



Rethinking women's experiences of depression and recovery as emplacement: Spatiality, care and gender relations in rural Australia

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ABSTRACT

In Australia and other OECD countries women who are recovering from depression in rural areas find that access to professional care is fraught with difficulties. Despite the emphasis on the social determinants shaping mental ill health and recovery, Australian rural support has been largely defined by biomedical and psy-expertise focused on correcting biochemistry and cognition through different models of formal medical care. Addressing the limitations of individualised biomedical models, this article offers a relational understanding of how recovery from depression is produced through rural and gendered emplacement (Pink, 2011). Theorising recovery through the notion of emplacement shifts attention from an individualised notion of embodied distress (symptoms, emotions, cognition) towards a social understanding of the dynamics of human and non-human relations that are afforded by different care practices (from medical treatment to social support). To date there has been little critical analysis of how women's distress and recovery experiences are gendered in relation to both formal and informal care in rural places. Extending the insights of geographers, social anthropologists and feminist scholars we analyse the recovery stories of women living in rural and regional Australia. We focus specifically on how rural women experienced uncertainty and stigma that emerged through formal care spaces and impeded their recovery -the gendered dynamics of em(dis)placement were identified. In contrast, we identify how particular informal care spaces enabled women's recovery through multiple relations with human and non-human others. Our research aims to contribute a critical understanding of how everyday professional care and self-care practices are intertwined with the complex gendered negotiations of emplacement and displacement that shape rural mental (ill) health.

1. Introduction

Support for the whole person, including their mental health and wellbeing, needs to be integral to all systems and supports. This includes services in rural and remote locations ... [Australian National Mental Health Commission \(2012:10\)](#)

In Australia and other OECD countries there has been increasing recognition of the social determinants shaping mental health in rural communities and the need for appropriately targeted recovery oriented services. [Rich et al. \(2013, p. 12\)](#) in a systematic review of the prevalence and correlates of depression in Australian women suggest that, "Much contention exists over the role of rurality in mental health outcomes, with different studies presenting conflicting prevalence rates and correlations". In terms of gender, the rates of rural women's depression are thought not to differ from their urban counterparts ([Australian Institute of Health and Welfare, 2008](#)) while other research

identifies poverty and isolation as connected to higher rates for rural women ([Craze and Reedy, 2014; Rich et al., 2013](#)). Rural women's experiences often pale into insignificance with the attention given to youth and men's suicide ([Caldwell et al., 2004](#)). Men's distress has been identified in relation to cultural associations with heroic rural masculinity ([Bryant and Garnham, 2015](#)) and with economic discourses of rural decline ([Malatzky and Bourke, 2016](#)). As we have argued elsewhere ([Fullagar & O'Brien, 2013, 2014, 2016](#)), feminist perspectives are needed to make visible the gender relations and social contexts that contribute to Australian women's higher rates of mental health issues and higher rates of hospital admissions for intentional self-harm (see also, [Harrison and Henley, 2014, p. vii](#)). This article addresses the lack of critical debate over how rural women's mental health experiences are gendered with respect to the experience of depression and importantly recovery. We also acknowledge the challenges of talking about 'rural women' as some kind of known or essentialist category. Hence, the importance of feminist insights that recognise the intersection of

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rurality and gender with other markers of identity related to culture, Indigeneity, sexuality, class, disability and age within the context of post-colonial rural Australia where whiteness is privileged (Malatzky and Bourke, 2016; Ramzan et al., 2009).

We extend the insights of geographers, social anthropologists and feminists who have begun to articulate a relational approach to recovery that identifies the embodied and spatial dimension of everyday life (Bondi, 2005; Crooks and Chouinard, 2006; Cummins et al., 2007; Duff, 2012; Parr, 2005, 2008; Parr and Philo, 2003; Pini et al., 2010; Tucker, 2010; Waitt and Gibson, 2013). Drawing upon qualitative research conducted with 16 Australian women in rural areas we ask, how are women's experiences of recovery from depression shaped by their "emplacement" (Pink, 2011) within the formal and informal spaces of rural life? In this sense, recovery is understood in terms of the embodied practices and spatiotemporal relations through which rural places are lived by women as they interpret, manage and care for their 'depressed' subjectivities. The dynamics of rurality are shaped by a range of emotional geographies, personal and cultural histories that both enable and impede wellbeing (Duff, 2012; Davidson et al., 2007). While recovery has been explored in relation to the creation of therapeutic landscapes within and beyond formal mental health services, little of this scholarship has explored the dynamics of gender and rurality (Davidson and Milligan, 2004; Herron and Skinner, 2012; Parr and Philo, 2003; Wood and Smith, 2004). Parr and Philo (2003, p. 485), in their examination of the social geographies of caring in the Scottish highlands, point out that rural geographies are "interleaved physical, cultural and social geographies that affect caring practices seen in both formal and informal caring relationships". Given the well established literature identifying a range of issues associated with formal mental health care in rural places (Alston et al., 2006; Harvey, 2009; Judd and Humphreys, 2001; Kilkkinen et al., 2007; Parr, 2008; Parr and Philo, 2003), we foreground women's experiences of uncertainty within formal care spaces that impeded recovery in order to then examine the informal self-care practices that enabled recovery in ways that are often overlooked by professionals. Our aim is to contribute to a more relational understanding of how everyday help-seeking and recovery practices are 'emplaced' as women move through the experience of depression (Pink, 2011). In this way we offer a critique of individualised constructions of recovery that ignore gender-place relations and instead we identify the enabling and impeding dimensions of emplacement that are affective, social and material (Duff, 2012; Pink, 2011). We acknowledge how formal and informal spaces of care are also experienced "through time" via the embodiment of treatment practices and recovery pathways. Hence, we understand care spaces to be produced through socio-temporal relations that "give life" to everyday settings (Tucker, 2017).

