpose of examining one account in detail is to identify the specifics of the process of narrative resubjectification as it continues on from stage 1 (addressed in Chapter 5). The focus of that chapter was on how the workers narrativised their responses to workplace change. Four themes emerged: workers' loss of a 'golden past', their loss of coherent selves expressed as not knowing who they were, the articulation of the present workplace conditions and practices in terms of what had been done to them and in turn what they did to themselves. This chapter focuses on Mark's progressive loss of agency through the internalising of workplace stress (Stage 2), the somatising produced from his discursive internalising (Stage 3), becoming a medicalised self (Stage 4) and finally his taking up of a pharmaceutical self (Stage 5). These four stages map the discursive processes that detail Mark's resubjectification from a non-coherent, non-viable worker self to a depressed worker self who has regained a viable life, albeit provisional, fragile and temporary.

6.1 Mark's story: overview

In Mark's interview he described himself as in his late forties, married, with a seven year old son. He has two daughters from a previous relationship, with whom he is in regular contact. He is on good terms with his ex-wife. Prior to major changes in the Police Force, his role entailed a high degree of autonomy and involved a great deal of

travel, both nationally and internationally. He enjoyed his work and had been successful in reaching the level of Police Inspector. Organisational changes required senior police staff to move out of administrative roles, working predominantly nine to five, to front-line policing. This workplace change required senior police staff to revert back to shift work, and to learn the modern technology used in policing operations, as well as learning to work with younger police staff who were university-trained, computer-literate, familiar with defensive driving and had acquired different skills in managing the general problems of policing, in comparison with their older police colleagues.

Stage 1: Mark's experience of workplace change

After the organisational change, Mark (reluctantly) was sent to a very busy inner-city station, where he was placed in charge of a shift. He had not worked in operational policing for twenty years, which he identified as a problem for him. Mark's narrative told of his distress, as he was expected to respond to huge adjustments on multiple levels, without being given any training. For example, working face to face with the 'rude and aggressive' general public; changes in technology and computerised data entry for every event on the shift; and new and sophisticated technology in the police cars, including hand-held and electronic surveillance equipment. Mark spoke of the rigours of returning to shift work and how this impacted on him and his family. The two most important issues that emerged from his narrative were his lack of computer skills, required for his daily duties, and his lack of competence with the technologies required for operation of the police cars. In his early working days, a telephone in the police car was the only equipment: all he had to do was pick it up and push one button to respond to a call.

Stage 2: Mark's internalisation of workplace change

In response to his experience of difficulties due to his lack of training and the lack of adequate support in his new role, Mark described himself as *wandering around in the dark and not having the faintest idea how the lights, siren and police radio and all that paraphernalia connected to the police car worked.* His overall response was *I felt totally naked.* The protracted physical and mental exhaustion brought into focus other matters, such as his age, his weight, his eyesight and the difficulty *of driving around in the police car at night all by yourself*, so he posed the question *why am I doing this?*

Stage 3: Mark's somatisation of workplace change

As Mark had not done shift work for nearly twenty years, he found the transition from day-work to shift-work extremely difficult. He spoke of poor sleeping patterns, going to work exhausted and consequently becoming sleep-deprived. His sleep deprivation led to red, sore eyes. He consulted with a police psychologist to discuss his workplace problems but did not regard the psychologist as being particularly helpful. Mark's belief was that what was being done to him was unfair; the psychologist's response allegedly was: *Who said it was going to be fair?* Later, on a holiday, when he contemplated suicide *(you would just jump over board and you would be gone)*, he frightened himself, so consulted a doctor.

Stage 4: Biomedicalising or re-interpretation of Mark's symptoms.

Mark's consultation with the doctor produced a diagnosis of depression, a prescription for Zoloft and a certificate for sick leave. A couple of months later, his doctor offered a medical discharge on the grounds of clinical depression. His official discharge from the police force was completed some months later.

Stage 5: Pharmacologising.

Mark offered no resistance to taking the medication, part of the diagnostic process of Stage 4. Mark has now taken up his new resubjectified self, as a depressed worker.

6.2 Analysis of Mark's narrative

Mark's narrative begins with his account of a complete restructuring in the organisational running of the police force in 1996. *I had been a Police Inspector for three or four years and had not been involved with operational policing for probably twenty years.*

Mark opens his account of workplace change drawing on the now-familiar contrastive rhetoric of past and present as discussed in Chapter 5: he speaks of his past position as a Police Inspector, a position he regarded as stable and unproblematic until the organisational restructuring of the police force required him to take up a new role as a duty officer. Mark ties his sense of self to a past time, when he was Mark 'the Police Inspector', an agentic, competent and coherent form of self. As a former police prosecutor, his coherence and agency had been achieved by his competence in *knowing what to do*. He had been provided with comprehensive training before and during this

position. Mark's experience was one of being capable of doing his work competently, being part of a 'team', having 'shared responsibility', experiencing 'collegiality' and being part of an interrelated system. These past experiences provided him with a stable and permanent workplace structure.

In contrast to the above scenario, the restructuring and the subsequent change in Mark's position eroded his agency. He no longer knew what to do and therefore no longer saw himself as capable. There were many complexities and contradictions in Mark's account of transferring from his prior position, as a Police Inspector in an office environment, to his new workplace role as the person in charge of a busy inner-city police station. These workplace changes were related to him feeling responsible for his own loss of agency, autonomy and other forms of self-engineered flexibility that were a by-product of his previous positions. In his narrative, Mark states that in his new role he was the highest paid worker, but had the lowest level of technological competence. The lack of technological competence was extremely relevant to his work, because there were times he had to work alone at night and did not know how to operate the equipment.

The new 'worker self' is expected to be more 'autonomous, mobile, flexible and self directing' and be capable of identifying and addressing their own 'deficits'. Part of the general rationale for restructuring in the workplace has been to employ fewer people with higher levels of expertise. Mark was positioned as such a new worker in his new role in the Police Force. However, his experience was that:

> *[T]here was absolutely no training at all given in relation to my role as a duty officer … everything had to go onto a data base. I don't know how this computer system works at all. … I was left to wander around in the dark for a fair period of time. Believe it or not, in a period of four years I only put in about two entries. At other times, I was assisted if the sergeant was friendly, or there was an administration officer, or a probationary constable. …I did not have the faintest idea how the lights, sirens and police radio and all the paraphernalia connected to the police car worked.*

From his position as 'old worker', Mark read the new workplace situation in terms of lack of training and lack of direction, as a result of which he *was left to wander in the dark.* He appears to have had an expectation that his employer would provide training, even though the employer's expectation seems to have been that he would already be competent in these areas. In the transitional spaces between the expectations of 'old

workers' and the workplace's expectations of 'the new worker', there seems to be an enormous discursive space that can be problematic for both the worker and the workplace.

One of the general findings of the study, as reported in Chapter 5, was that many workers reported a breakdown of older communal structures and the loss of other elements of past workplaces that had provided a more stable, certain and collegial working environment. Workers spoke of a sense of belonging to a team, or a family, where there was always someone to lean on. While Mark, in his narrative of workplace change, does not explicitly refer to the lack of having someone to lean upon or to be reciprocally dependent upon, the availability of such a person may well have diminished the unsettling effects of *wandering around in the dark* for so long. What is certainly missing in Mark's narrative is a sense of belonging and of connectedness to other staff. Newer staff may well have engaged with the notion of increased autonomy, as part of their construction of a new worker self, and be totally unaware of older workers and former workplace practices that provided someone to 'lean on' as part of a sense of workplace community.

The consequences of the absence of these older relationships is identified in the literature as a particular form of unhappiness known as Anaclysis (Harvey, 1999). This is a form of unhappiness that is often experienced by people when 'organisations' or belief systems we are dependent upon for emotional support are withdrawn from us. For example, when we are 'put down'… [or] when we go through organisational change, suffer through organisational restructuring or have to relinquish a cherished belief system' (Harvey, 1999, p. 112-113). In Mark's situation, particularly with respect to logging information into the data base, he had to seek assistance many times a day and had to rely on a friendly sergeant, probationary constable or office worker to help him. His ongoing need for such assistance positions him as an 'old worker' who assumed he would be given training, which was not available, and who was unable to take responsibility for training himself. Constant reliance on more junior staff reinforces his struggle to bridge the gap between his coherent self, as a senior person doing 'administrative' work, and an incoherent and incompetent self, engaged in front line policing work.

As the officer in charge of the shift, Mark is responsible for all the staff on duty. In the event of him being in a police car with another staff member not fully competent in police car technology, the car would be deemed unsafe for the people in it. As a 'new worker', the workplace may well expect that Mark, being on-duty, is responsible for recognising workplace deficits and rectifying them. This implies he would seek to become adequately trained in the technologies of the new police cars, rather than positioning himself as not having the *faintest clue*. If he had engaged in the act of seeking training himself, this would have represented a shift from his 'old worker' expectations, that the workplace would, as a matter of course, provide training to workers as required in their new positions.

Mark seems to see his lack of training as putting him in a powerless position but that is hardly the perspective involved in Foucault's (1990, p. 95) contention that power is '… imbued, through and through with calculation', meaning that decisions and choices are being made and aims and objectives are being formulated at every point in the power network. Foucault refers to this as the 'local cynicism' of power (1990, p. 95). Furthermore, Foucault states that where there is power there is resistance: 'the combat between power and resistance involves constant reorganisation, realignment, and redeployment of forces' (Foucault, 1994, p. 117). Power relations are said to be mobile and unstable. Moreover they are reversible.

What is not being said in this section of Mark's narrative is that his not seeking training for himself can be seen as exercising (albeit unconsciously) an actual decision not to do so, as nowhere in his narrative did he mention that he had pursued any avenue of training and been rejected. Under the umbrella of new workplace technologies, 'new workers' are expected to be responsible for themselves. The processes of 'responsibilisation' include the ways in which individuals become 'discursively constituted as fully responsible for management of the self in the myriad competitive choice-making activities that make up life under neo-liberal governance' (Davies & Saltmarsh 2007, p. 8).

Mark's responses to workplace change conclude with the suggestion that the unintended effects and culminations of the 'little things' that were stressful to him were the lack of competence he felt with data entry and police car technologies. These 'little things', according to Foucault, produce internalised surveillance mechanisms, where we become

conditioned to gaze at our own thoughts and actions (Lunbeck, 1994, p. 153). From the perspective of 'internalised surveillance' (Epson, 1993; Walkerdine, 1989), it seems that workers are discursively caught between positioning themselves as 'old workers' and having to function as new workers. These workers once had workplace stability, agency and coherence and now cannot sustain their internal surveillance on the effects of the workplace change on their 'old worker selves'. The workers' attachment to their 'old worker selves' may be understood as a 'regime of truth' or, as (Walkerdine, 1990) names it '… fictions which function in truth…' (p. 109). These truths are made up from workers' 'rules' of behaviour and expectations about their work.

Regimes of truth are not static, but can perform the function of identifying and measuring 'normal' and 'abnormal' behaviours. For example, Mark's 'lack of training' discourse, functions as a regime of truth that was developed from his experiences in another historical moment in his working life, yet this regime of truth no longer holds the same force in his role as a 'new worker' in the context of the new workplace discourse. That is, under an 'old worker' regime of truth, a worker was entitled to, and provided with, the necessary workplace training before being transferred to another position. In contrast, under a 'new worker' regime of truth, workers are more likely to be employed if they already have the skills to do the work. This implies that attainment of skills is the responsibility of the worker, not necessarily that of the workplace.

The tensions that arise between the 'lack of fit' between 'old worker' discourses and 'new worker' discourses can produce a range of responses, leading to workers' internalising their workplace stress. Internalising workplace stress can be read as the workers' 'care of the self' as understood in a Foucauldian sense (Foucault, 1988b; Hoy, 1986), meaning that self-care practices emphasise the individual's role and responsibility in enacting them.

Stage 2: Internalising

The purpose of this section is to investigate how internalising discourses work as technologies of both mind and body in the relevant sections of Mark's narrative. People who are distressed tend to internalise the distress and suffering to which they have been subjected as inner dialogues and these dialogues colour their interpretation of subsequent events (Adams-Wescott, Daffron, & Sterne, 1993, p. 262). Internalised conversations re-train people to a narrow description of the self. The feature of

internalisation in the workers' stories is that they limit themselves to oppressive stories, thereby limiting their perceptions of available choices in the workplace. According to Foucault (1982, p. 208), the most politically powerful discourses in modern society divide us from each other and invite us to treat our bodies as problematic objects. That is, they objectivise. Epson (1993) has named the kind of discourse that supports this process 'internalising discourses'.

The shift from stage one of Mark's experience of workplace change narrative to a second stage of internalisation is not straightforward, as he cannot always name what is happening to him. Indeed this was generally the case across all twenty interviews. Workers in this study do not always appear to have the language to describe how, or when, the shift occurred between describing what is happening in the workplace (externalising discourses) and the point when their unspoken internal conversations (internalising discourses) are taken up as first step towards becoming re-subjectified as depressed workers.

