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.

Keywords: Emplacement, women's depression, recovery, therapeutic landscapes, gender, care and self-care

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 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 interrelated, 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 provide and the (dis)connections felt between the person and rural environments, formal services and informal practices of care that offer insights into how places may enable or impede recovery.

In theorising emplacement Pink (2011, p. 344) provides a useful approach to thinking through recovery as a relational performance of self that is embodied and agency as dispersed. In contrast to humanist notions of personhood as rational and masterful (or self-efficacious), Pink (2011, p. 344) explores how embodied knowing and skill are transformed as we move and "become part of a specific configuration, or ecology, of persons and things". In this way recovery can be viewed in terms of the relations of care that are embodied and enacted within in a broader network or assemblage of human and non-human actors, objects and space-time configurations. Conceptualising recovery through the notion of emplacement foregrounds the (often little recognised) processes through which the self is moved, affected and transformed by intensities that are produced through rural place-events (Pink, 2011). Examples of such events or enactments might include care offered by medical and therapeutic services, as well as informal relationships with friends, online networks or leisure related pursuits. Emplaced recovery shifts our attention from normalised assumptions about what is helpful towards the range of embodied self-care practices that women identify (from walking, singing, consuming medication, attending therapeutic services) "as an intensity or nexus of things, in process and in relation to each other" (Pink, 2011, p. 349). In this sense the depressed-recovering self is not positioned as a static entity whose interiority (subjective feeling, cognition and brain function) is the centre of meaning, nor is her emotional self simply acted upon by structural forces (social determinants, patriarchy). The agentic capacities

of the self are thus understood to be produced through social relations of different 'scales' within a biopolitical assemblage of health service systems, structural inequalities, natural and urban environments, Big Pharma global capitalism, everyday cultural practices and sensory experiences of place (Duff, 2012; Tucker, 2010). These microindividual and macro-social forces are negotiated simultaneously and enfolded in particular time-space moments (or 'events') that constitute women's subjectivities in gendered ways that can produce relations of emplacement as well as displacement - the disconnecting or rupturing moments that impede recovery. In this way we move away from linear models of recovery that presume some kind of rational movement towards cure or normal functioning, to recognise how recovery experiences are produced through a multiplicity of relations – emplacement and displacement. Such temporal and spatial relations invoke the past and present through embodied biographies of girl and womanhood, the provision of services and availability of human and non-human networks of connection. In terms of gendered subjectivity, experiences of care are also negotiated through a range of normalising discourses about how to enact recovery as "dutiful" women; the medically compliant consumer, empowered consumer with medical expertise, the disempowered consumer with a lack of mental health services (Fullagar & O'Brien, 2014, 2016). Hence, we argue that place-based experiences of recovery need to be situated within a broader biopolitics of depression where gendered medical diagnoses (that are higher for women) and treatment pathways normalise certain care 'choices'. Choices about formal care in rural areas also exist in relation to the availability of social spaces of care and forms of resistance (survivor and service user movements) (Rose and Abi-Rached, 2013).

3. The research study

Elsewhere (Fullagar & O'Brien, 2012, 2013) we have detailed our research approach involving a large qualitative study in Eastern Australia with 80 women who described themselves as recovering from depression (79 were cis gender and 1 transgender identified). These participants were recruited from notices in community newspapers, fliers in health centres, e-mail lists and radio interview, and

rural women and women in urban areas volunteered their involvement in the project. Both authors conducted semi-structured interviews within women's homes or their preferred location. The interviews, which ranged from one to 2 h, explored women's experiences of depression and what helped or hindered their recovery. In this article we discuss the interviews from the rural cohort who comprised a sample of sixteen women. Participants were from different rural areas in two eastern states of Australia; a large regional town with high unemployment, alternative culture and a range of public services including higher education, health, social support and housing (3 h drive to the city); a small regional town in the far west with a hub of health and social services (6 h drive to the city) supporting mixed farming practices.

