Fullagar, S, O'Brien, W & Pavlidis, A (2019). *Feminism and a vital politics of depression and recovery*, London: Palgrave.

1. Towards a vital feminist politics **(included)**
2. Rhizomatic movements and gendered knots of 'bad feelings'
3. Reconfiguring recovery beyond linearity **(short extract included)**
4. Motherhood, hauntings and the affective arrangement of care
5. Moving-transforming bodyminds
6. Creative enactments in more-than-human worlds
7. Reimagining feminist futures: Vital politics, disruptive pedagogies

Chapter 1. Introduction: Towards a vital feminist politics

Prologue

The wide ranging experiences that women have shared through this research continue to haunt our understandings of depression and recovery. As we write this book we have been written, moved through the liveliness of stories, metaphors, silences that entangle speakers, listeners, writers and readers. We invite readers to engage with this book as a co-constituted process of reading-writing through visceral connections – guts, brains, hearts, skin, words, images, surfaces - to explore how gender matters. This is a provocation that seeks to question normative ways of thinking and responding to affective states, emotional life and biomedical claims to truth. Drawing inspiration from creative analytic writing practices we aim to offer ways of reading-moving otherwise, tracing out a vital feminist politics of personal and public feeling.

Certain stories are impossible to forget, they disturb us and the process of researching-knowing in unanticipated ways. Conducting her 39th interview, Wendy arrives in a cul-de-sac of a public housing estate in an outer suburban area:

> *I knock on Michelle's door, no response. I wonder what to do, so I call. In a slurred voice Michelle answers, apologising about how the medication that she has been 'forced' to consume sedates her, making it difficult to rise much before 10 am. My discomfort grows, the blush of shame spreads as my initial thoughts of drunkenness flash by, I am caught by an ambivalence about whether to continue or not with the interview. As Michelle struggles to emerge from the miasma of the medication, I*

compose myself. She wants to tell me about her experiences. I set up the recording device and begin the interview.

It is harrowing, I am drawn into Michelle's complex story in deeply unsettling ways. Sadness, anger agitating my guts, the injustice of her circumstances. I try to follow as Michelle oscillates between worlds, descending and surfacing. We stop the interview several times and at Michelle's insistence we continue. Occasionally she looks up when we talk about the everyday things that matter in recovery when she has lost so much. She writes when she can, crochets to pass the time and sticks to her routine of walking to the shops each day to see familiar people. But the medication troubles her deeply, slows her thinking and actions, but her doctors 'won't listen'. Little of this struggle is apparent in the transcript, it reads in a seemingly coherent manner with a few stops here and there. Michelle's account of depression-recovery was haunted by her disconnection from any meaningful infrastructure of care.

Talking about this interview, re-reading transcripts, we all feel the weight of another woman's suffering that remains invisible, unrecognised in ways that matter deeply. Her story pushes at the boundaries of what is assumed to be known about depression and recovery, what is 'helpful' and how women's lives become (in)visible in particular contexts. Haunting, it reverberates through our research, compelling us to re-turn to questions of how gender materialises in matters of mental ill health. And how feminist can work contribute to the creation of different futures.

Introduction

Despite the gains made in OECD countries across the spheres of education and employment, many national surveys (for example in Australia and the United Kingdom), repeatedly identify that women report higher rates of distress than men (depression, anxiety, self-harm, body dissatisfaction, suicide attempts and eating disorders) (Brown, 2017; McManus, Bebbington, Jenkins, & Brugha, 2016). While acknowledged as a variable in population health statistics, gender is largely ignored as an analytic category warranting deeper investigation. The rise of 'common mental health disorders' has been conventionally framed in terms of affective or cognitive problems of mind or brain that can be remedied through recovery oriented behavioural, psychopharmacological or lifestyle interventions. Advances in neuroscience, psychiatry, clinical psychology, psychopharmacology and digital health technologies all play a significant role in materialising (gendered) knowledge about the complex, invisible and immaterial dimensions of mental or emotional distress in the