What is critical is that there appears to be a problem at the internalising point, when workers can either take up a position that engages with new worker discourses of flexibility, autonomy, and self management or when they mobilise their internalised discourses of the psychological self. If they pursue the former, new worker, discourses there will be a greater tendency for the worker to become more autonomous, flexible, mobile and self-governing, as Rose (1996) suggests. However, the latter choice leads to a further resubjectification as they discursively expand on their inner dialogues and narrow their construction of their experience and as they mobilise already embodied psychological discourses of the self. I have used the term 'teetering' as a way to describe the backwards and forwards movements that workers draw upon to describe a specific phenomenon (in their account) when they were unsure and uncertain about which direction to take up. This 'teetering' self is de-agenticised, uncertain, confused, distressed, hesitant and undecided about which direction to take. Many workers successfully become 'new workers', yet the workers in this study internalised their workplace narratives and became medicalised subjects. Mark for example says:

> *It was humiliating and I suppose I felt totally naked, which causes me some forms of embarrassment that you are not able to perform at the level you expect of yourself. This was the start of what I consider to be the degradation of me as a person.*

Drawing on the analysis of the previous stage, it appears that, when Mark's sense of self moved further and further away from being able to meet the expectations of the workplace as a 'new worker', he positioned himself as less agentic, less autonomous and less capable than he was in his previous position. In these circumstances, Mark is also moving away from his old worker self and expectations, where he saw himself as more autonomous and capable. Perhaps he had become reliant on those feelings in order to be coherent and to have an agentic sense of self. Mark verbalises the experience of internalising these shifting senses as humiliation: *It was humiliating*. Yet Mark was not directly humiliated by any person at work; rather, it was his interpretation of, and positioning of himself within, the workplace conditions that produced his humiliation, specifically, the requirements of the technology and the lack of alignment between his expectations of himself and those of the workplace. Mark's discursive positioning with respect to these conditions was named by him – that is, constituted – his humiliation. The higher the workplace expectations of being more 'autonomous', the less autonomous Marks felt, contributing to his loss of a coherent self and experienced as humiliation.

Humiliation discourses can be used interchangeably with others such as shame, embarrassment, dishonour and degradation. These intersecting positionings share some overlapping elements, as suggested in Rose's conceptualisations, arising from articulations of 'the individual', 'the unitary self', 'the person' and the 'human subject'. The single images of a unitary self, such as the humiliated self, the embarrassed self, the dishonoured self and the degraded self, can later be reinterpreted by a doctor through medical discourses in the production of a diagnosis of depression via the application of those diagnostic criteria of the *DSM-IV* concerned with negative self-image. Mark's narrative showed that, in the context of his old workplace, his internalisation of the dominant old worker discourse meant that he remembered being happy, coherent and agentic. Contrastingly, in the context of the new worker discourse, the internalised old worker discourse lost its meaning and Mark felt naked and humiliated as he locates the problem within himself.

Living with the stresses of workplace change can be understood as involving a continuous process of re-positioning and re-subjectification, as Butler (1997a) notes. When Mark uses metaphorical language in *I suppose I felt totally naked*, his narrative begins to 'teeter'. This appears to signal that Mark no longer has an agentic discourse to

position himself in. The use of the first person highlights the shift into the individual in a process that (Rose, 2001 p. 188) describes as 'every human being has come to see themselves as being inhabited by a deep-interior psychological space'. Such 'psychological' discourses are internalised and are readily available to be mobilised, when situations change.

When Mark describes himself as being *totally naked*, I understood this as the kind of 'normalising' of depression descriptors I had already observed in the previous clinical group study when members readily understood each other's descriptors. That is, Mark assumed that I, as both researcher and informed member of contemporary society, would easily understand these psychological discourses. Rose (1996a) refers to this as invoking a disciplinary process, individuals applying 'techniques of the self' to facilitate the creation of compliance and normalisation in contemporary societies. While the observation is presented as an internalised statement, about what Mark felt, it can also be understood as a statement about how he saw himself in the eyes of the world: as a statement from inside the panopticon, as the object of surveillance.

Drawing on Foucault (1980b), surveillance is not just an apparatus imposed from a sovereign power or government, but its success comes from being interiorised by the subject. An interiorising of surveillance practices results in subjects 'exercising this surveillance over, and against' (p. 155) themselves in the form of 'self discipline' and provides a form of 'government at a distance' (Miller, 1993, p. 83). In a different historical moment, Mark might have selected other ways of mobilising discourses. The prevalence of dominant discourses that encourage people to be particular kinds of persons is problematic for people who do not adapt to them. This is the case for the workers in this study: while they have problems adjusting to the new worker discourses, they are able to internalise their loss of agency and coherence as a problem within themselves rather than the discourses. In his narrative, Mark appears to have taken on psychological discourses when he speaks about the start of *what I consider to be degradation of me as a person*. Mark's internalised self-surveillance coincides with a 'teetering' narrative, as he positions himself as moving from a previously coherent old worker self to a person with a psychological illness. By drawing on psychological discourses, he creates a surface of emergence for an illness that can now be understood within the terms of the dominant medical discourses as clinical depression.

Mark's reported inability to *perform at a certain level*, and the *beginnings of personal degradation*, can be read as opening a new discursive space and new forms of subjectivity that emerge as worker surveillance is increasingly internalised. By expressing his emotions in somatising discourses (physical attributes of his emotions), the process appears to offer Mark the only feasible way to bridge the gap between his external workplace experiences and his internal surveillance of his own thoughts and actions. The next stage, somatising, highlights the ways that embodied discourses are produced as meaning-making for Mark and work as a precursor to going to the doctor.

Stage 3: Somatising.

Both the somatising and internalising stages of Mark's story evidence the ways that he shifts from speaking about his response to workplace change to speaking about himself as experiencing a problem that is new in his work life. This section focuses on the process through which Mark's internalising narrative discursively expands to include his physical manifestations (symptoms) or embodied discourses. The crucial point here is that, as Mark moves further and further away from a coherent sense of the self he once understood, the more he will seek out other discourses to give his life some meaning and credence. Exploring the process of achieving this transition is the work of this section.

Mark implements a discursive choice in his narration, when he draws upon the somatic symptom of his *sore eyes* as connected to his lack of sleep. Somatising discourses are part of the medicalised and psychologised sense of self that are already inscribed upon workers' subjectivities. As Foucault (1973) says, 'the symptom abandons its passivity as a natural phenomenon and becomes a signifier of the disease, that is, of itself taken as a whole, since the disease is simply a collection of symptoms' (Foucault, 1973, p. 92).

This argument is furthered when we suggest that, as Mark appears less able to sustain his internalised 'gaze', his agency becomes more depleted. Understandably, he begins to reposition himself as a somatised worker by deploying what Foucault (1988a, p. 18) terms the 'truth games' related to specific techniques that people use to understand themselves. What Foucault refers to as 'technologies of power', involving 'an objectification of the subject' and 'technologies of the self', involving transformation of the self (1988a, p 18), are both relevant to Mark's somatising narratives. As Foucault notes, 'these technologies generally do not function separately, as each one is associated

with a certain type of domination' (p. 18). One of the functions of technologies of the self can be seen when Mark mobilises the readily available and internalised somatic discourses to re-subjectify himself from the narrow description of an 'internalised self' or emotional self, to a new 'somatising self'. His choice of somatising discourse allows him to engage with embodied discourses in his attempts to assign meaning to, and constitute himself as, a person with physical symptoms of stress that require medical intervention.

Mark's resubjectification as a 'somatised self' can now be incorporated within appropriate bio-medical discourses. As Mark takes up this new discursive move, he subjects himself to the 'gaze' of the dominant biomedical discourses that are empowered to re-interpret his somatic symptoms as part of their locus of medical agency. This bio-medical agency reconstructs Mark's somatic symptoms as a biologically-based illness that is therefore treatable by medical means. The considerable lack of precision that characterises such diagnoses (see discussion in Chapter 2) renders the medical process far more a discursive than a scientific process. Indeed, the articulation of biological causes for depression has been described in rhetorical terms as the 'studied use of vagueness' (Edwards, 1992, p. 162). The narrative articulation by a patient such as Mark of somatised 'symptoms' would seem in such a context to provide reassuringly solid evidence of dysfunction.

For Mark himself, the more immediate effect of his somatising discourse is in terms of Rose's (2007) understanding of the ways somatising discourses 'function to provide persons with techniques to judge themselves and to guide persons in the ways to act upon themselves in the name of improvement' (p. 26). 'Improvement' for Mark could be understood through his choice to somatise his workplace uncertainty in the re-construction of his agency as a worker who is no longer physically well. This was the option that Mark did indeed take, leading him eventually out of the workforce.

It was equally available to Mark, however, to improve himself or to take care of himself by reconstituting himself in other ways. He could have taken up neo-liberal workplace technologies, thus requiring him to be responsible for the management of himself through a myriad of choice-making activities. For example, he could have sought training in the new technologies of the workplace. This option does not appear to have been taken up. However if it had been, all the skills and experiences of his 'old worker'

self may have been integrated into his new working role, and could have proved to be of great benefit to himself and his staff.

Nonetheless, in the following excerpt we can see the particular teleology or goal of Mark's self-forming activity of attempting to govern himself by becoming a somatic subject. The shift from internalising to embodiment discourses is apparent when he explains his experience of a massive struggle to do the twelve-hour shifts and the subsequent effects on his eyes and his body:

> *I would struggle through the twelve-hour shifts. They were a massive struggle, my eyeballs they'd look like red traffic lights, and I would have to get up and go to work again, totally exhausted. I began waking up early on my days off – twelve mid night, half past twelve, one o'clock, two o'clock, three am …*

Punctuating the framing discourses of 'twelve hour shifts' and the changes in sleep patterns that left him *totally exhausted* is an instance of what is a recurring vision metaphor. Here it manifests in his talk of *my eyeballs, they'd look like red traffic lights*. Within the broader context of the narrative, one can read Mark's use of vision metaphors emerging from the prevailing conditions of his inability to see any way around his current difficulties, other than to take up somatising discourses.

One of the first vision metaphors in Mark's narrative occurs when he positions himself as *wandering around in the dark*. He was unable to do his work competently and efficiently as he had done prior to his workplace change. His inability to 'see' his way through his workplace dilemma produced another account of his construction of himself as being *totally naked*. Being preoccupied with his metaphorical nakedness could have precluded him from having the ability to anticipate future events and developments in the workplace, not only from a strategic policing of his area of command but also from the perspective of a discursive loss of agency and coherent self.

When Mark arrived at his new posting, his sense of agency had been formed through his previous competencies expressed as knowing just what to do at work. His clarity of vision was produced through his old worker discourse. That is, he could 'see' what needed to be done. As he did not engage with the 'new worker' discourses, it could be possible that his workplace 'vision' was compromised by his inability to see a way out of his work-related problems. However, by re-constituting himself as somatised, an embodied self with sore eyes, he has re-positioned himself as a worker who needs

medical treatment. When he describes his *eyeballs, they'd look like red traffic lights*, his inability to 'see' was transferred to the much wider arena of an embodied discourse that can then be read through bio-medical or bio-ophthalmic discourses to be medically managed.

Following on with the vision metaphor, it is also possible that not being able to 'see' at work produced an unprecedented level of fatigue and hypersurveillance which is without limits (Bogard, 1996). Hypersurveillance involves people being 'on guard', ever watchful in an attempt to maintain control in both real or imagined situations.

I suggest that Mark has discursively internalised hypersurveillance to the extent, that he is 'watching' or 'on guard' twenty-four hours a day. Mark spoke of the rigors of returning to shift work and how it impacted on himself and his family. Mark's early morning wakenings noted earlier (*I was totally sleep-deprived*) could be a way of testing whether he could 'see' when he was off duty, compared to being 'unable to see' at work. Bogard's theorisations of 'panoptic surveillance' suggest that Mark's vision metaphors needed to be continuously upgraded. His lack of clarity in 'seeing and thinking' is supported by the following comment:

> *when you are sleep deprived your mind doesn't work as efficiently as you hope it would*

If sleep deprivation is to be included as a 'vision metaphor', it could suggest that Mark's lack of continuous sleep occurred in part because of his difficulty in not being able to see, or get clarity at work. Alternatively, Mark's investment in 'sleep deprivation' as a part of his narrative trajectory moved beyond his internal surveillance of images of the unitary self, to include his embodied discourses that further contributed to his breakdown in agency. This 'sleep deprivation' was a turning point in Mark's storyline. It concerned the workplace change that required him to do shift work after twenty-odd years of 'office hours'; his beliefs about sleep; and his conflation of ideas fostered in the police academy about risk, responsibility, public presence, being on the alert and being on the lookout for pockets of potential trouble. Most of these work related issues require him to be well rested and fully alert. When Mark takes up his body as a discursive site, the complexity and ambiguities of somatising discourses are highlighted. These somatising discourses may however, have other meanings that are

revealed when 'the docile body comes under medical surveillance' (Foucault 1997, p. 136), as when Mark visits his doctor.

The body or embodiment as a term generally refers to the 'lived body' yet, as McHoul & Grace (1993 p. 76) write: 'Foucault does not enter into the dispute about the "nature" of embodiment in general. Whether bodies are 'really' this or that is strictly outside of his problematic'. Butler's theorisations on embodiment provide a way to understand the relevance of embodiment in the somatising discourses. As Mark engages, he tries to produce a coherent narrative of the ways the body is discursively brought into existence. Butler (1993) suggests that our 'linguistic constructions create our reality in general through [T]he speech acts we participate in every day … in the performative act of speaking, we "incorporate" that reality by enacting it with our bodies, but that "reality" nonetheless remains a social construction' (p. 272). Furthermore, Butler (1993) says: 'one is not simply a body, but, in some very key sense, one does one's body and indeed, one does one's body differently from one's contemporaries and from one's embodied predecessors and successors as well' (p. 272).

Stage 4: Re-interpreting

In this penultimate stage of the analysis, Mark consults a doctor after he 'frightened' himself by contemplating suicide while on a cruise ship holiday:

> *I went to see a Police doctor and I think at that stage he put me on a low dose of Zoloft, I went back again and he increased my Zoloft and sort of said something like well do you want to keep working, he said go home and talk it over with your wife. I came back five days later and because I could not see any change in the process I was in what I considered to be a downward spiral. It obviously meant that that my ideas of controlling my life were starting to be controlled by external forces. I found that I was drinking in excess to a state of drunkenness, I had lost interest in my home, I was over eating, and over drinking more than I should, I was in a downward spiral you're sort of right down*

This study does not have access to data that shows what actually transpired in the doctor's office. However, using Mark's internalised and somatic descriptions of his lack of sleep, anxiety about his work, exhaustion at work and his contemplation of suicide, there would appear to be a *prima facie* case for him meeting the requirements for a diagnosis of clinical depression as outlined in the *DSM IV*.