Participants' ages ranged from 30 through to 75 with the majority of women in the 30–40 age range. Amongst the sample there were a broad range of occupations from those who were engaged in paid work as cleaners, retail assistants, farmers, bookkeepers, counsellors, paramedics, police officers and health or welfare service managers, to several women who were retired or unemployed. All women had sought the help of a medical professional, either a GP or Psychiatrist, and all had been prescribed anti-depressants at some point. Fourteen of the sixteen women still consumed anti-depressants at the time of interview; the remaining two women indicated that they no longer took anti-depressants.

The majority of the women indicated that they began experiencing depression before the age of 25, and the majority (10) had experienced more than three episodes (a range of diagnoses were described from postnatal, mild through to major depression). Three women indicated that they had only had one episode of depression. Participants identified how they had also sought help from range of allied health professionals, from counsellors (13) to natural health practitioners (6) as well as some support services (6). We note that the period of data collection (2006-7) occurred prior to the uptake of various digital technologies that are now being introduced to address gaps in rural service provision. All identified as heterosexual, eight women were either married or in a de-facto

relationship and the majority had two children, several were widowed and six identified as single. Apart from two Russian and Irish migrants, the majority of the sample were white Australians although very few had lived their entire lives in the same rural place, which highlights issues of mobility and belonging in new communities. Interview transcripts were analysed by both authors in relation to how formal and informal care spaces and practices figured within participant stories. While we critically question assumptions informing humanist research traditions we acknowledge that our methodology in one that embraces a theoretical "reading of data that is both within and against interpretivism" (Jackson and Mazzei, 2013, p.vii). Hence, we engage with women's diverse experiences and interpretive repertoires to identify themes concerning emplacement that cohere around the material and discursive dimensions of gendered experience. This is not to assume an essentialised truth or homogeneity amongst women exists or that we are seeking to 'represent' the truth of women's experiences. We examine the negative emotional and spatiotemporal relations of 'displacement' in formal care spaces that intensified women's sense of disconnection from self and others and hence worked to hinder recovery. We also consider the informal relations of 'emplaced' recovery, and the embodied and social relations, with both human and non-human nature, that were healing and comforting and supported women becoming well.

4. Analysis and discussion

4.1. *Formal care: displaced recovery*

In this section we analyse how women articulated their negative experiences of accessing formal care spaces as a relation of displacement (emotional, spatial and temporal) within their rural communities. Extending the notion of emplacement (Pink, 2011) that emphasises how multiple relations shape embodied experience in rural places, we conceptualise 'displacement' in terms of the disruptions and uncertainties that affected women's recovery. All of our participants identified how 'formalised' care was highly uncertain in terms of the nature of rural service provision and cultural norms that stigmatise mental ill health. We situate our analysis of spaces of formal care

within the context of services provided through public hospitals, outpatient clinics or private therapy. In these spaces, medication was prescribed in surgeries and dispensed in pharmacies to all 16 participants, and counselling and self-help practices were engaged to different degrees through face to face encounters in community centres, self-help groups, at home or in other public spaces (prior to the more widespread use of digital communication technologies now). In terms of engaging with 'formal care' systems, a woman seeking support for emotional distress required a diagnosis (of depression for example) from her GP in order for a referral to subsidised psychological treatment sessions or for a prescription of medication. If her symptoms were severe she may have been hospitalised locally if a bed was available or away from home in a larger regional centre. There may have been limited or no local community based mental health support. Formalised mental health care access in more remote areas may be available intermittently (fly in fly out workforce) or it may be provided by a GP where concerns about stigma and confidentiality are frequently identified in the literature (Craig et al., 2005; Harvey, 2009; Judd and Humphreys, 2001).

Women spoke of constantly negotiating the intensity of emplacement/ displacement (Pink, 2011) through professional relations of care that were often tenuous and hence produced liminal experiences that exacerbated their feelings of "being lost", "alone", "fearful of selfharm", "exhausted" and "uncertain". Women also had to continually negotiate gendered relationships (feminised ethic of care) with self and others, with rural expectations suggesting they should be "stoical, used to adversity and self-reliant" (Alston et al., 2006, p. 3). Women described attributions of self-blame (some extending back into childhood), lack of social support because they were new to the town or having to manage home life alone if they had a husband who worked away. While a few women indicated that they were lucky to have a local GP who understood them, they also overwhelmingly described other formal care services in regional and rural towns as ill-equipped to provide the care that they sought when their emotional distress overcame them to the extent that they were unable to cope on their own. omen spoke of the limited availability of doctors, particularly female, as heightening their sense of displacement. Corrie, for example, had wanted to