contemporary moment (Blackman, 2012; Rose & Abi-Rached, 2013; Ussher, 2011). What is curiously missing from public discourse about tackling depression or anxiety are the critical insights of feminist researchers who have long documented the historically situated relationships between women's emotional lives, the politics of mental health diagnosis and various forms of discrimination, inequity and violence (Appignanesi, 2011; Chandler, 2016; McDermott & Roen, 2016; Stone & Kokanovic, 2016; Stoppard, 2000; Ussher, 1991; Wiener, 2005). At stake in these debates is the key issue of how women's experiences of mental health come to be culturally imagined and felt as personal troubles, rather than as "public feelings" that are deeply entwined with historical, sociocultural, economic and political conditions (Cvetkovich, 2012). When gender is acknowledged in mental health policies, professional practices and biopsychosocial research it most often figures as a static category of identity (the sameness of all women, the sex/gender difference from men) that ignores the institutional practices, cultural contexts and affective relations that shape the diversity of women's[1] lives.

Stepping back from the diagnostic authority that so commonly shapes public and personal knowledge of mental (ill) health, this book considers how embodied experiences of distress (thoughts, feelings, actions) are imbricated in 'depression' as an organising device (Duff, 2014; McLeod, 2017). The classification of different types of depression within diagnostic cultures [Diagnostic and Statistical Manual of Mental Disorder, DSM-V] (American Psychiatric Association, 2013) promises a sense of certainty (experience as illness) that stands against often uncertain, frightening and overwhelming affects (symptoms, life histories and events) that individuals are supposed to recover from. With respect to this entanglement with the phenomenon that is depression, we ask how recovery as a transformative process is rendered *intelligible* through the material, affective and discursive relations of everyday life (Fullagar, 2017b). We explore how gender comes to matter through the thoughts, feelings and actions that are entangled with disruptive affects and flows (from distress through to joy) that *disassemble and reassemble* women's subjectivities at particular moments in their lives.

In contrast to the popular and academic focus on recovery as primarily about the initial loss and subsequent 'finding' of personal agency (psychologised experience increasingly shared with others via social media, biographical narrative and mental health

[1] We use the term women to refer to a gender category that is a matter of self-identification and subject positioning (cis and transgender). We also note the limitations of either/or categories of gender for non-binary identifications.

literacy campaigns), we approach recovery as "an intra-active, entangled process through which agency is produced and performed in its embodied multiplicity" (Fullagar, 2019). We think through the flows of affect that intensify entanglements and profoundly shape how depression-recovery are experienced in terms of subjectivity (affect-emotion) and cultural formation (McLeod, 2017). While acknowledging the different theoretical trajectories that shape how emotion are affect have been thought, we take up Ahmed's (2004, p. 6) crucial point that, "the distinction between sensation and emotion can only be analytic".

This book responds to the challenges of thinking through the complex relations that shape how distress is experienced and responded to as simultaneously an individual and broader cultural concern. We offer a critique of the normalising imperatives that govern the moral terrain of recovery (compliance with psychopharmacology, better coping and self-help) and the fantasy of restoring autonomous, rational agency that is paradoxically implicated in the conditions of depression (and the Othering of those with more severe and enduring mental health experiences who identify with service user, survivor, mad or related identities, such as, the hearing voices movement) (Howell & Voronka, 2013). Within the biomedical assemblage that characterises mental health policy, promotion and service provision, the complexity of recovery as a transformative experience remains little understood despite the acknowledged challenges of 'relapse' and 'recurrence' of depression in conventional treatment (Dalal, 2015). Likewise, the well-known 'placebo effect' in antidepressant treatments raises a host of questions about the complex mind-body and nature-culture entanglements of medication with affective investments in the desire to be well, commercial imperatives and the material significance of objects (Moncrieff, 2010; Trivelli, 2014; Wilson, 2015). In addition, recovery that is not attributed to professional intervention is often referred to as simply 'natural or spontaneous' change that acts to discount the relations of care that women enact to recover their everyday lives (Clark, 2011).