Mark's account would seem to indicate that he effectively subjected himself to the medical 'gaze' when he could no longer sustain his internal surveillance. As a technology of the self, Mark was taking care of himself by handing himself over to the care of the medical profession.

Mark's narrative does not detail his response to the diagnosis of depression. He would seem to be positioned as a 'docile' accepting subject, as he does not seem to have resisted the doctor's offer of treatment in the form of medication, sick leave and, eventually, medical discharge. Perhaps the confessional act of 'telling the doctor', and subsequently 'telling the researcher', about the events of the past few months meant that he 'felt better' and had forgotten the significance of being diagnosed as depressed. As Foucault (1990) notes, 'Since the middle ages at least, Western societies have established confession as one of the main rituals we rely on for the production of truth' (1990, p. 58).

This theoretical notion of 'setting himself free' could work in conjunction with Mark's understandings of bio-medical discourses and a re-interpretation of himself as a depressed worker. A diagnosis of depression gave him a range of medical and workplace options that could be construed as a 'freedom' from the tensions and stresses that he had been experiencing at work – that is, the workplace tensions that emerged when Mark attempted to hold onto his 'old worker self' narratives when he was required to function in an environment that clearly was organised in accordance with new worker and new workplace practices.

The doctor's consultation was taken as constituting a régime of truth that Mark had internalised a long time prior to his workplace change experiences. This is quite in accordance with Rose's view that we are already medicalised (Rose 2007). The diagnosis of depression, when stressed about work, seems also to be in discursive alignment with the embodied and readily available health and ill-health discourses that accompany the doctor's role in 'fixing' sick people.

When Mark talks about medication, return appointments and discussing options with his wife, he appears to be capable of greater agency. Interestingly, when he is in this medical environment, he appears to be able to take up new discourses, in this case the bio-medical discourses of depression, as a matter of course, and as a given. This appears

to be in stark contrast with his non-acceptance of changes in his working role and the out-of-control *downward spiral* he is experiencing in his personal life.

Stage 5: Pharmacologising

As a consequence of Mark's active participation in his own diagnosis and the following pharmaceutical intervention, Mark's doctor can engage with his own medical agency by offering Mark a diagnosis, medication, sick leave, as well as a range of familial, restitutive, compensatory or exiting-from-work-permanently options.

Mark tells how *I came back five days later and because I could not see any change in the process I was in, what I considered to be a downward spiral* he accepted the gamut of these options. It seems he has taken up the construction of himself as depressed worker and is sincerely considering the alternative options the doctor has offered him. This excerpt would seem to reflect a moment when Mark saw himself as being offered 'a flight into health'. This means that people who have mobilised a range of internal and somatic discourses are suddenly given a diagnosis that allows them to make 'sense of what they have been experiencing'. It allows them to let other people know they are 'actually sick'. These other people include family, co-workers, friends, managers, and human resources departments. Their 'truths' about themselves have been medically ratified.

By his use of the first person singular, Mark would seem to see himself as having no choice in the matter: he can no longer sustain his internal surveillance. The doctor has taken responsibility for his uncertainty and workplace stress through the process of medicalised depression discourse. Simultaneously, Mark has not been asked to make decisions that require him to do the kind of learning that his workplace had been demanding. This means he can now revert to his former agentic self, who was skilled in decision-making: he is able to make a decision about his future working life in five days. He is not so subjected to the demands of others that his own sense of himself, his subjectivity, has been dimmed. He no longer has to *wander around in the dark, not having the faintest clue what to do*, as had been his experience in the new workplace.

By positioning himself as a depressed worker, Mark now has a ready-made platform from which to speak about the loss of his idea of controlling his own life. Mark articulates his experience of depression as part of a linear, inevitable pathway where he is being *controlled by external forces*. These external forces could be interpreted as

discourses that constituted him as having limited personal agency not dissimilar to the workplace change, which he also experienced as a series of losses, in particular, the loss of his 'old worker self' competencies.

This discussion about the reinterpretation of Mark's internalisations and somatisations of his experiences of changes in his worklife, that were reformulated by the doctor as clinical depression, has been interpreted as the final stage in the process of resubjectification. In the first stage, there were a significant set of losses, such as the loss of what he constructed as a better past, of autonomy, of a team, of sociality and of agency. In the second stage, Mark gives an account of his reactions to workplace change that involve him 'swallowing' his uncertainties and stressors and beginning the process of engaging in stage two internalisation. This is a turning point in Mark's narrative, as it was at this juncture that Mark could have exercised some choices, in terms of mobilising, repositioning, subjection and resubjectification that may well have actively addressed his workplace problems. Instead, he has taken up the 'option' of embodiment. In stage three, Mark's embodiment (somatising) discourses included sore eyes and problems with sleep that became the fulcrum by which to transform his internal conversations onto bodily symptoms. It was this 'body' that, in stage four, was taken to the doctor who, through the technologies of medicine, provided Mark with a diagnosis of depression. The five-stage process demonstrates the loss of Mark's initial agentic sense of self, which became more apparent as his unhappy experiences of workplace change progressed. Once diagnosed, however, he was reformulated or resubjectified to a new position where he could exercise options at work and with his family, and was once again able to make decisions about his future. He now had, invoking Butler (1990) again, on the paradox of subjection/subjectification – subjected to and becoming a subject of, a viable life, albeit a medicated, fragile one.

6.3 Demonstrating the corpus across five interviews

The rationale for focusing in this chapter on a single interview was that it provided a way of doing a more in-depth analysis of the process of resubjectification. The chapter concludes with five further accounts from the corpus, dealt with more summarily by means of a series of quotes from the interviews, letting the interviewees speak for themselves. This data makes clear that the process of resubjectification described in detail above was by no means unique to Mark.

Worker one – Amber's story

Stage 1:

> *…the expectations of what we'll do for the next twelve months, there's always this curb or a gradient, you've got to do better the next time. You've still go the same number of people allegedly working the same number of hours but the expectations of what management want from you is higher from year to year.*
>
> *Downsizing, that's, I mean that's a lot of stress on you as a person and department you know. They expect you to function as you were with half the resources you had previously. That drives me absolutely insane.*

Stage 2:

> *I bitched and moaned to everyone, work colleague, and friends. I ended up in tears sometimes through frustration and just hopelessness because no-ones listening to you … you get rundown mentally and physically.*

Stage 3:

> *I was feeling depressed. I was ready to slit my wrists, I couldn't cope, Yeah, you know you get super stressed and frustrated and you tend to get sick and you tend to have problems sleeping, so I mean there is all these other symptoms…*

Stage 4:

> *You front up at the doctor looking for answers. I said, look I'm having trouble at work, I can't cope, I don't think I can cope with this and you get a diagnosis of depression.*

Stage 5:

This story involved a different scenario from all the other interviews, as Amber had prior experience with anti-depression medication. While she took the prescription that was offered, she had many reservations as to the proclaimed merit in the literature: *You take this stuff and believe that it will help, but my experience is that all it does is mess with my head*. The messing with her head was minimised by her doctor who reassured her that this medication was new, and she should try for a few weeks to see the results.

Worker two - Graham's story

Stage 1*:*

... at the start of restructure, and all that sort of thing started to hit home. A whole different theme, again our business didn't really have any sales focus, didn't have any really management focus. It was always pushed at the back when there was only discussions and very short brief details of that sort of business and the theme was milk it and let it go.

Yearly they'd have to cut costs, as there were new requirements for higher margins and lower costs, so people would get retrenched each year. Over the years it was just constantly depressive and demotivational from that point of view because you knew that the business wasn't being focused on, or enhanced, re-built or anything and it was just gradually being milked and decayed away... all that relationships, mateship, and knowledge base that you could easily tap was all going out the door.

Stage 2*:*

I just I just lost all motivation. I just dragged my feet around I used to bring it up with the local management all the time and he used to say have to you keep yourself generating your work. I said well give me something to do you know something new.

Stage 3:

The depression, the depression you get I suppose is just I don't know. I just think, you probably just think, what's the point.

Stage 4:

I just sat in the room with him for half an hour an hour and he just sort of asked a few questions and I was diagnosed with depression.

Stage 5:

I hope that these things work, I would like to feel a lot better.

Worker three - Heather's story

Stage 1:

Coming back into a school of that kind, I knew the difficulties of administration and I knew the demands, it was a different type of structure. I was shocked at the lack of cooperative structure that was there for me to buy into, to become part of.

I was being loaded up with jobs that were complex and which affected the senior part of the school in a very direct way, and when I said I didn't have enough background knowledge and it also required computer knowledge and files and backgrounds, none of which I had skills in.

Stage 2:

There is always that sense in a school that I had experienced right back at the beginning of my teaching career that last in gets the worst deal.

Stage 3:

I started to get classic symptoms of stress. I would start to get hot flushes, I'd get teary so that I couldn't sleep, I'd find my health would pack up very easily, like I'd get a cold very easily and I'd find it hard to shake.

Stage 4:

I went to see a psychiatrist because I wanted anti-depressants but I wanted to understand why I wanted them - in my situation I had superannuation I wouldn't have been able to retire early if I didn't have it.

Stage 5:

I began taking the pills but had to change them a few times until I found one that worked for me.

Worker four - Len's story

Stage 1:

gradually and gradually we started getting tighter, budgets got tighter, you couldn't get the latest equipment, or you couldn't get it on time and so on and little by little the whole flavour of the place changed without a doubt, absolutely a different work ethic altogether. You can't do it this way you can't do it that way,

you've gotta do it this way you've gotta do it that way. It was about getting the numbers up on the board.

The organisation is flattening its structure like most organisations. So that means more decisions, more control from Melbourne in our head office, our national one, and that's becoming quite autocratic, you know, do as you're told.

Stage 2:

I'm working myself to death here for what, … I thought why am I doing this? I went hang on a minute, hang on a minute, what's going on here. Who's gonna benefit out of this? I'm just hopeless, like it doesn't matter what I do, it makes no damn difference, it doesn't matter what I think or how I express myself or what I try, nothing works, so you think why bother trying.

Stage 3:

Quite often I'll have two three days of a week off because I'm just stuffed, I just can't be bothered - what's the point?

Stage 4:

I went to the GP … I'd read about this new drug Prozac, I tried that for three months it was good. It helped. Got me over that hurdle.

Stage 5:

I started on Prozac it was really great, I stopped smoking and took up running.

Worker five - Mary's story

Stage 1:

Over the last few years now as business has become tougher and tougher. The company moved out of that training and concentrated solely on the more high end technical training. I wasn't trained to do this work, so I was moved into sales that I had never worked in before.

I also have never had training on managing client relationships or building business, none of that. I've come from a teaching background in South African schools, so my knowledge of Australian business is not terribly in depth and certainly it is more education focussed rather than business focussed.

Stage 2:

I was just so withdrawn from absolutely everything.

Stage 3:

My stomach, just absolutely upset, my stomach was so bad I was not sleeping well at all.

Stage 4:

I got my GP to refer me to a psychiatrist. Before that she did get me to fill in on a chart marking from a level of one to five how I felt etc and I did feel at that stage that I was depressed.

Stage 5:

I was started on Zoloft.

In these accounts, the initial stages of the workers' experiences of workplace change were situationally and conceptually different. However when these five narratives arrived at stage two (internalising), and stage three (somatising), it is possible to see the ways that these two stages become the 'point of no return' in their resubjectification process. This intersection becomes the fulcrum for all of their narratives. While there are some differences in the discursive renditions of internalising and somatising, the overall picture points to the similar ways these workers problematised themselves. Once the position of 'I am the problem' is taken up, what then becomes available is the construction of the nearly predictable trajectory, resulting in the resubjectification of workers who come to understand themselves, each acting upon themselves, as a depressed worker self.

These five narratives provide further evidence of the narrative stages constructed by the interviewees around the process of being resubjectified and taking up a new form of 'viable life', albeit fragile and transitional. The pattern is repeated across all of the interviews in this study. The 'same' story is told: the experience of workplace change, the speed of the diagnosis, the normalcy of depression descriptors that were accepted by medical practitioners as discursive evidence of a medical condition, the total acceptance of the diagnosis of depression and the minimal resistance to the routine prescribing of antidepressant medication. It was, then, no coincidence that it was the same story as had

emerged from the hospital therapeutic experience that had led me to conduct the interview study in the first place.

Conclusion

The primary focus of this chapter has been the exemplification of stages two, three, four, and five of the resubjectification process through Mark's account. By using a fine-grained analysis of his account, it was possible to explore thoroughly the resubjectification process. Mark began by internalising his workplace stress, a situation which led to the somatising produced from that discursive internalising. This was followed by his becoming a medicalised self and his taking up the available position of the pharmaceutical self. These four separate stages mapped his discursive progress to illustrate how he became resubjectified. His new life, as a depressed worker self, is certainly more viable than the life he was living: it is a life in which both the problem and the workplace is made to go away, at least for the duration of the narrative itself. To what extent it will remain a life that Mark will continue to want to live indefinitely remains to be seen, of course.

Drawing on a Foucauldian perspective on discourse and his insights into technologies of power and technologies of the self, this chapter has explored how Mark's account of his subjectivity changes throughout the four stages illustrated in this chapter as he takes up four new forms of selfhood in his telling. These new forms of selfhood draw upon the pre-existing psychological self, that make it possible to construct, in succession, the internalised self, the somatic self, the medicalised self and the pharmaceutical self.