see a female doctor, feeling that a relation with someone of the same gender would be more supportive, but was also unable to get an appointment for 6 weeks she said she “just got to see ‘a’ doctor”. The experience was so dislocating that it led to Corrie not seeking help for another 12–18 months when she finally made an appointment. She felt that if she had been able to see the doctor from the beginning of her “illness”, she would have been able to develop a different relation of care, and her treatment and recovery would have been much better. However at the time of her greatest distress Corrie felt that she “had no one to call out to … I had no one to reach out to, there was no one who could help me in this town and I felt really lost”. In this regard, rather than offering her solace, the lack of (gender sensitive) formal care in her rural location intensified her sense of isolation. Corrie's story, and others that were similar, suggest that displacement exacerbates distress and impacts on help-seeking in ways that invoked negative and isolating spatio-temporal relations to place. Corrie was caught within particular material-discursive relations of professional care (waiting/ expecting, receiving/not receiving care) that required the performance of recovery oriented around “dwelling” within depression (Duff, 2012).

Lengthy waiting times to see health professionals along with a lack of continuity of care were frequently identified by women as intensifying their distress so that they were often stuck dwelling in anguish. Sandy was unable to see a doctor and had tried community health, however she said:

> you have to wait 6 weeks; you have to be assessed, you have to wait for the team to make a decision as to whether you're worthy to come … on board … I mean when you're depressed you want help now … there and then … you don't want to wait 6 weeks.

Having reached a crisis point, seeking help became urgent as sufferers did not want to become trapped by a sense of dwelling within intensifying distress that further isolated them from others. This sense of agentic stasis – of being stuck - within relations of displacement was also aggravated by an absence of continuity of care. Sandy spoke of a visiting allied health professional with whom she thought she had developed a good relationship. However, to her dismay, the professional simply

stopped his consultancy. Sandy said she felt really “angry … because he stopped coming and he didn't let us know … I felt like I was left in the lurch”. Sandy's experience illustrates how conventional mental health services informed by biomedical expertise can generate formal relations of care that are tenuous and exacerbate distancing, displacement and othering.

For many women simply finding any type of formal services located within their local town often proved a substantial hurdle in their help seeking and recovery efforts. Jessica searched for help and spaces of formal care, but felt there was no-one in the rural town to whom she could turn. She rang the local hospital and the mental health unit who said that they only dealt with dementia, bipolar and schizophrenia, not depression. She also rang church groups, searched for pamphlets on support group in doctor's surgeries but her search proved futile. She left messages for an appointment with a visiting psychologist that spoke of her fears “I was scared of self-harm and I was just really living in fear and she never, ever returned my calls and … these were the messages I was leaving her”. In desperation Jessica had to move from a space where she may have felt a sense of comfort and familiarity, to drive 6 h to a larger rural centre where she was able access a psychologist who reassured her that what she was feeling was normal. Limited therapeutic services propelled women outside their rural communities through spatio-temporal relations (uncertainties, long journeys requiring cars/expense) that exacerbated a further sense of vulnerability.

The issue of confidentiality was significant for many women and they discussed problems with knowing the health professional socially or the person's reputation was not well respected in the town. They described the acutely felt distancing effects of stigma associated with mental illness and contact with formal services (Parr and Philo, 2003). The social proximity within rural towns generated fear that their mental illness marked them as different or not belonging – recovery was threatened by stigmatising displacement. While Sparky's comment that in a small town “people talk a lot” appears quite benign, at its heart are social relations that intensify fear and shame. Gina captured the judgements and othering processes that she felt were produced through a diagnosis of