Our response to these theoretical and practical issues is to ask questions that reorient our thinking about what recovery 'does' as a material-discursive process that is intimately bound up with relations of affect (sadness, despair, loss, anger, shame, joy, belonging, pleasure etc). How does recovery materialise through expert practices that seek to treat pathologies and transform ill subjects into healthy, self-managing individuals? How do recovery approaches produce particular kinds of gendered subjectivities and with what effects on women's lives? Despite the intention to enhance health, does the moral imperative to recover in mental health policies work to increase the burden of responsibility on individuals by ignoring gender (and other) inequities? And what can we also learn from women's

accounts of everyday recovery practices that can contribute to reorienting recovery thinking beyond normative models and assumptions about selfhood? Extending the body of qualitative research on personal experiences of recovery, we shift our focus towards developing a relational ontology to grasp the movement of self through recovery and depression as an enactment of multiple self-world relations. With this aim in mind, our concern is less with identifying alternative prescriptions for mental health and more with making visible gendered patterns as a means of troubling, diffracting and creating different knowledges to think with.

Reconfiguring the bio-psycho-social model

The so called *biopsychosocial model* of mental (ill) health has yet to fully engage with the sociocultural forces that shape the conditions for depression to flourish, how emotional life is understood and alternative ways of supporting recovery, resilience and prevention. While medical models are increasingly called to broaden their focus on biopsychosocial processes in recovery, the bio-psycho-social are not often thought together in terms of ontological assumptions about self and world (Blackman, 2012). Much of the focus of traditional research has intensified an ontological politics of mind-body that is implicated in producing decontextualized disorders, as neuroscience privileges the imbalanced but plastic brain and psychology the disordered but resilient mind (Pickersgill, 2018; Pitts-Taylor, 2014; Pykett, 2015; Rose & Abi-Rached, 2013). The default location of agency *within* the psy-individual (in particular within the brain and mind) actually creates dilemmas in mental health care systems that require the active performance of self-care that aligns with expert treatment within contexts of high demand (but not necessarily high success rates in terms of recovery)(Dalal, 2015).

At the same time, we acknowledge that social constructionist and feminist critiques have generally steered away from the 'biological' and embodied dimension of women's mental health experiences for fear of being positioned as essentialist. There are also many limitations that arise from trying to retain a biomedical model of illness that simply adds on social factors or determinants of mental health (gender difference for example) as a gesture towards an external context for individual deficits (brain chemicals or personal coping skills). Moving beyond these entrenched biology-culture, structure-agency impasses involves

exploring the entanglement of *biopsychosocial* forces that shape the gendered phenomenon of depression and recovery as it is researched, managed and experienced. In this way we springboard from the growing momentum supporting different ways of thinking 'with' biosocial ontologies to deepen our sociological engagement with vital, more-than-human questions about health, wellbeing and social justice (Fitzgerald, Rose, & Singh, 2015; Fox & Alldred, 2016; Pickersgill, 2013; Pitts-Taylor, 2014; Puig de la Bellacasa, 2017; Pyyhtinen, 2016).

Our approach in this book is to draw together strands of sociocultural and feminist thinking that has explored the formation of – personal and political spheres of life, private and public feeling, the psychobiological and the social self, nature and culture, mind and body - into a vital politics that reconfigures recovery as a *matter* of 'aliveness'. We drew this metaphor from women's stories of moving through the deadening effects of depression in the desire to 'feel alive' again. These vital accounts of change turned our attention towards the everyday practices and relations through which recovery materialised as a messy process of *assembling/disassembling* gendered subjectivity. Stacey Alaimo (2017, p. xv) outlines the emphasis that new materialism places on "how bodies, substances, technologies, and environments not only are acted upon but also act. Matter is not inert but instead is actively, lively, and sometimes surprising". In this sense recovery can be understood as enacted in ways that are temporally emergent *through* relations with particular nonhuman places and social practices (doing exercise, tinkering with medication, changing work and care for others/self etc). New materialists extend poststructuralist critiques of discursive formations to open up the agentic possibilities of material, discursive and affective entanglements to consider how practices matter and what nonhuman capacities can 'do' (rather than what they 'are') (Coole & Frost, 2010). In this vein, Jane Bennett (2010, p. vii) argues for the recognition of a 'vital materiality' where 'things' (in our case medication, gym equipment, dogs, public parks, women's centres, GPs etc) matter through their agentic capacity to impact and change other actants within assemblage relations. Exploring the materiality of mental health through this relational ontology involves a challenge to the very basis of bio-psy models that privilege the 'interior self' as the site of agency (ir)rational mind, (im)balanced brain and expert intervention.