Using these understanding it is possible to see some of the discursive struggles engaged in by Mark and the five other workers whose stories are (partially) told in this chapter. The commonality of their telling begins with their stories of workplace change structured in terms of the strategy of a contrastive rhetoric. They tell of a time when they had experienced the workplace as offering a more stable set of structures in contrast with the new workplace requiring them to become new kinds of selves, selves they saw as either or both unachievable and undesirable. The commonalities of the tellings continue through all five stages of the process of resubjectification they undergo in their attempts to make meaning out of their workplace stress. By drawing on readily available psychological and biomedical discourses that can be recognised by the

medical and psychological community, these workers shifted from a non-coherent, non-viable worker self to a depressed worker self.

Chapter 7

Looking back and looking forward

This thesis was framed within the story of its origins, as told in the Prologue, from my initial professional practice as a Systemic Family Therapist working with a year-long psychotherapy group with people diagnosed as depressed. This experience led to me becoming curious about what was leading to significantly increased numbers of people being diagnosed with depression. Since my practice as a Systemic Family Therapist alerted me to the significance of stories, I became increasingly aware of the repetitive pattern of stories about how the workplace had contributed to increased levels of stress. Such stories raised questions about the lack of input of worker experience to the management of their depression in a hospital setting. Workplace change was not being recognised as relevant to the diagnosis of depression, by either health professionals or by the patients themselves, but its effects were emerging as a consistent storyline in patient narratives.

The available literature (reviewed in Chapter 1) made clear the rising incidence of depression globally and the significant costs of workplace depression to the global economy but there appeared to be no accounts from worker perspectives of what the experience of workplace change was like for them. From the perspective I was coming from, this was a significant omission that this thesis has set out to rectify as one of the two major tasks it has addressed.

I asked at the beginning of the thesis: How has depression come to be more regularly diagnosed in the late 20th and early 21st centuries? What is it about workers' experience of the workplace that is making such diagnoses more likely? Might it be the case that more workers are increasingly unhappy and that unhappiness, particularly manifested somatically, through bodily 'symptoms', is increasingly likely to be diagnosed, and medically treated, as depression? Arising from such questions, the two major tasks of the thesis can now be put retrospectively as the following two questions:

- How is depression in the workplace currently conceptualised, and with what consequences for intervention and treatment?
- How might worker depression be (re)conceptualised if attention was paid to the experience of workers diagnosed as depressed?

This conclusion consists of two parts. The first part is an overview of the work of the thesis and its accounts of how depression in the workplace is currently conceptualised, primarily as an individualised and medicalised phenomenon, and how it can be re-conceptualised by attending to the experience of workers diagnosed as depressed. This reconceptualisation draws on poststructuralist frameworks which make it possible to do three kinds of work. The first is it situates depressed workers in both time and place, making the workplace a three-dimensional reality in people's lives, which needs to be dealt with as something more than the location of an essentially medical problem. The second is that it provides an understanding of the phenomenon of becoming a depressed worker in terms of resubjectification, that is – the process of progressively becoming different kinds of subjects or selves. The last is that it produces workers who accept the diagnosis of depression and, in doing so, regain some kind of viable lives.

The second part of the conclusion was intended to be more speculative when it was planned. It had become apparent from the literature, and from the interviews, that the tipping point for workers at risk was the somatising stage: this was what got many of them to a doctor, recognising that something was wrong, and it was these somatising phenomena, translated into 'symptoms' by doctors, that led directly to diagnosis and treatment for depression. But the pattern of worker narratives from this research had made it abundantly clear that two other well-defined stages preceded the somatising stage. What if it were possible to intervene during a process of major workplace change, and to do so earlier, using techniques essentially from SFT where the individual worker was understood as being part of the workplace 'system'. Such intervention would be designed not simply to identify and support individuals at risk, though it could and would do this, but to build up the resources of individuals for understanding the system itself and the patterns of relationships they were part of. To this end, a series of questions was formulated that could potentially do some of this work. But there was no context for it. At this point a serendipitous meeting with a visiting scholar took place which introduced me to the application of Systemic Family Therapy principles in workplace contexts, work known in Europe as Systemic Counselling or Coaching (Stiefel, Harris & Zollman 2002, p. 38). This meeting completed the circle, as it were, from its starting point in my own professional practice as a Systemic Family Therapist. It seems appropriate to conclude the thesis with a brief account of this body of work,

together with some speculative comments about how insights gained from this work might be of future relevance in relation to this research.

7.1 Conceptualising and re-conceptualising workplace depression

In seeking to understand a phenomenon, particularly if it is a new phenomenon, it is commonly useful to investigate the various elements of that terminology. The phenomenon at issue here has two elements, depression and the workplace (including the worker), which involves a variety of terms: worker depression, workplace depression, work-related depression. Most of the literature assumes that the phenomenon at issue is essentially a medical one (depression); the workplace is merely the context within which this particular depression with these particular economic consequences occurs. Thus the phenomenon is primarily individualised, then medicalised.

By taking an essentially genealogical approach, however, the thesis seeks to understand how to situate this set of new terms within the parallel histories that bring them together out of two pathways, that of depression together with that of work. A new vocabulary is being constructed for the new phenomenon, emerging from what have been until recently separate domains, with separate histories: on the one hand, that of what Nikolas Rose calls the 'psy' sciences – the domain of depression; and on the other, that of the workplace and workplace change. This is the account that Chapter 2 produces, in the terms of the realist individualism familiar from both medical and workplace stories of individual sickness, in which individual workers fall ill and are medically diagnosed and treated.

The story told complicates such a straightforward, realist account. The categories of diagnosis of depression have become so broad and so numerous that fewer and fewer spaces exist for individuals to experience any kind of significant unhappiness without being diagnosed as medically depressed. Secondly, the complexities of the interrelationships between the pharmaceutical and the medical industry, especially the psychiatric professions, together with the contemporary practices of defensive medicine, make medication difficult to resist once a diagnosis of depression has been made. The individual worker diagnosed as depressed therefore needs to be understood as situated in a complex layering of interrelated social phenomena, and not simply as having an individual illness.

The medical/pharmaceutical sections of Chapter 2 explain how and why significant expansion in the diagnosis of depression is currently taking place, in terms of the expansion of the diagnostic criteria for depression, as well as the powerful claim that SSRI pharmaceuticals treat depression by correcting imbalances in brain chemistry. However, the expansion of the diagnosis and treatment of depression takes no account of the context in which the depression occurs: the workplace. The remaining sections of Chapter 2 give accounts of both the changing workplace in the late 20th-early 21st century, and of a range of current approaches grappling with the new conjunction 'workplace-depression'. The gap in the literature which this research has attempted to fill, is the contextualised stories of workers' depression.

It is on the basis of the iterative struggle with this narrative material that a new conceptual resource for addressing the phenomenon of worker depression gradually took shape, drawing on the understanding in particular of Nikolas Rose, that people's selves are not final achievements but are always in process and are never singular but always multiple. The conventional, individualised medical accounts do not make sense of stories that workers tell. Another kind of notion of self is called for that is more provisional, and contextualised. Hence the thesis turns to poststructuralist theory in Chapter 3, with its emphasis on how people constitute themselves as particular kinds of persons through the ways they speak and act. This turn is intrinsic to someone trained in SFT.

The reconceptualisation of the self involved a progressive narrative telling of the re-staging of each self as damaged and progressively reconstituted, evidenced in the telling of their stories. Chapters 5 and 6 involved two perspectives on the narratives told by the workers. The two perspectives brought out the remarkable regularities and patternings across all the stories, in the ways that both the experience of workplace change and the process of being diagnosed as a depressed worker were narrated. All interviewees essentially told the same story. Chapter 5 involved a horizontal perspective across the data set, focusing on the experience of workplace change as told in the stories of a number of the interviewees. It laid out in considerable detail the pattern of loss and grief. Each fragile psychological self was more strongly located in the past than in the present. Chapter 6 involved a vertical perspective, following one interviewee (Mark) in detail through the progressive stages of his resubjectification, through various non-viable and incoherent positionalities to a self that was (at least for the time being)

intelligible within bio-medical discourses. He was a depressed person in a new narrative.

The new self that Mark achieves at the end of his narrative has been produced as an outcome of a series of narrative stages, common to all of the interviewees, produced out of and producing a series of narrative selves. The first self, the *psychological self*, articulated a wide range of losses following workplace change. Once the psychological self was mobilised as the self articulating difficulties with workplace change, the following stage, that of the *internalised self* was mobilised. This self was evidenced by the taking up of workplace issues as personal issues prefaced by 'I' or 'me', and was combined with speaking about workplace management in the third person as 'it' or 'they'. The next self to be mobilised was the *somatised self*, characterised by references to bodily symptoms that were experienced as 'different to usual'; for example, changes in sleeping, eating, and concentration. In each story, the combination of the first three discursive 'selves', led to each worker making the decision to seek medical help. Once in the medical practitioner's office, the range of 'somatising selves' were matched with the Diagnostic Criteria for depression in the *DSM-IV* and a diagnosis was made. All the workers were subsequently recast as the fourth self – the *medicalised self* – the worker who now had a diagnosis of depression. The *pharmacological self* was the final self that was automatically offered a prescription for SSRIs, a sick leave certificate and/or a referral for psychotherapy, and a new understanding of themselves as neurochemical beings.

It may be argued that the above mentioned process, once normalised, became taken up as a 'truth'. It is the deeply grooved track that people go through in order to cope with workplace change in lieu of having any alternatives in this historical moment. Emerging out of Chapters 5 and 6 is a new way of thinking about the ways that worker depression is constructed. For a therapist, the obvious next question is: What do we do? As long as depression is medicalised, and individualised, it is hard to envisage alternative pathways. But it is clear that more systemically-oriented pathways are already being envisaged. The Victorian Health Department study (2005), discussed in Chapter 2, is one indicator.

In a less medicalised (and a less economically-fraught) climate, it might be possible to envisage collaborative work between therapeutically-trained counsellors and Human

Resources or other workplace personnel during a process of major workplace change designed to facilitate productive participation in that change. The contemporary policy environment in Australia, under the Rudd Labor Government, for example, even in the midst of the global climate of economic insecurity, is beginning to open up a more complex discursive space within which the more narrow forms of economistic human capital thesis, where labour is viewed simply as another kind of raw material, are being supplemented by social capital ideas, including a focus on social inclusion and social well-being. In such a policy context, it becomes possible in principle to pay greater attention to practices directed at the social sustainability of organisations.

7.2 Applying SFT principles to workers involved in workplace change

Connections between workplace change and worker depression need to be studied more extensively in order to examine in detail how work place change is implemented. Can additional interventions using a more explicitly SFT-based strategy than the more generic 'systems approach' discussed by the Victorian Health Report (2007) better support workers as they experience workplace change and, in so doing, make possible earlier identification of those particularly vulnerable to stress and depression?

Below are three basic interview questions from a SFT perspective that could be asked to ascertain the individual worker's experience, and used to expand their vision to include their systematic interrelationships with other individuals in the organization. These three questions may be asked to either individuals or groups of people.

> Could you tell me about your experience of workplace change?
>
> How do you think other workers view workplace change?
>
> How do you think your manager views workplace change?

After an explanatory commentary, each of these basic questions is opened out, using SFT principles, to a series of potential follow-up questions:

Could you tell me about your experience of workplace change?

This first question addresses the experience of depressed workers in workplace change rather than the medical stories which are more commonly sought by respective E.A.P services, medical practitioners, psychologists and psychiatrists. Questions from a systemic perspective are always interventions in a system and are generative in nature.

While closed questions ask for specific information, for example: *How many people work in your organization?*; this type of question requires only a short answer. In contrast open questions invite respondents to express opinions or points of view, through their framework of interpretation of events.

Hence, the main purpose of this first question is to provide an opportunity for the worker to relate their experience of workplace change and the meaning that they ascribe to the changes. Such a line of questioning allows for the ascribed meanings in the stories to reveal a range of invisible dynamics that have previously not been articulated. Generally, individuals are unaware of these invisible dynamics but when an open question such as the question above is asked respondents have access to the invisible dynamics through reflecting, describing and making comparisons between past and present experiences of workplace change.

The purpose of revealing invisible dynamics is that it provides access for the interviewer to deconstruct the worker's beliefs about events, ideas about those events, and the relationship patterns within the organisation. This in turn makes visible the system structure from a meta-position, that is, from outside and beyond the usual perspective.

A worker might recount an experience of workplace change such as the following:

> Management just told us that our division was going to be restructured and the existing four teams were to be reduced to three teams, and people would be offered redundancies, or redeployed into another part of the organization.

A pattern of circular questions such as those that follow could be used here to illustrate the lack of a simple pattern of cause and effect, and to demonstrate the complexity of a workplace issue that is not only multidimensional but involves a range of worker's expectations:

> And what did this announcement mean for you?
>
> How do you find that?
>
> What did you do?
>
> What do you think you should do?
>
> What did your co-workers do?
>
> Did anyone benefit from this restructure?
>
> What could make the problem worse?

What would a good solution look like?

Was there a success story?

The interviewer's job is to understand as much of the complexity and dynamics of the context from the worker's perspective as is possible as everything that a person does has meaning from a SFT perspective. Embedded within the worker's story are the patterns that inform their actions, behaviours and thinking. It is these that contribute to how they construct their version of the story, including workplace dyads, triads, and coalitions between groups of workers, and hence what they communicate to other workers in the system.

From an SFT perspective, such 'invisible' dynamics do not only govern individual or group workplace behaviours, they ultimately affect the workplace system as a whole. Workers' beliefs, thoughts and perceptions are viewed by the systemic therapist as 'symptoms' of much larger family/organisational issues.

The responses provided by the technique of circular questioning offer new perspectives and insights that can be used by the interviewer to ask a range of other kinds of questions: interventionist, differentiating, hypothetical and those concerned with behavioural effects. These questions are used as a way of destabilising or perturbing a worker's linear coherent account. What the worker may construe as a problem, the therapist construes as a symptom of, or within, a system. Once a symptom is understood or reframed in a more positive light (as a therapeutic intervention), workers have the opportunity to see that they are part of a process within the workplace system. Reframing the problem as a workplace symptom provides a way for workers to begin to reconceptualise themselves as being part of a much larger system, rather than simply as one individual experiencing a problem with workplace change.