2. Rethinking recovery through gendered emplacement

Feminist geography has importantly contributed to making the gendered performance of everyday life in rural contexts visible with respect to (hetero)normalised discourses, identities (mothers, daughters, wives) and care work (Herron and Skinner, 2012; Pini et al., 2014). The intersection of rurality and gender can mean that the effects of gendered norms about 'self-reliance', and caring for others first, remain invisible when rural women minimise their own care needs and fail to access help when needed (Alston, 2006; Herron and Skinner, 2012). Harvey (2009) argues that rural women may not access health services, believing that they should be able to cope on their own. Women in rural and remote areas also take on the burden of care in relation to the family health and may be involved in the family business (Price and Evans, 2009). Being seen to be unable to cope not only inhibits women from seeking help, but also engenders fear that they will be ostracised and stigmatised within their local community for failing to achieve the normative ideal of the "good woman" (Stoppard, 2000). What is often challenging for women with different diagnoses and experiences of 'depression' is the negotiation of an illness identity that

invokes potential stigma and shame (Outram, 2003). Do they tell others in seeking help or do they attempt to perform 'normality' to avoid stigma, or being positioned as 'ill', when they may not wish to have their emotional distress medicalised as depression (Gammell and Stoppard, 1999)? Given the challenges of mental health service provision in rural communities related to social inequity, stigma and isolation there is a compelling argument for critically examining how gender relations shape place-based experiences of recovery.

Conceptualising recovery as a social and gendered process that is constituted in the relations between the self and place involves questioning normative biopolitical ideals of recovery. Within a biopolitical context common models of recovery are oriented around supporting individuals to 'find personal meaning' (Slade, 2012). Such models presume and valorise an autonomous and genderless individual who is able to undertake self-care and symptom management in order to return to a normative state of productivity in everyday life (Fullagar & O'Brien, 2013). Critiques of individualised models of recovery have been articulated through a range of calls for more 'relational' approaches that acknowledge the complex discursive and affective interrelationships between the becoming self and the materiality of the social world (O'Brien and Fullagar, 2008; Duff, 2012; Vandekinderen et al., 2012; Fullagar & O'Brien, 2014; Fullagar, 2018). The 'relational turn' seeks to re-envision recovery by examining the importance of social relationships, civic participation and 'social prescriptions' as a means of providing everyday support and care that extends beyond the medicalised space of the General Practitioner (GP) clinic (Bungay and Clift, 2010; Stickley and Hui, 2012). Slade (2012, p. 703) argues for the need to also understand informal relations of care, suggesting that "recovery begins when you find someone or something to relate to. The job of the system is to support the relationship and connection with self (permanence) and others (commonality)". Extending this approach into rural contexts requires "new ways of thinking about recovery which begin with an acknowledgement that recovery is not solely about changing aspects of individual people but is about changing the places in which we all live and recover" (Yates et al., 2012, pp.111-2). Drawing upon the insights of feminist geographers we argue that the gender dynamics of rural life importantly figure in this move towards relational thinking.

To understand the spatiality of rural life we need different ways of thinking about the experience of place that is not simply as a static or stable space, but rather "the coming together of the previously inter-related, a constellation of processes" (Massey, 2005, p.141). As Duff demonstrates in his Australian mental health research, the experience of "dwelling" in place recognises the "intimate web of associations, processes and transactions that enmesh people and places, 'person' and 'context'" (2012, p. 1389). Contributing to this relational ontology we draw upon Pink's (2011) notion of *emplacement* to foreground recovery as embodied through different relations of dwelling with and moving through depression. Emplacement moves our thinking beyond humanist models of subjectivity and agency that privilege coherence and inner meaning to consider how the depressed-recovering self is shaped by more-than-human relations that are material and discursive, spatial and temporal (Pyyhtinen, 2016). From this perspective experiences of embodied distress and wellbeing are not bounded, distinctly human phenomena, rather the recovering self is shaped through multiple relations; human and non-human nature (animals, forests, parks), digital technologies (medication, Apps) and material practices within the networks of social life (leisure, paid and unpaid work, unemployment, education and volunteering as dwelling and moving practices) (Cromby, 2011; Laws, 2009; Pink, 2011; Fullagar et al., 2017). This more-than-human approach also connects with literature on therapeutic landscapes that pays attention to the affective qualities afforded by certain place relations as "healing" and "comforting" (Laws, 2009, p. 1828). Reading the notion of emplacement alongside work on therapeutic landscapes enables an examination of how various "sites 'off the map' provide 'spaces to re-envision care'" (Laws, 2009, p. 1831). It is the "unmappable qualities" (Laws, 2009, p. 1833) that such spaces

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