a mental illness. She said " It's this stigma thing, even though you know it's silly … you know, it's not a way to judge people, I still went home and cried my heart out when she wrote that script for the Zoloft". Sandy, who was a teacher, also spoke of the fear that she felt should it become known that she was seeking help for her distress. She said "because if that gets out in a small community you … it becomes … just it becomes known, and it's a labelling and it's the stigma factor … so I felt very conscious … it's very hard in a small town". In engaging with spaces of formal care, women took the risk that they would be inferiorised as lesser women because they were unable to cope within the gendered context of rural life (less than good mothers, self-sacrificing wives, and stalwart community volunteers). The experience of formal care (and its lack) was interconnected with the complex 'informal' gendered networks of work, leisure, family and friendship that shape the conditions of depression and possibilities of recovery. Rural women's sense of displacement can be understood through the spatio-temporal relations that generate uncertainty surrounding formal care (access via diagnosis, distance, waiting, lack of continuity and gender sensitivity). In addition, the intensified effects of stigma played out through normalising gendered judgements about performing as a 'good rural woman' for the wellbeing of others.

4.2. *Informal spaces: everyday relations of care*

In this section we examine how women identified everyday care relations that involved particular everyday practices and social connections where gender responsibilities could be questioned, and different relations with self, nature or other people was possible. Through these informal spaces alternative subjectivities that were not dominated by depression, stigma or shame were enacted. The majority of the women in the study identified the limitations of professional care in rural communities and sought out alternative informal relationships of care to support and sustain their recovery. While these everyday practices are conventionally described as forms of 'self-care' we argue for a rethinking of care relations beyond the 'autonomous' individual through a relational understanding of emplacement. We examine the informal spaces and spatio-temporal relations that

enabled women to sustain their recovery, as well as the limitations identified in being able to access desired experiences that supported becoming well.

4.3. *'Getting out' of the interior space of depression: dwelling, moving and immersing oneself*

Backyard gardens as informal spaces of care featured in several women's accounts of enjoyable experiences of 'dwelling' in rural places. For those women who enjoyed gardening, it often assumed the status of a burden of care when they were depressed, emotionally depleted and unmotivated to go outside. Yet, in moving through depression women spoke of renewing their relationship with the garden and how this space continued to support their recovery. Gina, who had struggled to care for herself and her family when she was depressed, discovered that gardening allowed her to expand the "boundaries in terms of what I can cope to care about, I'm in the middle of a major health clean really … I work inside out … I mean that's one of the things I'm looking to build into my life now". Gardening had also provided Renata with a space where she went to get away from the demands of her job (in the care profession) and care work in the family. In terms of the "unmappable" quality of the space (Laws, 2009), Renata couldn't quite articulate what it was about gardening that provided relief and gave her the opportunity to move herself into another space, she said "it just got me out". Getting 'out' into the garden (and out of being stuck dwelling in depressed) had become an important aspect of Renata's recovery practices that was becoming part a different experience of self. Renata's example also highlights the affective relations with nature that produced an energy (pleasure, satisfaction, joy) that sustained her recovery. Fenella also spoke of the sense of energy as care for self that was created through the embodied practice of gardening. She drew on the metaphor of nurturing herself through nurturing her garden, indicating that gardening kept her grounded. She also felt her garden "keeps me living in this particular place". The garden as an emotional landscape was extended to nature in rural places more broadly in a number of comments made by participants. In this sense women had appropriated the garden as an "off the map" site (Laws, 2009, p. 1831) within the materiality of emplacement (Pink, 2011) that invoked different

sensory experiences (hands in the dirt, scents, hearing birds, feeling the sun or shade). These women's experiences were within the private space of their own gardens; other women spoke of a longing for a garden but were unable to access one within their present living arrangements (affordable housing with no backyard). This points to the importance of public gardening opportunities that can facilitate an etho-politics of care when people live without private spaces (see Fullagar, 2004).

For other women, creating a relation to home with stability (often contrasted with previous relationship breakdown, domestic violence, migration, (non) work stress) provided them with a renewed space of connection. Jessica for example, who had struggled with relocation to her small rural town, began to recognise both human and non-human relations of care that created a sense of being "home" with her emotional self. She said:

> I've got a wonderful husband … and two boys … they're affectionate in their own way, but they do little things that … they love you … and so I made my home life more secure…I looked around at what I had and I realised that I could concentrate on what I had at home my animals ….