The research data reveal several insertion points for early workplace intervention through asking specific questions (that are interviewer led) about a worker's experience of workplace change. One intervention could be a second round of interviews that include circular questions, ranking questions (to reveal differences), relationships (who likes whom, who is distant from fellow workers) likes and expectations to (reveal different types of relationships and what workers expect from those relationships) that could be useful for exposing differences and similarities between workers' experience of workplace change.

How do you think other workers view workplace change?

The purpose of this second question is to invite individuals or group of workers to broaden their horizons concerning the effects of workplace change, that is, imagining the perspectives of others as well as their own. It is an invitation to think about their workplace as a system of interlocking relationships. Such a perspective could lead to new insights or solutions. Further sets of questions generated by the responses provide a different platform or path for the interview. Questions aimed at exploring one person's understanding of another person's beliefs, expectations and emotions can also be asked, such as:

> What do you imagine is the worst thing that other workers think can happen to them?

This question could help in eliciting different beliefs between workers. Differences need to be tabled and discussed, in order to facilitate problem solving, and to minimise worker isolation and to reduce the perpetuation of maladaptive behaviours of withdrawal, hiding, isolation and presenteeism and increasing amounts of sick leave.

If a worker feels trapped, anxious, unheard, invisible, these blocks need to be creatively explored, both cognitively and emotionally. An understanding of the emotional differences and interpretations of the same problem is important for creative problem solving to occur, either in the interview or at a later stage when analysing the workers' narratives, as workers may be unaware of the circular nature of the maladaptive patterns and the flow-on effects across the organisation.

How do you think your manager views workplace change?

This third question is the beginning of a new set of circular questions that seek to generate additional insights and information. New information is required to explore the worker's deeper sets of beliefs, dislikes, rituals, patterns of thinking, expectations, prejudices, world views, expectations and roles for themselves and for those around them. For example, if the worker has no opinion about the manager's view of workplace change, then it becomes an important site for further exploration. It may be that the worker was not included in ongoing conversations about the implementation of workplace change, nor included in feedback loop sessions from the 'shop floor'. The experience of exclusion could be expressed/experienced as 'not being trusted enough, or valued enough, or important enough, or intelligent enough' for their contribution to the

planning of workplace change to matter. The story of exclusion may reveal a lack of relationship between worker and manager/managers. In turn, the worker who experiences a lack of inclusion in the process of change is often less likely to realise their maximum working potential and when formally appraised by their managers, their workplace behaviour may be construed as uninterested, lazy or lacking initiative. Questions about 'other's' experiences of workplace change are one way to uncover hidden meanings behind problems.

The application of an SFT line of questioning as with the above three suggested questions, provides a way of moving beyond linear, coherent narratives. This allows the multidimensional, dynamic and complex workplace issues to become visible through deconstructing the dynamics within the organisation. The complex, changing, fluid, contradictory and partial worker's experiences require careful analysis through their stories of workplace change. This may provide an opportunity for organisations to address a range of pre-existing organisational problems that may have gone largely unnoticed prior to the introduction of workplace change. Paradoxically, it may not be workplace change itself that is the problem, but rather that the use of SFT questions have made visible pre-existing workplace problems that have been exacerbated by change. Systemic questions are deliberately aimed at facilitating at the expansion of workers' thinking, thus introducing possibilities to workers changing their cognitions.

Analysis of the data derived from systems of circular questioning such as these could identify workplace problems much earlier with collaborative interventions being systematically introduced, alleviating the need for workers to go through the protracted and painful multiple process of resubjectification as depressed workers as described in this thesis.

7.3 Looking forward

A brief account with recent work in Systemic Consultancy and Systemic Constellation methods provide some insight into possible ways forward (see for example, Hellinger, 2001; Simon 2004; Königsweiser & Hillebrand 2005). Located within European traditions, both of these methods have recently been practised in European countries and the United States of America yet in Australia and New Zealand (Stiefel, Harris & Zollman 2002, p. 38) components of these methods are used in organizational coaching and consulting. Both Systemic Consultancy and Systemic Constellation practices are

based on many of the principles from family therapy and systems theory that offer 'a less unified and closed view of the world than a mechanistic view … [a]s is the case for other disciplines such as economics and psychology' (Königsweiser & Hillebrand 2005, p. 27). In large corporations, these practices are similarly utilising circular questions to assist group members to deconstruct original statements in order to gain a much deeper meaning, both cognitive and experiential, the purpose being to make the 'invisible visible'; to reveal contradictions; and to provide feedback loops to the family or workers.

Systemic Constellations are divided into macro-level interventions or systems that involve the whole of the organisation and micro-interventions systems that involve individual workers. Systemic views of an organisation focus on 'complexity and dynamics as characteristics of a living system that is non-linear, non-mechanistic, non-one dimensional connection between what happens on the inside and what happens on the outside' (Königsweiser & Hillebrand 2005, p. 35). The space between macro-level intervention and micro-level intervention from a Systemic Consultation perspective, could address a question for the future: Can additional interventions using a 'systems approach' support workers better than the current 'individualistic' approaches for managing worker depression?

Clearly, for such an intervention to be envisaged, much less implemented, several perspectives on systems approaches to organisations need to come together that draw on a range of theoretical frameworks, with both macro and micro orientations. The approach to workplace stress in the Victorian Health Department Study (2005), (discussed in Chapter 2), clearly invoked a macro approach in its endorsement of a systems approach for organisations. The account of its own concerns and procedures suggests that there is no reason, in principle, why their type of systems approach could not be connected to existing work in Europe, the US and Australia known as Systemic or Organisational Systemic Coaching. This would enable access to micro procedures for interviewing workers based more directly on SFT theory and practice.

Taking account of, and working with, workers' experience of workplace change may succeed in interrupting processes of worker resubjectification from healthy workers to depressed workers. This in turn offers the potential to reduce the numbers of depressed workers currently reported as a component of global economic workplace problems, as

outlined in Chapter 1. Rethinking the economic costs of micro interventions in workplaces prior to workers experiencing such distress as to require them to take up psychologised and medicalised selves as 'sick' is as yet unknown. It would appear, on first analysis, that the economic burden of such intervention would be cost-prohibitive, given its intensity and scale, and especially in times of major financial instability, as is currently the case, world-wide. However, these costs must be positioned in relation to the projected costs of worker depression (eg, in Australia of $3.3 billion in lost productivity Chapter 1, p. 4.) Reconceptualising the costs of early intervention as a preventive investment may have distinct fiscal advantages, both for the work place and for workers.

This study has developed an analytics of resubjectification that, in turn, can inform and enhance systemically-focused therapeutic intervention into workplace change. In doing so, it contributes new insights informing a paradigmatic shift in the approach to depression in the workplace.

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Appendix 1

Interview questions

1. Given that this research project is about stress/depression in the workplace perhaps we could begin by you telling me about your workplace and what your job is?
2. Has your job changed much over the past few years – how do you think this change has come about?
3. What changes have you experienced at work and how have these changes affected your job?.
4. When did you first begin to notice or feel stressed because of the work situation?
5. What did you do about it?
6. How did you get a diagnosis of depression?
7. How did you feel when you were diagnosed with depression?
8. Were you treated with anti-depressant medication? If so how did they affect you?
9. Given that depression used to be strongly associated with mental illness and was rarely discussed in public. Do you have any hunches as to why there is so much 'depression' around today and how has it become such a household word?
10. Was there ever a time when you did not feel as stressed at work?
11. How do you understand that people often see themselves as the problem when they are depressed rather than seeing work as the problem? When you look at workplace stress how do you think people get to understand that they're the problem?
12. If you had a magic wand and could change one thing in terms of work place change and workers depression what would that be?

Appendix 2

Profiles of research participants

Introduction

These brief introductions are intended to provide examples of the processes of workplace change and the effects of these changes. The people interviewed were sufficiently invested in the narrative of themselves to offer their time, and their personal accounts of what is or has been a very difficult and destabilising period in their working lives, where they experienced uncertainty and multiple losses. These accounts were individually and collectively provided in the hope that they might make a difference to other people who are experiencing stressors wrought by ongoing workplace change.

Description of the research subjects

The first part of this section introduces the research participants, illustrating how they discursively position themselves as particular kinds of subjects through constructing a linear account of their worker selves prior to becoming a depressed worker.

Amber	Journalist
Anne	WorkCover inspector
Ashley	Accounts payable clerk
Barden	Electrical engineer
Cleo	Call centre worker
Daniel	Flight attendant
Graham	I.T. manager
Heather	Teacher administrator
Isobel	Social worker
James	Systems analyst / auditor
Ken	Head teacher - administrator
Len	I.T. manager
Mark	Police inspector
Mary	Computer software salesperson
Megan	H.R. manager
Molly	Recruitment consultant
Paul	Psychologist
Peter	Chemical engineer
Stefan	Podiatrist / musician.
Sue	Lawyer

Amber - Journalist

Amber is a twenty-something with a background in radio journalism, which she describes as 'very stressful' due to its high-pressure environments and hourly deadlines. Several years ago Amber held a position in Dubai, UAE, where she ran a state-of-the-art radio station with poor technical support. Management was also problematic; while her experience in radio had included team work, workplace protocols, resource procedures, occupational health and safety, here there was little regard for such practices.

Prior to going to Dubai she believed that she could 'pick up work anywhere', but following her return to Australia she found only short-term contract work, before taking a maternity-relief position at the university.

Her current job at a Sydney university is very stressful in a different way, due to several months' backlog of work—the completion of which is constantly interrupted by new demands. This arrival of 'new work' is unpredictable; she was once called at 5am by a radio station in Canberra wanting to set up an interview. Amber identified other work disruptions as the introduction of new technology that, while exciting, 'diverted her from the realms of her job'. Furthermore, although she is considered to work seven hours a day, there are many unpaid hours. These unconventional hours are part of journalistic surveillance, keeping an 'eye on' current events, and lead to being unable to 'completely switch off'.

There are also constantly changing workplace expectations, where based on the media department's achievements of the previous year, 'there is always this curb or a gradient—you have got to do better the next time'. She reports that 'even though you have the same amount of staff, the expectations of management get higher and higher. They want more and more international coverage, they want you to increase getting spokespeople out, as opposed to just developing research stories. In short, you are expected to maintain more output with the same amount of staff.'

Amber describes her response to these workplace changes as 'bitching and moaning to everybody and ending up in tears through the hopelessness of the situation and the way that no one is listening… You have pride in your work but over time you become

physically and mentally run down and they don't care. You could kill yourself in the job and they would step over your corpse and say, "Now we have to fill that position".'

Although recently consulting her doctor for her workplace stress, she informed me that she had been prescribed Prozac for another matter some years earlier. When offered Prozac again, she refused, as in the past Prozac has made her depressed. 'I was ready to slit my wrists. I couldn't cope with that bloody Prozac'. She managed her depression through counselling, but complained that all she got was a 'moral ear bashing'.

It was evident in the interview that she is very passionate about her job. However, she stated that she would like to relinquish the need to strive for approval from other people. She held little hope for changes in work practices.

Anne – Work Cover Inspector

Anne has fourteen years' experience with State Government Departments; her current department seems totally disorganised and ten years behind her previous department. Her current role is to follow up on reports received about unsafe work places and workplace accidents.

She states that her previous department was dominated by the old boy's network. When her section was redeployed she secured a new position on a higher grading, and although she was now equal to a male co-worker, he 'considered himself to be her boss and that was very hard'. Soon after she took the position he and another male worker appealed against her appointment. 'They removed my company vehicle, yet the other male was allowed to keep his, there was discrimination going on against me at many levels from day one on the job.'

Complaints about her work occurred on a regular basis; her self-appointed boss would not allow her to 'do anything'. She was not allowed to attend important meetings, he would take all the conference calls, and he would hold on to relevant work-specific information so she did not have the 'right information to do her job effectively'. Anne described the trauma of being an advocate for women in a male workplace, as she was often considered to be 'trouble'. According to Ashley the public servant world is littered with the corpses of women who tried to make a difference.

Her new workplace has remnants of the 'old system', such as the boss being served his coffee by one of the female staff. After being in her new job for four years the male

domination persists. Anne's workplace experiences became overwhelming and she became ill. She was diagnosed with depression and was off work for many weeks. However, she knows she cannot change the workplace; she can only change herself.

Ashley – Accounts payable clerk

Ashley transitioned from temporary work (in a bank that no longer provides permanent work) to permanent work, and found that the advertised position and worksite do not live up to the expectations formed in the interview. Ashley believed that she was employed to 'clean up their major home-builders-accounts'. Shortly after starting work, the other workers in the credit department started to freeze her out, as *'it was their mess that she had to fix and they did not want to admit their mistakes… No-one wanted to help me, no-one wanted to know about what other messes I was finding'*. I became a total outcast. No one wanted to answer my questions. All they wanted was results. They even physically isolated me in a goldfish bowl of an office in the middle of the department so they could watch what I was doing.

About three months into this position the credit manager informed the staff that the credit department was moving to Queensland but no one would lose their job. Ashley was told individually that management was really pleased with her work, as she had recovered a huge amount of money, and not to worry about losing her job.

Despite the assurances from her manager, Ashley felt a sense of paranoia about losing her job because nobody liked her. She obsessed over unpaid bills and huge ongoing commitments to the point where she was not sleeping and crying all the time. To offset her fears of unemployment she began to work untold and unpaid hours up to fourteen hours a day so she would be seen as 'getting the job done'. Ashley recalls a time when she worked in the hospitality industry for years and 'it was just like one big happy family', while in her current role, there is 'not only the pressure of getting the work done, but the pressure of other people isolating you—it is horrible, horrible.'