From this perspective, we problematize normalised accounts of recovery that articulate a process of returning to one's normal self through adherence to prescribed treatments and phases. In doing so we reorient our understanding from the limitations of individualised notions of agency (configured as (ab)normal), towards a focus on the gender

relations and micropolitical assemblages through which agentic capacities are materialised (sensing, feeling, moving)(Duff, 2012; Fox & Alldred, 2016; McLeod, 2017). Understanding recovery beyond individualised models foregrounds the complex assemblage of relations with things, objects, people and non-human nature to open up ways of thinking about agentic capacities and embodied affects through engagement with women's stories as 'subjugated knowledges' (Fullagar, 2019). Despite the recognition of 'gender differences' in the categorisation of distress as depression within mental health policy and practice, feminist research is rarely drawn upon as means of examining how gender relations materialise through everyday affects. Policy instruments, diagnostic devices, therapeutic modalities and technologies of recovery act upon women's lives in a context where there is little accountability for how they are implicated in gendered regimes of power.

Vital feminism

Drawing upon theoretical insights across new materialist feminisms, science and technology studies, post-phenomenology, biosocial sociology and cultural theories of affect, our engagement with a vital feminism explores and experiments with an ontological politics attuned to gendered life (Alaimo, 2017; Asberg, Thiele, & Van der Tuin, 2015; Coole & Frost, 2010; Ringrose & Renold, 2014). Vital feminist knowledges escape capture in biopolitical formations, their visceral, affective qualities disturb normalised masculine ordering to produce diffractive patterns that are necessary to think otherwise (Anderson, 2012; Barad, 2007; Bennett, 2010). Material feminisms have conceived the political in multiple ways across theoretical, empirical, activist and pedagogical work to mobilise different desires for moving-thinking-feeling our way through and against pathologised formulations of mental health (within and beyond the academy)(Braidotti, 2013; Colebrook, 2008; Grosz, 2013; Hickey-Moody, Palmer, & Sayers, 2016; Johnson, 2015; Norman & Moola, 2017; Washick, Wingrove, Ferguson, & Bennett, 2015).

This line of thinking offers another way to re-turn to the 'personal as political' as an embodied and conceptual problematic, while also proliferating analytic practices that are critical, affective, creative, hopeful, and even playful (Hinton & Liu, 2015; Hook & Wolfe, 2017; Ringrose & Coleman, 2013). Karen Barad's diffractive writing on the matter of thought resonates with our desire to rethink recovery beyond a return to 'normality' and thus question how the reterritorializing affects of patriarchal arrangements are entangled with gendered depression. Barad outlines her strategic repurposing of "re-turning – not by returning as in reflecting on or going back to a past that was, but re-turning as in turning it

over and over again...We might imagine re-turning as a multiplicity of processes, such as the kinds earthworms revel in while helping to make compost or otherwise being busy at work and at play" (Barad, 2014, p. 168). Feminist thinking offers us different ways of enacting a politics of re-covery that begins with the question of how to engage with complexity and multiplicity rather than reduce experience to biological, psychological or sociological categories (Howell & Voronka, 2013; Swist, Hodge, & Collin, 2016).

Reconfiguring depression and recovery as embodied, relational matters can serve to make visible gendered experiences and the effects of normalised psychopharmacological 'solutions' to open up different, lively modes of becoming. By researching how recovery matters we foreground a *pedagogical* moment that is produced in the intra-active space between our own feminist desires and those of many women participants who sought to articulate, share and learn something from depression in order to change the conditions of its emergence. To frame recovery primarily as the restoration of normal functioning and a cessation of debilitating symptomology is to do a profound disservice to the embodied knowledges that women have produced. Expert ways of knowing-diagnosing women's emotional lives can also close down uncertainty and the possibilities of more relational (and political) ways of understanding troubling affects (as they are often bound up with stigmatised contexts such as childhood abuse, gender based violence and other feminised shaming practices). There is much to learn from women's subjugated knowledges of recovery that can trouble the micropolitical assemblages that perpetuate distress, as well as producing other ways to feel-move-think our way through more vital relations. In the traditions of critical, post/decolonial and feminist pedagogies, learning and recovery also involve the practices of *unlearning* master narratives and normative framings of issues, identities and solutions (Cvetkovich, 2012; Hickey-Moody et al., 2016; Mills, 2014).