This intensified sense of place also extended more broadly to the rural community, and here the proximal distance provided comfort rather than unease. Having moved away Janet commented on her desire to return to her town because she felt at home through her relationships to people and nature, "I've decided that [place name] seems to be where I love; I've got friends, it's a nice place just interact together … I had to come back". Gina felt that living in a rural town that was somewhat removed from a larger urban centre gave her a space of peace and less pressured life with her gendered responsibilities (juggling work, study, commuting, child care). She described it as a "secret paradise here that the rest of the world hasn't discovered". The attachment to rural places was an affective relation that was generated through everyday pleasures (in contrast to the weight of depression) and sustained women in their recovery (Duff, 2012).

In contrast to the sense of dwelling in place, other women spoke of moving away from the familiarity of their town to escape the familiar reminders of depression (and stigmatised associations), poverty or loss that characterised their lives. Justine (a policewoman, who had left her social support behind and had a son diagnosed with Aspergers) preferred to travel to another town, even if it was work related. She said that "I need that every now and then, to get … at least every 2 months, to get away for the weekend". Yvegenia, a Russian immigrant who was unemployed and finding it difficult adjusting to a small English speaking town, articulated how confined she often felt and how her depression worsened. She said that when she was able to get away from "all my problems … it's really helpful when I leave this area, I feel it's also not really heavy - a little bit lighter". If she was unable to get away, she also wanted to "get out" of the house, just to sit in public spaces such as the park and watch children play. Some women escaped within the space of home, as Janet did through computer games which she said took her to "another world". Leisure practices within and beyond the home enabled women to find the space to experiment with different identities, beyond the gendered norms of mothering that put the needs of others first (see also, O'Brien and Fullagar, 2008). This was often a struggle for many and Meredith spoke of her frustrations with challenging 'good mother' ideals and the heteronormative expectations of her husband and children which meant her desired immersion in artistic pursuits was often difficult. However, through her longing to paint and create spaces where depression loosened its grip, she spoke in terms of recognising a productive sense of multiplicity "there are different parts to everyone; you're not just a housewife, you're not just an artist". While she will take some time out to relax, her dream is to go to a nearby regional town to do an artistic workshop. Meredith's desires for a different space were connected to her yearnings to attend art groups, where she could "indulge in ….my skill, my passion". However, Meredith also found that her needs often became lost within the demands of heteronormative caring responsibilities that pulled her back to home and family. These responsibilities were often intensified during school holidays when the lack of leisure programmes left her children requiring more attention. Meredith therefore spoke of a wish to get

away from these responsibilities, whether it was when she was able to get away by herself, and she feels “free”, or when the children themselves are away, and Meredith again feels “free”. In both instances Meredith drew upon leisure resources as an event - assembled by her desire, skills, finances, availability of art classes etc. – that produced a spatiotemporal intensity within her on-going struggle with depression and the nuclear family dynamics.

Swimming also figured as an immersive intensity that enabled women to embody different relations to self. Corrie spoke about how when she was feeling down, she went swimming in the local pool to “feel the water”. She said “it's another substance … and I was really at one with the water, I love the water…and I could do lap after lap”. The space of the public swimming pool, which often evokes gendered fears about bodily imperfections, was also place of solitude. Women could lose themselves in the water and the rhythms of swimming produced affective relations of pleasure, strength, joy, etc., away from family and or work responsibilities. For Sparky, a single mother with two children, this was particularly important as she felt that “you can just swim laps and you're in that zone, the water's blue and you just swim … no-one can talk to me”. The ‘zone’ of swimming was a blue space through which she enacted a relation of care when many other activities fell away during her grief after her partner died. Swimming was quite a contrast to Sparky's responsibilities as a single mother. She often found that the caring demands made on by her children would overwhelm her at times and she had little energy to go swimming. When there was little childcare support, rather than an enabling space of pleasure, exercise became a form of duty to care for her wellbeing. Hence she often found that she isolated and excluded herself simply because she did not have the affective resources to go out and enjoy herself. This example indicates the complex relations between leisure spaces or facilities (having an accessible pool) and the gendered relations of women's lives where there is often a lack of available support (childcare for leisure participation is largely a private responsibility).