Ashley became so ill she admitted herself to a hospital that specialised in mood and anxiety disorders. When she forwarded a sick leave certificate to her work, 'they were so shocked, they even sent me flowers'. Ashley spent some weeks in hospital and later returned to work. During her time off, the workplace had reorganised her work to take some of the pressure off her, but for Ashley the damage had been done. She felt totally

violated by the workplace, her co-workers and the management for not listening to her. She waited until she found another position and promptly resigned.

Barden – Electrical engineer

Barden worked as a design and sales engineer for a large multinational organisation. He found parts of his work challenging and exciting. However, he worked on his own most of the time—'It was just me and the computer pumping away for eight hours at a time—design is inherently an isolating task and leaves you mentally drained at the end of the day. There is nothing left.'

The aspects of his work with which he was least satisfied were the interpersonal relationships, especially with his boss, whom he felt had particularly unrealistic expectations of people. He was arrogant and narrow in his thinking: 'He couldn't accommodate people's work methods or other ways of working that differed from his.'

Having been in the workforce for 'only eight years', Barden felt that he had limited experience; however, he said that during those eight years he has seen many changes. He believes every organisation is 'culture dependent'. In his previous job he described the culture as 'pushing people around, with no regard for the worker; just meeting the strategic targets and then wanting more and more out of each worker.' Barden feels many workplaces believe: 'If it is too hot, get out of the kitchen.'

In his current role he is on call for international clients until up to 10pm at night, and still has to be in at 9am. He believes that there is less hierarchy now and workers have greater choices about how the work is done, and although they have more autonomy they have less control. 'The downside of technology is that what people don't realise is that it enslaves them; if your mobile rings you answer it. It is as if technology is controlling us; work never ends even when you go home—at some level work is always there.'

He states that people are pushing things to be done at a faster pace, with shorter deadlines and time expectations. Marvellous technologies like email and internet facilitate communication, expediting the process. The distribution of information is almost instantaneous; however, the worker is the bottleneck so there is greater pressure.

Barden reports starting to feel overwhelmed by the pace and volume of work and, as depression 'runs in his family', he went to his doctor and was diagnosed with depression. He has started taking antidepressants and counselling.

Cleo – Call centre worker

Cleo deals with angry claims of unsatisfied customers for work or services that never materialise or are incorrect. Cleo negotiates a money settlement or credit for incorrect listings in a directory. Since she began this type of work Cleo has noticed that people are getting more educated and 'they're expecting the earth and they don't always tell the truth'. She also deals with the sales consultant who sold the product, which frequently involves two completely different stories.

Staff turnover is high and all managers are under thirty. Cleo feels that each new manager implements new working practices; for example, with each claim the workers have to show how much money they have 'given away' and there is constant pressure to keep it under 20%. They are expected to do four large claims per day, equalling twenty claims a week and eighty claims a month. As each target is reached the bar is raised.

When each new directory is released thousands of claims are made. Many of the claims are for hundreds of thousands of dollars, while others may be for fifty thousand or five hundred. Some matters can be settled quickly within the designated two minutes, and other people want to 'whinge'.

Recently Cleo engaged other workers to speak with their manager about the unrealistic expectations of the organisation. The outcome was that one of the senior division managers called all the staff in and she 'tore strips off each of us'. From this point all the claims are individually logged and all phone calls are monitored. Cleo was allocated a supervisor to sit with her to see where her performance needed to be improved. The final straw for Cleo was when after a difficult week a customer said, 'I am going to cite you for holding up this claim.' 'He wanted to speak to my manager immediately and that is when I lost it. I did not realise that my voice was raised and everybody heard me. I eventually got off the phone, took off my head phones, switched off my monitor and walked outside and burst into tears.

Her team leader was called and asked her what was the matter. Cleo said, 'I can't handle this anymore, I'm sick of this place, I'm sick of these customers, I'm sick of the lot. I want to go home.'

The next day her team leader provided her with the name of a counsellor that she should go and see to talk things over with. The counsellor was receiving a lot of complaints from the workplace and recommended that Cleo resign as soon as possible.

Cleo was positioned as having the problem, as no other staff member had taken time off for stress. Cleo was diagnosed with depression by her local doctor but declined chemical intervention as she was a natural therapist and would treat herself.

Daniel – Flight attendant

Workplace change took place for Daniel when the international airline he works for was privatised. In the past he could go to his manager and negotiate almost anything that he wanted—a day off, taking leave, or getting on a particular flight to a particular place. 'Nothing was a problem'. This included his family; if his wife or child were ill he could change to a shorter flight, which meant swapping with another staff member, who would complete his roster. These conditions afforded him a high proportion of flexibility, autonomy and workplace freedom.

Following the privatisation of the airline, there was nothing but financial and operational cutbacks. For example, if personal circumstances changed and he wanted to drop a shift, the managerial response was: 'If you drop a shift you lose your hours, and you know we will use you when it suits us, not when it suits you.' The safety was gone. 'It's like a sporting team. They keep it changing all the time to keep you on edge. It's as if they think, "What can we do to upset the flight attendants?".'

> *Management was getting big bonuses for making cuts that staff had to deal with, such as children's kits and menus, meals catered exactly and on some flights catered ten per cent under if there was a night sector.*
>
> *Every time you go to work they are changing something, doing something. You feel like they are out to get you. I think I can't stand this. I will have to leave, it is like there is a war going on.*

Daniel said he started to construct events that never happened. Then he became physically 'crook' in Japan. He visited a doctor, who had him fill out a questionnaire

and left his office with a diagnosis of depression and was off work for some weeks. Afterwards he understood himself as having a 'chemical imbalance in his brain' that would necessitate him having ongoing medical intervention.

Graham – IT manager

Graham's disenchantment with workplace change occurred as a series of nearly constant and ongoing changes over the past ten years. Graham constructs workplace change as not change that is followed by a period of restitution but as change that relentlessly permeates every facet of the organisation in some form or other.

Over the years there was a series of new managers, new strategies, new practices, new policies, new formulations, relocations, downsizing, which Graham sees as 'constantly depressive and de-motivational as the business is no longer focused in the way it used to be when people knew what they were doing from one day to the next, when there was mateship that was built on trust and getting the job done.'

Graham's narrative includes the effect of widespread redundancies and the stressors and associated loss of motivation that workers experienced when they didn't know whether they were going to be taken over and retrenched, taken over and restructured, or not taken over and go back to the old way. This uncertainty went on for twelve to eighteen months during one most difficult time around 1999 and 2000.

As work began to be outsourced, Graham noticed a reduction in team meetings, the loss of a team-building environment, disenchantment with projects that had once involved many workers and were now being taken over by fewer people in more states in Australia and overseas. Many of the team leader positions evaporated overnight as the restructuring continued. Conflicts between the remaining staff started to occur on a regular basis, Graham received his performance appraisal and was 'virtually marked as bad as his manager could and I went right off—we started yelling at each other and that is when I walked out. I had enough.'

The HR department referred Graham to a counsellor, whom he saw once. Graham was diagnosed with depression and is considering his options of early retirement, working as a contractor, or opening a small business.

Heather – Administration head teacher

One aspect of Heather's work was to arrange for relief for the school's 76 staff when they were absent for staff development, sport, changes in routines, sickness and so on. Her other work involved supervision of the ESL program in the school, as well as being a regular teacher of English and History.

Her administrative tasks started to grow and included activities such as developing a timetable for the trial HSC in such as way that accommodated a large range of subject areas for 160 students.

The previous head had held the role for twenty years without leaving much information about how it was done. It required computer knowledge and skills in files and backgrounds, none of which she had. Heather had to interview each of the 160 students to find out their timetables, and what their particular program was to make sure that the schedule she was developing was suitable. Despite her attempts to do the right thing, there were many clashes, and the staff at the school accused her of upsetting the HSC students. These students were described as the most vulnerable in the school and the most important in the teachers' minds. At the same time she was expected to turn up and teach her own class.

She vividly remembers the day one teacher actually screamed at her for not attending the lunchtime staff meeting. Heather screamed back at her and said that she had had enough and could not manage all the work that was being heaped upon her, such as starting at 6am and ensuring that she had enough relief teachers, which had became very difficult, as more and more teachers were taking 'sick leave' or 'stress leave'.

Prior to taking up this position Heather worked in policy development and teacher training. Coming back into a school, she knew how complicated things had become and how demanding administration was. What shocked Heather was the total lack of support and a cooperative structure that was there for her 'to buy into or to become part of'. After her first year in this job she took a year off to complete her PhD and the staff thought that she was leaving and gave her a big farewell. When she returned a year later everything crashed around her when she realised they did not want her back.

Over the following months her stress levels increased and she started to get symptoms such as hot flushes, teariness, insomnia, and numerous colds that were 'hard to shake'.

She was becoming more isolated from other staff and decided that it was time to see her doctor. Being diagnosed with depression was a relief, as it made sense of her symptoms. Heather took early retirement.

Isobel – Social worker

Following her return to work after maternity leave Isobel noticed a 'significant change in the atmosphere at work'. It seemed the Non Government Organisation for which she worked was in organisational chaos, with a succession of resignations, restructuring, and staff dissent due to changes in work practices and a shift in the focus of the work..

A succession of 'acting managers' left Isobel with the feeling that she had to take on more and more responsibility as each manager was new and did not understand the historical legacy or the current workings of the organisation. She felt overwhelmed by the notion of having to be responsible for the whole of the state-wide carer's program that used to have one-and-a-half staff members to do the same amount of work.

Retrospectively Isobel saw the organisation as continually growing and expanding; staffing levels were stable or increasing, people were settled in their roles and the organisation appeared to be in a good financial position. Now, however, there were conflicts about where money should be spent, and there was more discontent.

The critical incident that led to Isobel feeling totally enraged and powerless was when her new manager said she was not coping and suggested that she had postnatal depression and that she should go and get some counselling. Isobel recounts how she discussed this unsolicited opinion with her family, who thought the problem was the changes in the work place.

A visit to her doctor disproved postnatal depression yet she was given sick leave for "work-related stress'. Isobel appreciated this change of diagnosis, as 'it validated, it confirmed what was already in my heart'. Soon after this episode she left the organisation.

James – Systems analyst and auditor

James positions himself as lacking appropriately trained staff in his dual working roles as a senior systems analyst and an IT auditor. Over the past few years management has undergone significant changes where staff have been redeployed, made redundant or

resigned and the gaps left in the working continuum have not been filled with people who can do the work. The result is that James has taken on more of the work and faces the constant dilemma of trying to sort out what parts of his dual roles to outsource, reprioritise or literally drop altogether.

James described a series of different management styles and the effect these had on his work. James said he approached his manager with new ideas about software and received no reply, even after following up three times. James decided he would no longer initiate anything as it was a waste of time and energy. Over time James eventually stopped speaking to the manager completely, outside of a fortnightly emailed report.

James recalls the onset of his depressive symptoms, when he felt like he was walking in a fog, not doing anything, with an unprecedented loss of purpose, direction, and control. He reports becoming impatient with others although he is generally quite tolerant. His work performance was down, he wasn't keeping up with or enjoying his work, and was frustrated with his boss for not giving him any feedback.

James' doctor noticed that his speech had changed and he wasn't putting sentences together. This medical observation was followed by a few questions and James was diagnosed with depression. He started on anti-depressant medication but decided that it was not helping him, so he stopped taking it. He saw a psychiatrist weekly prior to receiving workers' compensation for his depression. At the time of interview he was still seeing his psychiatrist fortnightly and working part time.

Ken – Head teacher (administration)

Ken is a teacher and administrator in a school with 1500 students and has 30 years' experience. Ken's most pressing issue is the constant and rapid implementation of the newest version of the Higher School Certificate. 'Not only do we have a syllabus imposed upon us which is totally different for us but it is a lot of brand new material for which there has been no training, no real support, and disciplinary action threatened if we don't get certain results.'

Ken had to attend a meeting with the deputy principal where it was implied that 'somehow I had failed these students, because they were failing and not performing'. He became very angry and defended his position by saying that you can only try your

hardest and some kids don't try, don't have the ability, or the courses in the HSC are not suited to them.

Ken's care, frustration, and compassion for his students is clear. Throughout the interview he refers to his 'bunch of strugglers', as well as his very capable students. He worries about the increase in the amount of socioeconomic problems that the students bring to school and the ways that these stressors are being manifested in student stress, depression and suicide.

He speaks of the school system in the seventies, when levels of stress and depression among students were nowhere near what they are now. He describes 'one kid who hadn't slept for months until Ken intervened and got him to see a counsellor', as well as students with anorexia, and so forth.

Ken's depression manifested as a 'personal crisis'; he started bursting into tears, hiding under the bedclothes, had constant thoughts of suicide and did not want to go to work. Following his diagnosis of depression he began seeing a counsellor and taking medication. He began to seriously consider his options of leaving work, saying, 'With us oldies, I would be out tomorrow if I could get my superannuation.'

Len - IT

Len is a warm, engaging man in his late fifties, juggling his options of waiting for a redundancy package or taking early retirement due to his depression. He and his wife purchased a take-away outlet as part of his retirement plan. Unfortunately the business did not do well and they found it difficult to keep their 'heads above water'. He was philosophical about his 'failed business', laughingly saying, 'It's not the end of the world, and we will move on and try the next one, try something else."

Len has worked in IT at Australia Post for most of his life and his work involved 'troubleshooting' computer problems in NSW post offices. He believes that his work is exciting but he is not happy with a change in management, which relocated headquarters to Melbourne ten years ago, while acknowledging change is 'par for the course—change is change and change happens'.