As feminist researchers our ethical claims to 'know' the experiences of other women is only ever partial, precarious and produced relationally through multiple embodied connections and differentiations (whiteness, sexuality, age, geography, education, embodied histories of trauma, dislocation and pleasurable movement, etc). Our feminist orientation is less concerned with creating knowledge about 'women' and more concerned with how we can draw upon women's different experiences to contribute to ways of knowing that diffract and trouble normative, gendered practices of othering as they also intra-act with racism and whiteness, heteronormativity and saneism among other forms of injustice. However, we cannot escape the mediations of power within which our lives and knowledge are entangled and enacted in ways that contribute certain forms of privileged 'telling' that reveal and also

obscure particular histories and knowledges (particularly those of Indigenous Australian women, several of whom participated in the project). Importantly, different ways of materialising recovery practices are opening up through Indigenous and post-colonial knowledges, experiences of oppression and relational ontologies that counter the dominance of white, western biomedical and psychological knowledge (Ahmed, 2017; Kalathil, 2011; Lavallee & Poole, 2010; Mills, 2014; Nelson, Macdonald, & Abbott, 2012). We write through these tensions, not seeking to resolve their complexity, rather to acknowledge the workings of privilege (our whiteness for example) and the limits of any claim to know or speak 'for'.

While we avoid positioning women's stories as unmediated sources of truth about recovery or romanticise their efforts as evidence of feminist resistance, we want to stay with the trouble at the heart of feminist research by problematizing any division between personal and political, experience and cultural production (Haraway, 1992). To trace the multiple affects that assemble and disassemble women's lives through gendered knots of depression and recovery, we need to re-turn to non-dualistic ways of knowing and learning through bodyminds, naturecultures and human-nonhuman relations. We also continue to re-turn to previous feminist work on depression and recovery in order to redeploy ideas in ways that help us explore how power materialises through performative, regulatory and affective flows. Stoppard (2000) and other feminists (Kokanovic et al. 2013; Lafrance and Stoppard 2006; Stoppard and McMullen 2003) have significantly contributed to critical understandings of depression as closely bound up with cultural practices that require the performance 'good' womanhood.

Lafrance (2009) importantly identifies how recovery-from-depression (as biomedical illness) subject positions become desirable for women who seek 'legitimization' of their distress given gender blind, hostile or essentialising contexts of work, family and health services etc. In light of this point about the desire to have gendered suffering recognized and alleviated, our critique of the dominance of biomedical knowledge is not a simply refutation of biology or the potential of treatments (medication or therapy) to be helpful in some way. Rather, by pushing beyond constructionism or reductionism we find a more complex scenario that requires critical and generative modes of engagement that do not position different women's recovery experiences as morally superior or inferior, right or wrong, politically aware or ideologically naive. We want to shift the focus away from this kind of reliance on a humanist subject in qualitative research as the base for truth claims about the authenticity of recovery experience (often with the best of intentions to empower women) in order to show

the mediating forces and contradictory layering of meaning imbricated in the depression-recovery assemblage. An individual may articulate multiple, seemingly contradictory and context specific understandings of how she came to be depressed and what changed through her recovery. We would argue that the affective tensions between different discourses of gendered personhood may well be implicated with the conditions enabling depression to flourish.