4.4. Social spaces and different temporalities: replenishing energy

Apart from the desire to escape the affective weight of depression, move away and immerse oneself in different spaces, women also created a different spatio-temporality that enabled social connection and replenished the energy they needed to care for their emotional selves. Renata felt that caring demands were often placed on her that left her feeling quite depleted:

> if you're going to give out your emotional tank, or your energy tank, and you give out, and you give out, and you give out and you give out. If you don't fill up the tank, then you're going to end up being on empty. And I think that reading, or the movies … helps fill up that tank to get it back up.

Creating time to engage in leisure, often a difficult task as women with families are time pressured (Gunthorpe and Lyons, 2004), was also key to enabling women to engage with spaces that enabled recovery. Renata said that she noticed when she had not made time for exercise or done something for herself, she "will start to go off the rails". At this point she tried to recognise the "signs" and she will "kick in the self-care … the massage". Tayla, whose husband worked away, struggled to find time for herself, and had begun to recognise the importance of taking an hour or so to ride her horse or a walk with a girlfriend. Jessica had decided that her time for herself was so important that she resisted the desire to measure it when she was enjoying being with her animals on her property:

> I'd go outside and I wouldn't take my watch, I wasn't interested in the time. I thought 'No, it makes no difference whether it's 3 o'clock, 4 o'clock or 5 o'clock, things will get done when they get done', you know. So I'm going to sit out here and play with the dog.

Corrie also made a connection between replenishing her energy and calming her mind. She did this through yoga, meditation and relaxation, which she said enabled her to let go of accumulated embodied stress, "you know, through meditation, relaxation and through yoga … then your mind is ….then your body is just so much calmer, you know. You don't hold it so tight; you hold it in check all the time. That's something that's really important". While Yoga had been an extremely significant calming space for Corrie, she had difficulty accessing reliable classes. Other women also expressed a

desire for access to yoga classes as a relaxing space where they could find quiet time and to counter the emotional energy expended through the work of caring for others. Several women indicated that their yoga teacher also provided a caring relationship that was not organised around an 'illness' identity. In this sense yoga figures as a significant place-event in that it generates affective intensities that enable women to enact the work of recovery and care for others (and at times also resisting those gendered care obligations).

Relations with others were identified by some women as a space of social connection and support. Women spoke of a support network that sustained them when they were struggling to engage in the practices that helped them sustain their recovery. Tayla had mobilised her family and social network to create a space through which to enact recovery:

> I said 'I can beat this with husband, kids friends', when I felt isolated, because I used to feel a bit isolated, you know with [husband's name] travelling away … but during the week, everyone's busy, they'd make the effort to drop in during the week, like after work, you know, 'oh what are you doing?' just thought I'd drop past and I knew what they were up to, but it was really good … they'd drop in bring tea, or a video, or say 'hey come over to our place'.

In this way relationships provided material connections (conversations, sharing burdens, providing practical care) that generated intensities and energised affects for Tayla. The materiality of social relationships (what they 'do' for recovery) emphasises the dynamics that constitute the self (and others) in new ways (Duff, 2012). The friends and family who had taken care of the children had sustained Tayla's recovery over the longer term. An important aspect of social relations that supported recovery for several women, was finding the resources to invite people back into their homes. As Duff (2012, p. 1392) argues the "materiality of home was regarded as therapeutic insofar is it afforded particular activities, practices and/or feeling states". For Sparky, being able to have people "drop in at 5 o'clock" and saying "'Oh do you want to stay for dinner?' and just make

something" opened up her home as an enabling place that allowed a change in her affective relations with others. For those without secure housing tenure or supportive relationships this spatial relation was unavailable to enable recovery.

Other women had decided to close off certain social relations, as they impacted significantly on their sense of emplacement and hampered recovery efforts. Janeka felt that receiving support from family and friends was very important however, she also said that she had some limitations on her friendships. She said that she had recognised "what I actually want from people, in my friendships and relationships". Women were often deciding how they would manage their own emotional space and would not take on all of the emotion work within the family. Sandy said that she had "realised I was doing all the emotion work and I stopped … I'm not going to do this for you anymore. I'm not going to be angry. If you want to be angry that's fine". Ruth an older woman, who was single and whose close family were deceased, had created another family of "sister cousins" who provided her with support. She had also chosen to close down an aspect of her emotional life that had caused her pain in the past, deciding that she would never be in an intimate relationship again. She said "imagine having to live with someone again"? These examples point to the significance of recognising the relational dynamics of recovery and the gendered context through which women negotiate expectations, identities and space-time for their wellbeing. Both human and non-human relationships were bound up with the enactment of home as an enabling space that bolstered their affective resources such as solitude, connection, safety and confidence (Duff, 2012, p. 1393). Home was often an ambivalent place with contradictory meanings about gender identity and expectation bound up in heteronormative family life. In addition, the sense of emplacement that home could generate was difficult for women to enact against histories of childhood abuse, family violence and high levels of mobility for work and financial reasons.