Len recounted a time in Australia Post when his job was fantastic, with no constraints or carrying-on. His fellow workers shared information and knowledge and learned together. The move to Melbourne meant budgets became tighter and tighter and he

could not get the latest equipment, or couldn't get it on time. He also felt that with the relocation of management and the network becoming local, Australia Post was getting a different 'breed of people'.

As time passed and the organisation flattened, Len experienced these changes as increased control and Melbourne became more autocratic with minimal consultation with workers. He maintains that Melbourne saw IT workers as 'being able to get a job anywhere' and subsequently IT positions were cut.

Redeployment, retraining, or redundancy were offered to existing workers, which meant that IT workers became 'floaters', who circulate in the organisation waiting to be picked up by other sections that may require a certain kind of worker. Len said that without an office and other benefits, he felt 'chopped off and put into the wilderness until someone can gainfully employ you again or you get a redundancy package. The stress is that there are no redundancy packages. When you are unattached, it is like musical chairs—one person gets left out. No chair.'

Due to the uncertainty and stress of the work situation Len felt he was going backwards. He experienced a loss of direction and clear-cut guidelines. In this new leadership vacuum, Len stopped contributing at meetings and started to perceive some of his fellow workers as caged animals snarling at everybody constantly. He later identified the problem as his manager, whom he described as one of 'these wacko, bing-bong, bing-bong people who want to grab you and tickle you one day and the next day won't say hello'. One of the effects of this manager was to a great increase in staff absenteeism and the workplace complications that protracted absenteeism created.

Len's marriage broke down and he was diagnosed with depression and began taking Prozac. He took many days off work, feeling that he was no longer contributing to it in any meaningful way.

As time passed, Len gave up smoking, started running every day and reinvented himself, also remarrying. While still waiting to see how he will exit Australia Post, he says:

> *I would like to contribute to this study, because I think it is very important, as people at my level in life, in organisations and so on, we will look after ourselves, we will make those adjustments that are required and hopefully without hurting*

others, and we will survive. But I worry about the little people that I managed in the last town. They don't have the capacity to look after themselves and they suffer the most, I don't think it is right. They did not do anything wrong to be crushed and used and abused as they are.

Mark – Police inspector

Major changes in the workplace that began some seven years prior to the interview were seen as the most influential factor in Mark's depression. He identified the changes as starting to occur after a change in government when the police force was restructured.

Mark had been in the police force for nearly thirty years, most of which was spent as a Police Prosecutor and then at the Ombudsman's Office, where he mainly dealt with internal affairs. After the organisational change, Mark was sent to a very busy inner city station where he was in charge of the shift. One of the problems was that Mark had not worked in operational policing for thirty years.

Perhaps the greatest difficulty Mark experienced was the huge adjustment he was expected to make on multiple levels, without being given any training, for example, working face to face with the general public, and adapting to changes in technology and computerised data entry for every event on the shift, as well as sophisticated technology in police cars and hand-held electronic surveillance equipment.

I didn't have the faintest idea how the police car worked as such, with sirens, lights, police radio and police tracking systems—I was being paid the highest salary yet I was un-conversant in operations. I found it extremely difficult to come to grips with.

Mark spoke of the rigors on himself and the family on returning to shift work. The protracted physical and mental exhaustion brought into focus other matters, such as his age, his weight, his eyesight and how 'driving around in the police car at night all by yourself' was difficult. He asked himself: 'Why am I doing this?'

Mark became depressed and could not see any way around his problems. He contemplated self-harm but then decided to visit his local doctor, who diagnosed him with depression, put him on an antidepressant and started the process of a medical discharge from the police force. This medical discharge was successfully completed after this interview.

Mary – Sales representative

Mary experienced the effects of restructuring and the effects of being changed from one position in which she felt competent to another position in which she felt inadequate and pressured to account for her every sale, or lost sale.

Mary taught English and computer programs in South Africa prior to coming to Australia and taking up a position in 'applications instructor or high-end technical training'. Initially she was happy with her role but as the business changed to 'just high-end technical training' she experienced a loss of confidence, as the new role superseded her workplace skills.

She then took up a different position in the same firm. The new role involved selling training packages. The problem with sales work was that Mary had a hearing problem and sometimes she would miss fragments of the prospective clients' comments, which was embarrassing and also meant that she had to concentrate very hard with each call. Having little or no training for this work, she also experienced difficulty with 'the opening minutes of the calls when she was cold calling' and 'making small talk'.

Prior to going on leave she was called into the manager's office and was given a written warning to the effect that she was not performing well enough and was being put on notice, as she consistently failed to meet her monthly target. The rationale behind this warning was that the company had changed from private to public and now the shareholders were looking at performance-based outcomes. When she returned from leave the 'whole culture of the organisation had changed. No one laughed and joked, people were working many unpaid hours overtime. It was all head down and bottoms up.'

After some deliberation Mary retaliated with a letter outlining her concerns about the organisational changes and the impact that it was having on her health, namely, an upset stomach, hormones, headaches, insomnia and depression. Mary also felt that people over forty did not fit the corporate image, meaning workers could no longer expect tenure.

Megan – Human resources manager

Megan has been in her current position as a senior manager for about nine months. Prior to that she was a National HR manager for the same organisation. She describes that role as stressful in terms of having a team of HR people who report through her but are service providers to different units in the organisation. As organisational mergers have occurred, Megan has inherited more responsibility while attempting to build her own team, whom she described as not having a lot of experience. On average, the HR staff was working ten to fifteen hours a day. Megan worked sixty to seventy-hours a week and took another seven hours' work home on the weekend just to catch up. As a salaried employee she took the position that there is an expectation that you do what's required of you to get the job done.

A further complication for Megan was that in her current position she underestimated the amount of coaching, guidance and development that her current staff require. The degree of support soon became evident when she found herself fielding a lot of enquiries that a generalist HR person should be capable of responding to. Meanwhile, senior managers and executive teams within the organisation requested workplace operations to move to a higher, more strategic level. Megan described herself being pulled in opposite directions.

After a series of 'behavioural' problems that Megan had tried to address through a number of different ways, the staff member in question sought legal advice in response to a decision Megan had made. Some of the legal issues involved disparity between the staff member's salary and that of other staff members in a similar role; the salary discrepancy was read by the staff member as 'victimisation'. Other issues involved a breach of an enterprise agreement, which moved the case to the Industrial Relations Court, taking some eight to nine months to resolve.

The outcome of the protracted legal action was Megan doubting her ability to manage. She felt that it didn't matter what she had said or did, nothing would satisfy the other staff member. During this process Megan developed asthma, a stomach ulcer, migraines and panic attacks, as she still had to work with the other person every day.

During this industrial dispute Megan's confidence eroded to the point where she became isolated and so withdrawn that she no longer attended social events. When

finally she could not enter the building at work, she went to her doctor. Her first psychiatric diagnosis was ‘anxiety reaction’, which was soon changed to ‘depression’. She then began seeing a psychologist in conjunction with taking anti-depressants. She found the diagnosis of depression to be reassuring, as it validated her experience of knowing that even as a manager she had no control over the process.

Molly – Recruitment consultant

Molly is a recruitment consultant filling temporary positions, which involves a high volume of interviewing candidates and finding personnel at short notice. Receiving a request at 11am for a person to start work at 1pm was not uncommon. Molly felt if she did not fill the request she had failed in her work. Admitting to putting excessive pressure on herself , she says she would just keep on trying and trying until the commission had been achieved. However, this position ‘filling’ was just one aspect of her work. Then there was the meeting of various other targets, such as cold calls to recruit new business, the number of candidates interviewed, the number of phone calls and so forth. Molly managed the largest account and was the longest-serving staff member.

The high rate of staff turnover was attributed to workers’ misconception of recruitment consulting as glamorous work. The shine soon wore off when they didn’t get lunch breaks and worked unpaid overtime on a regular basis. ‘I have gone from having three or four staff to just having me, who has to manage the entire desk myself, so it is a constant sort of change. I sometimes feel that I am being taken advantage of because you know they (the directors) think ‘she will manage’. There are times when I feel I am really sinking—then I am told that they will get me some help but that takes four to six weeks, then they have to be trained, which takes two months, until that person is up and running.’

Molly prides her self on giving good client service. As each consultant leaves she takes on more and more clients, because ‘I had built up a relationship with them and I don’t want to let them down’. In order to get the work done she routinely works from 7:30am until 6pm, and does not take a lunch break, because that is when she interviews candidates.

Molly explains certain aspects of her work, such as trying to get people from the public service with 'skills shortages' into workplaces. These people have specific skill sets for a specific department but their generic skills often need a lot of work prior to putting them up for temporary work. She deals with these older workers' stress when they find that they need a huge amount of retraining, which some of them are not prepared to do, but over time some of them come around and understand that the workplace has changed.

Molly first started to notice changes in herself when it came to the weekend and all she wanted to do was to stay at home. She saw her isolating behaviour as putting stress on her eight-year relationship, as a great deal of the conversation was about her working such long hours and having nothing left of herself on the weekends, and her partner 'wanting her to give it all up'. Molly thought she was depressed and considered her workplace as a major contributor; however, at the time of interview could not see an alternative option in the near future.

Paul - Psychologist

Paul noticed differences between the public and the private sector, where he worked as a counsellor. He had been in private practice for seven years and upon his return to the public sector 'everything had become computerised' and as he saw it, the focus was now on statistics and measured outcomes rather than on people in recovery.

The tension for Paul was basically philosophical, as to his way of thinking, the preferred approach to treatment was abstinence based. In 1985 the 'harm-reduction approach' was introduced into the public health services and he attempted to change his practice to cope with this 'new approach to treatment'. However, following his seven years in the private sector he believes that the current harm reduction approach has gone to extremes, which he finds difficult to come to terms with.

After the Major Drug Summit in 1985, he feels the 'harm reduction approach' was implemented but the people implementing the new programs were not necessarily counselling anyone or seeing anyone with drug health issues. He holds the view that people in recovery at some stage need to take responsibility for their recovery and that is 'the guts of it'. He has watched many workers go for the harm reduction philosophy,

as if nothing else existed; these workers ‘actually paraded along with the client’s addiction and suffering by being very co-dependent’.

A further contentious issue was the refocus from primary intervention to secondary intervention, which means that beds for sick people were reduced significantly for those who could not afford private health insurance.

In a nutshell, there were two issues: It was all about numbers—the number of people seen every day, rather than the work done with them; it was the monthly statistics that were important. The second issue was the increased surveillance, and attempts at deskilling workers. For example, a senior counsellor manager had been writing court reports for 25 years and now was required to have the simplest letter signed off by management before it could leave the building. At times the stress of having to perform in such a prescriptive manner resulted in mild to moderate depression. Rather than taking chemical intervention Paul regularly uses his support group to help him to refocus on what his priorities are and why.

Peter – Chemical engineer

Three years ago Peter began working from home for his company, which pays for his office space and all the utilities required for him to do his work. The positive side of this move is that while he has a good boss, he makes most of his own decisions and enjoys his autonomy, saying that it is like ‘running my own business from home but I don’t get all the profits’.

Another positive aspect to his situation is that he can combine ‘babysitting pre and post school’ for his two primary-aged children with his work. One of the unforeseen effects of this plan was that he needed more hours in the office to compensate for the additional hours that he spent supervising and taxiing the children to various events. He compared his 7am to 6pm hours with those of his previous workplace, where the hours were 9.15pm to 4.45pm, and noticed that his extra hours ‘started to wear him down a bit’.

Family intrusions started to impact on his concentration, his phone calls and business meetings, as the family appeared not to take him working from home as seriously as they did when he disappeared to ‘work’ for eight to ten hours a day. He applied to go back to the office but was refused on the grounds of costs, as the head office was now situated in Melbourne.

Working alone in Sydney, Peter started to feel disconnected and isolated, as the only people he saw were 'the door knockers' and people wanting him to complete 'surveys'. His resentment started to build as 'people's perception tends to be that you are working in pyjamas and drinking coffee all day. The other perception is that you won't be putting in the same amount of hours as people in an office.'

Peter went to see his doctor, saying he was feeling a bit tired, and following a set list of questions the doctor diagnosed him with depression and Peter was 'gob smacked', saying, 'I just could not believe that I had depression.' Peter solved part of his isolation problem by taking up nude modelling at the local TAFE college, which changed his life and his outlook on work.

Stefan – Musician and podiatrist

Stefan works in two practices as a podiatrist and quite enjoys it. He describes himself as permanent casual, which suits both his employers and himself. The only downside of these arrangements is that he has no sick or annual leave entitlements. This is offset by his work as a musician, which requires him to go on tour from time to time. He views himself as enjoying the best of both worlds in terms of worker autonomy and flexibility.

The stress for Stefan stems from the music industry and the uncertainty associated with work hours, locations and dates. Recently he lost one of his regular gigs, which he felt was relatively insignificant but it still constitutes part of his income and he relies upon it. He describes the unpredictability and uncertainty of the music industry as producing both anxiety and excitement. He claims to prefer this prospect to the thought of being in the same room five days a week for the next thirty years. One the other hand, as a podiatrist he will always have work, albeit work that may not be anywhere near as exciting as the music industry.

The music industry also involves the anxiety and stress of performance, as well as his working relationship with others. He is philosophical about the ups and downs of the business: 'When things are good you are on top of the world but when things get difficult you think there are too many egos and I have to get out of here.'

Stefan's experience of stress lies in the discrepancy between the predictability of podiatry and the excitement and buzz of the music world, between which he is unable to decide. Stefan believes this work/life tension scenario causes his depression.

Sue - Lawyer

Sue has worked as a senior associate in a medium-sized law firm for eight years. This work is very time oriented and structured in that the workers have to be budget focused, invoicing seven billable hours per day, and 'account for every sixty minutes of your day'. Although annual appraisals include many aspects of the work, the main focus is the relationship of the work to the individual worker's budget.