Recognising the dangers of assuming self-present meaning we also want to pay attention to what is not said or sayable about depression and recovery, as well as trace out the conditions and contexts that preclude talking about gendered dimensions of emotional life. The possibilities of drawing upon and extending existing feminist insights (research, theory, data) is made possible by thinking with theory through a mode of listening-feeling for the "interference" of diffractive patterns and multiple meanings that move together and apart to trouble gender norms and dualistic thought practices (Barad, 2014; Kaiser & Thiele, 2014). Donna Haraway (1992, p. 300) describes how diffraction shifts our analytic focus from representing gender difference to revealing the materialized effects of gender power relations,

> Diffraction does not produce "the same" displaced, as reflection and refraction do. Diffraction is a mapping of interference, not of replication, reflection, or reproduction. A diffraction pattern does not map where differences appear, but rather maps where the effects of difference appear...the first invites the illusion of essential, fixed position, while the second trains us to more subtle vision.

Thinking with Haraway, Barad and other feminists we find the metaphor of diffraction useful in a number of ways - as an analytic technique and a way of thinking about recovery in terms of the multiplicity of relations that diffract subjectivity. Moving in a new materialist direction has involved us re-turning to ontological questions about how we think with theory and everyday stories to acknowledge the "cuts" that mediate all knowledge practices in our desire to address the limitations of interpretative humanist research (Barad, 2003; Hinton, 2013; E. A. St. Pierre, Jackson, & Mazzei, 2016). As Barad suggests (2003, p. 802) "A *performative* understanding of discursive practices challenges the representationalist belief in the power of words to represent preexisting things". Hence, our approach is to produce a generative analysis that is attuned to affective relations, flows of power and material processes as they constitute lively, performative knowledge practices that do not rest on 'woman' as a stable humanist subject at the centre of meaning.

Bodyminds

Through a post-representational approach we explore the forces of affect, as they are entangled with recognised feelings and emotions, to identify what they "do" in the embodied performance of recovery (MacLure, 2013b). In refusing a coherent humanist subject as the source of meaning we pursue a more distributed sense of agency that is bound up with things, places, objects, senses and the affective working of gendered power. Through our interview intra-actions women recounted a diverse range of vital practices through which they experienced visceral, sensory relations that normalised, enlivened and unsettled the gendered patterns of everyday work, care and leisure – from bio-psy practices of ingesting anti-depressants (biomedical and complementary), talking-listening therapies and self-help groups, changing food and alcohol consumption, through to rituals of walking, immersion through travel, gardening, shopping, yoga, art and reading, to alternating rhythms of swimming, work, study and social connection. Rather than document such activities or behaviours as examples of individual agency in recovery, our approach considers embodied experience as multiplicity – our own and those of participants are co-implicated in the production of embodied meanings.

Moving beyond phenomenological or foundationalist claims about 'the body' as an individual whole that is separate from the world, Manning (2010, p. 118) troubles the formulation of a singular, bounded corporeal entity by emphasizing the relational, "more assemblage than form, more associated milieu than being". By extension we employ Merrell's (2003) term *bodymind* to evoke the entangled experience of mind, body and affect that comes to be felt and enacted as depression-recovery phenomena in particular relational contexts. The question of gender is implicit in Barad's (2003, p. 809) argument that "any robust theory of the materialization of bodies would necessarily take account of how the body's materiality —for example, its anatomy and physiology—and other material forces actively matter to the processes of materialization". Investigating how recovery is enacted through human and non-human relations requires attunement to the materiality of everyday spatialities, movements and affective experiences that enable different practices of care and freedom (Jackson, 2013; Puig de la Bellacasa, 2017)

Conventionally both 'bodies' and 'places' for recovery practices have been conceptualised ontologically as spatial 'settings' or environments for the unfolding of human behaviour. Positioned as inert matter in mental health promotion campaigns (eg, Five Ways