5. Concluding remarks

For many rural women suffering from depression the organisation of formal spaces of expert care often impeded their recovery. Women struggled to access care that would help ease their sense of being lost or disconnected from self and others. A paucity of gender sensitive care spaces (such as female GPs) along with lengthy waiting times and travelling to access services served to increase a sense of displacement and stigmatisation that intensified distress. Individualised and normative notions of recovery that circulate through biopolitical spaces often ignore social or other relations (both human and non-human nature) that are implicated in self-care practices supporting the process of becoming well. Recovery can be understood through women's articulation of their embodied experiences and gendered relations of care for self and others as they are enacted through place. Recovery is not a self-evident process that 'occurs in' places, rather recovery is enacted through place based relations that invoke human and non-human relations (professionals, friends, swimming pools, homes, art and yoga groups, dogs and horses, netball teams and computer games). In this way we reposition depression from being thought of as largely an individual problem of the mind (chemical imbalance or unhelpful thoughts) to a sociocultural understanding that recognises how embodied emotions and relationships are implicated in the conditions that shape distress, wellbeing and recovery. As Pink argues, emplacement enables us to think about the potential transformative experience of how we embody place, "the body itself is simultaneously physically transformed as part of this process" (2011, p. 347). The women's stories in this study articulated depression and recovery as embodied phenomena – the loss of energy, desire for life, weight of pressures – enacted through the dynamics of rural places that assemble different configurations of formal and informal care.

Everyday relations that enabled self-care featured very strongly in women's informal recovery practices. The materiality of women's of recovery was experienced through diverse care spaces, such as moving into the garden, immersing oneself in water and resisting gendered expectations to care for others first. Our research has demonstrated how recovery cannot simply be understood in terms of individual 'self-care activities', instead a more nuanced understanding is needed of the material

affordances that everyday spaces provide for mental health. Recovery involved micro-political transformations of self through multiple spatio-temporal relations of embodied connection with the human and non-human world. These affects and spatial relationships contributed to transforming women's desires and emotional lives in ways that formal medical care was often unable to do. As Ahmed (2004, pp. 164–165) argues “pleasure involves not only the capacity to enter into, or inhabit with ease, social space, but also functions as a form of entitlement and belonging. Spaces are claimed through enjoyment, an enjoyment that is returned by being witnessed by others”. The importance of a relational understanding of recovery, through the notion of emplacement, is largely unrecognised within biomedical contexts that individualise distress and treatment. Rather as Slade (2012) suggests finding something or someone to relate to and supporting relationships and connections with the self and others is an important aspect of everyday care that may sustain recovery in rural contexts.

In this article we have argued that women's accounts contribute to an understanding of how rural recovery is emplaced/displaced through a multiplicity of relations of formal and informal care. The notion of emplacement enables a different conceptualisation of agentic subjectivity to be advanced that does not assume a given, coherent ‘self’, rather greater emphasis is placed on the dynamic relationships that have the capacity to support women who are moving through depression and recovery. Recovery and self-care practices can then be understood in terms of multiple relations (with home, objects, nature, public services and others) that can counter the immobilising stasis of dwelling within depression. Emplaced recovery involves thinking through the range of embodied practices women identify as intensely linked, in process and in relation to one another (Pink, 2011). This research has implications for the development of recovery oriented rural services within and beyond conventional mental health provision (housing, parks, sport, arts, employment, childcare, education). For example, in contrast to traditional ‘expert’ driven therapeutic encounters (Laws, 2009) how can women be engaged to coproduce gender sensitive ways of knowing-doing recovery that has relevance to the local context of rural areas.

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