Sue's work involves conflict litigation and since being appointed as an associate she has taken on more responsibility and undergoes less supervision, while facing greater demands for guidance from the junior staff. Sue constructs herself as focused, ambitious and disciplined, with a high work ethic. She understands that in order to achieve her goals she must deliver a fantastic budgetary performance, billing more than seven hours per day.

Sue would like to start a family but to date is having difficulty conceiving. Sue believes that the work stressors have contributed to this. She describes the discursive split between her sense of worth and personal achievement related to her work. 'If something goes wrong at work I see it as a personal blow rather than a professional blow.'

Her first set of depressive symptoms included 'not being able to concentrate properly', 'things were getting on top of me', 'finding it increasingly difficult to attain seven billable hours per day despite being in the office for ten to twelve hours a day', 'becoming nervous about ringing people', 'withdrawing from people in the office', and 'not wanting to go to work.' She says, 'I couldn't talk to people, I was crying all the time.'

Six months after the onset of these symptoms, Sue was diagnosed with depression. Her first thought was, 'What will they think of me at work?' Sue was very conscious of the stigma associated with not being able to cope. When she was first off on sick leave she realised that she was so work oriented that when she went out for a walk or a coffee she was preoccupied with the thought that someone from work might see her not looking at all sick.

Another concern was antidepressants. While not averse to taking medication as such, she was worried about people's perceptions and that if she were to get pregnant it would affect the baby. Since being diagnosed with depression Sue has attempted to take a

more balanced approach to her work. Ideally she would like to think of her work as less all-encompassing, saying, ‘If something goes wrong at work it does not necessarily mean that I am a failure.’ Her attempts at reprogramming herself have been difficult; as a highly ambitious person with a strong work ethic, it is not a simple matter of unveiling these other selves.

Appendix 3

Research participants' demographics

Workers who volunteered to participate in this study did not represent the diversity of workers in Australia, as participation relied on the fact that workers had access to a computer and could use email to respond to the email address published in *The Sun-Herald*. These email responses revealed the workers' excellent literacy skills, providing a clear description of their construction of depression and why they believed their workplace had contributed to their depression.

Respondents who went on to participate in this study shared some common characteristics; for example, they were all employed at the time of the interviews and they all wanted to have an opportunity to tell their story. They all expressed the hope that this research (when published) will enable their stories to move out of their local place of work (where they were not being understood) into a larger arena, such as the media, workplace management schools, and scholarly journals.

There were twenty participants in this study, comprising ten men and ten women. This gender split was designed to ascertain the similarities and differences in the effects of workplace change based on gender. All interviewees lived in the Sydney metropolitan area. Their age range was 23 to 60 years. Four were single and living alone, and sixteen had a variety of living-together arrangements. All were working full time, with one participant being home based, as he required flexible working hours to meet his family's childcare needs.

The diversity of the participants' workplaces included the following: a law firm, an international bank, an international airline, a telemarketing company, a podiatry practice, telecommunications I.T. division, a specialised paint company, an employment and recruitment agency, and an insurance company.

Nine participants were on antidepressant medication at the time of the interview, and the remaining eleven had tried pharmaceutical intervention at some time, but had chosen not to continue. As nineteen of the research participants had been officially diagnosed

as clinically depressed, some for only a matter of months and others for the past two years, these accounts were retrospective.

In the following section I will draw on the data to illustrate the ways in which the interviewees experienced workplace change and the effects of these changes. This includes the loss of the following: a coherent self, a golden past, certainty, autonomy and privacy due to increased surveillance in workplaces.

As discussed in Chapter 3, discourse analysis using a Foucauldian approach addresses not only the obvious statements, but also seeks to understand why specific things are said in certain places and at specific times, which can result in attending to one experience rather than another (Davies 1989).

Emerging from these interviews are: the blurring of the boundaries between work and home; the expectations of the workplace, which now requires workers to bring more of themselves to work; increased expectations of self-governance; increased contradictions between worker autonomy and increased surveillance; and problems with lack of sustainability of the new worker self.

Reflections on the research interviews

This section reflects on the processes through which the research interviews were conducted, outlining: the novice researcher; the formation of the research questions; the recruitment process; therapeutic differences between practice and the research participants; strategies employed to avoid stressing the research participants; and the insights gleaned from the interviewing experience.

When I started my doctoral research I had a reasonable understanding of myself as a psychotherapist, a teacher and a supervisor of other therapists. I experienced myself as belonging to professional groups of people who were skilled in working with individuals and families with physical, mental and drug health issues. In the early stages of my candidature I was required to conduct research interviews, which I thought I could ‘do well’.

However, I realised that the skills required for my professional work bore little resemblance to those required as a ‘researcher’. I started to ‘behave’ as if I had two very distinct selves; the competent therapist self and the much less competent researcher/writer self. I reached this degree of awareness when my supervisor suggested

that I reflect upon the shape of the interviews that I conducted some three years ago. I realised that when I was analysing the interviews I had not considered my role of engaging at multiple levels and in reciprocal action.

For this research project I had compiled a list of twelve open-ended questions. The reason for this choice of interview format was to provide interviewees with the opportunity to expand on certain questions in their own time and way, with minimal prompting from me. The overall purpose of the interviews was to gain an understanding of the research participants' experience of workplace change, its effects on them, and the contributing factors to becoming depressed workers.

As an opening question I asked the research participants to 'tell me about their work and the changes in the workplace'. My rationale for this choice was to prevent the research participants collapsing into depression discourses at the outset, necessitating terminating the interview prematurely, as well as my concerns about my dual positioning as researcher and therapist in this setting.

Participants volunteered for this research project and expressed the hope that their workplace change and depressed worker stories would be heard in a wider arena and in the long term that this study would benefit other workers in similar situations. These self-referred interviewees felt that worker depression was widespread and that there had been little opportunity for 'their side of the story' to go beyond their workplace, social contacts and family. They believed that most of the information on worker depression came from depression statistics gathered and collated by private and public institutions.

Interestingly, most private clients I have seen do not express concerns about others in similar circumstances, nor do they consider that their personal concerns and their experiences could make a difference in the wider social context. Perhaps this 'difference' could be assigned to the interviewees' understanding that a 'research project' will occupy a public space, whereas individuals seeking 'therapy' seek private spaces.

A further distinguishing feature of interviews with clients is that as a counsellor I am constantly aware of the power relations that result from a power/knowledge base, and hence I am mindful not to take advantage of a client (by using terms, labels, or

descriptions that are therapeutically specific) who may not have these same skills but inevitably will have a different set of skills that I lack.

Decisions about the broad structure of the interview were guided by my research requirement to determine how these people were experiencing their workplace, while my therapist positioning required me to begin with a relatively less risky question to avoid depression discourses in the early parts of the interview. My therapeutic responsibility towards the research participants was to provide a safe place to talk about their experiences, while containing and managing the interview's internal psychodynamics as each person exercised power in a different way.

In addition, I now understand my lack of awareness regarding the concepts of protecting the interviewees' coherent sense of agency. It is important to note my dual therapeutic/researcher selves and the careful staging of these interviews will have an effect on the kinds of knowledge produced.

Furthermore, although during interviews I was aware I was not engaging with the subject from a therapeutic perspective in terms of an ongoing relationship, I still engaged with the subject from student researcher position. I regarded myself as an invited guest into their place of work, where they had the advantage of the familiarity of their workplace, and set up the time and day of the interview. By setting up the research interviews in this way I had attempted to promote a quid pro quo situation.

One tension previously not considered by me was that 'depression' is usually portrayed as the problem of the individual, with a deep interior personal self that responds to the 'gaze' of the professional, either individually or in a group setting. Alternatively, workplaces are more or less abstract, external, purportedly transparent and open to analysis by organisational methodology. So here is (an invisible) binary, whereby depression is discursively situated in a private immeasurable space and workplaces are discursively constructed as a public measurable space that responds to and is dependant upon the technological 'gaze'. The workplace 'gaze' is significant in terms of its ability to audit, measure, and forecast its potential growth.

A second revelation was that research participants presented a heavy personal workplace agenda, which they could clearly articulate in terms of the problems with their work and places of work. It appeared that their working lives were easier to talk

about, even to the point that they had discussed their issues with others or rehearsed their responses.

It is evident that the first question addressing work and workplace change proved to be a highly energised starting point. This is perhaps because workplaces are public places with measurable discourses and associated language, whereas depression (the discussion of which was positioned mid interview) is a place of private selfhood with immeasurable spaces, particularly from a therapeutic point of view.

It was in the middle of the interview, where notions of depression were explored, that interviewees divulged what they considered to be the most instrumental of event/s and their subsequent experiences leading them to become depressed workers.

However, at the conclusion of the interviews most interviewees appeared to have 'run out of steam' and were at a loss to consider their problem from any other aspect.

It is evident in the transcriptions that without exception the interviewees' opening replies took up by far the greatest amount of time and text than any other reply to any other question. It is as if they were excited about having the opportunity to share their story, which waned as time wore on.

Further, regarding the first part of the interview, many participants indicated that they had lost 'parts of themselves as they previously were' and these fragmentary losses were frequently positioned within a framework of past and present workplaces. When drawing upon past experiences of a workplace they often referred either explicitly or implicitly to a time that focused more on the 'group' or 'family' aspects of a worker's life, where mateship, character, loyalty, collegiality, and sociality were most highly valued and work was constructed as a time of 'great fun'.

In comparison, the accounts of contemporary workplaces seemed to lack the more positive aspects of a 'Golden Past,' which has now been replaced with a workplace that focuses on the profit-making capacity of the institution. This relocation of alleged values was not seen as particularly helpful to the workers, as it was considered to be the most significant contributor to their loss of coherent self, loss of certainty, loss of autonomy and loss of privacy. The loss of privacy was not articulated, yet it became more evident with each subsequent reading of the interviews.

Technologically automated surveillance was spoken about to the point where it was normalised by many of the workers. Meanwhile, what seemed to be occurring simultaneously was that the workers were internalising the external 'gaze' of technology. This was evidenced by working longer hours of unpaid labour, filling in the staffing gaps, being available for work 24/7, and so forth.

In the middle section of the interviews, workers introduced somatic discourses as an entrée to receiving a diagnosis. This was interesting for me in terms of the shift from comparisons between past to present workplaces (What they did to us). Then they followed on with working longer unpaid hours, and so forth (What they did to themselves), and then came the embodied discourses where they drew upon pre-existing psychologised and medicalised selves as a sense-making tool (German precision crafted tool). As the workers began to somatise their experience of workplace change, they started to teeter under the unsustainable weight of the workplace gaze that they had now internalised.

As the interviews proceeded, it seemed that their (dominant discourses) accounts 'ran out of steam'. This could have occurred for many reasons, such as talking almost non-stop for one hour with minimal interruption, having to collect their thoughts on the spot with a relative stranger, knowing that they were being taped, and trying to provide a lineal account of the way things happened for them, being asked questions that were out of their frame of reference or normal vocabulary, the emotional exhaustion that can occur when a person is involved in the telling of many thoughts that may never have been verbalised prior. Additionally, they may not have anticipated the depth or breath that a research interview would involve, despite receiving information, which was followed up by a phone call in which the specifics of the interview were discussed at length.

For example, they were informed that the interview would take about an hour to an hour and a half, and that they could discontinue the interview at any point without any recriminations from me.

It was interesting to observe that, when I posed the last question, which was, "*If you had a magic wand and could change anything, what would that be?*", this appeared to be too difficult for many participants. It was met with 'laughter' and sometimes it was as if the

idea of ‘changing anything’ from their temporal positioning of themselves as depressed workers was beyond the realms of possibility.

My final reflection is about myself as a humanist therapist self at the time these interviews occurred. Since then, many changes have occurred, including changes regarding my previous notions of self, which have been influenced by Post structuralism, to the extent that my ‘pre research worker selves’ and professional practices have come under scrutiny. At the time of writing these reflections, I now question some of my therapeutic practices, as well as my original ideas about what depression is. Having come this far, it is only now that I can begin to understand the tensions and the contradictions that I have experienced as a doctoral researcher/experienced therapist writer self, who once believed that narrative had a beginning , a middle and an end only, as did the workers in this research.

Today many private and public organisations are undergoing significant changes due to economic rationalisations and technological innovations. Shifts in workplace directions produce many varying effects and workers have different perceptions regarding the complexity of factors responsible for not only the initial phases of restructuring but also the ongoing changes.

Appendix 4

Kessler Scale

KESSLER SCALE PLEASE TICK THE ANSWER THAT IS CORRECT FOR YOU:	ALL OF THE TIME	MOST OF THE TIME	SOME OF THE TIME	A LITTLE OF THE TIME	NONE OF THE TIME
In the past 4 weeks, about how often did you feel tired out for no good reason?	○	○	○	○	○
In the past 4 weeks, about how often did you feel nervous?	○	○	○	○	○
In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down?	○	○	○	○	○
In the past 4 weeks, about how often did you feel hopeless?	○	○	○	○	○
In the past 4 weeks, about how often did you feel restless or fidgety?	○	○	○	○	○
In the past 4 weeks, about how often did you feel so restless you could not sit still?	○	○	○	○	○
In the past 4 weeks, about how often did you feel depressed?	○	○	○	○	○
In the past 4 weeks, about how often did you feel that everything was an effort?	○	○	○	○	○
In the past 4 weeks, about how often did you feel so sad that nothing could cheer you up?	○	○	○	○	○
In the past 4 weeks, about how often did you feel worthless?	○	○	○	○	○
	SCORE 5	SCORE 4	SCORE 3	SCORE 2	SCORE 1

K10 score Likelihood of having a mental disorder.

10 - 19 Likely to be well,

20 - 24 Likely to have a mild disorder,

25 - 29 Likely to have a moderate mental disorder,

30 - 50 Likely to have a severe mental disorder.

(Kessler, & Mroczek, 1994)