to Wellbeing), parks, gyms and public spaces are to be used by agentic individuals desiring to change behaviour and mood (Guthman & Mansfield, 2013). In contrast, new materialist thinking understands these bodymind practices to be sites of dynamic intra-actions constituted through bodies-environments, biochemical flows, affective states and relational power. The focus on intra-actions helps opens up everyday practices and "infrastructures of care" (Butler 2014) beyond biomedical models that question the normative notion that bodies are spatial containers or that bodies are receptors or mutable only via human intentionality (Guthman and Mansfield 2013). There is an ontological politics (Mol, 1999) at stake here concerning the way recovery services and interventions for mental health are imagined and provided within the biopolitical context of a shrinking state, growing privatization and commercialization of care, medicine and health (Healy, 2004; Moncrieff, 2010). While the struggle for increased mental health service provision continues in the face of growing demand in Australia and elsewhere, there are also the insidious effects of 'austerity cuts' in countries, such as England, that are reducing the collective provision of parks, leisure centres, community sport, childcare, libraries and health programmes etc. These cuts to public services that contribute to collective wellbeing also have a greater impact on women who have fewer economic resources and greater care responsibilities (Craddock, 2017).

A post-qualitative approach: Thinking with theory

> Doing theory requires being open to the world's aliveness, allowing oneself to be lured by curiosity, surprise, and wonder...Theories are living and breathing reconfigurings of the world. Karen Barad (2007, p. 2)

While we have written about our research into the gender relations of recovery over the past ten years or more (Fullagar 2008; Fullagar & O'Brien 2014), this book takes a distinct new materialist turn in our desire to engage more deeply with an ontological politics of feminist knowledge and to think through the materiality of mental health (Fullagar, 2018). In doing so we have re-turned to questions that are informing post-qualitative inquiry (E. A. St. Pierre et al., 2016; St Pierre, 2012) concerned with how we engage in different ways with the materiality of research – from transcripts, visceral memories of interview conversations and contexts (homes, cafes, university offices, workplaces), the affective power of women's stories that moved us in multiple ways and our collaborative intra-actions with feminist theories. As Barad (2007) argues all research is assembled through particular kinds of

apparatus (lab, survey, interview contexts etc) that are entangled with human-nonhuman relations and embodied practices (talking, listening, questioning, recording, listening, reading, writing), thus producing particular ontological "cuts" thorough which (un)knowing materialises. A key tenant of new materialist scholarship (Berbary & Boles, 2014; Fox & Alldred, 2015; Ringrose & Coleman, 2013) is the understanding of research processes as coimplicated in world-making rather than simply 'representing' the truths of experience or social worlds from some kind of objective or subjective position. Barad (2003, p. 802) argues that "the representationalist belief in the power of words to mirror preexisting phenomena is the metaphysical substrate that supports social constructivist, as well as traditional realist, beliefs".

While acknowledging the contribution of interpretative understandings of how individuals experience depression, and in narrative traditions recount stories with particular plots about health and illness (Frank, 1995), we move away from some of the troubling ethico-onto-epistemological assumptions that have informed realist and constructionist 'representations' of the human subject, experience and power (Fox & Alldred, 2016; Lather & St. Pierre, 2013; Mazzei, 2013; Elizabeth Adams St. Pierre, 2014; Woods, 2012). Rather than reiterate redemptive narratives about recovery we reorient our qualitative focus away from a hermeneutics of lived experience that privileges an interpretive subject, and towards the material-discursive and affective relations that make women's recovery (im)possible (Butler, 2014). In this way our post-qualitative approach reorients our engagement with women's experience through what Jackson and Mazzei (2013, p. vii) describe as a theoretical "reading of data that is both within and against interpretivism".

The semi-structured in-depth interviews (80 with women from 20-75 years) (Fullagar & O'Brien, 2014)[2] were key techniques in the qualitative research apparatus that mediated our intra-actions with a range of rural and urban participants who self-identified as 'recovering or recovered' from an experience of depression. Thinking through the materiality of language we engaged with the metaphoric meanings through which women enacted recovery to evoke disruptive and transformative moments and movement through depression (such as, feeling alive). Resisting the homogenising of data into aggregated themes, we have re-turned to the data to *read* women's everyday accounts of transformation and multiple intra-actions of self and world in order to *write* through a focus on the enactment of human-nonhuman agentic capacities. As St Pierre (2014) argues post-qualitative approaches do not

[2] This study was funded by the Australian Research Council.

offer methodological recipes to follow but rather articulate an ontology of concept as method. What makes 'thinking with theory' different from other methods of analysis is the 'relation with' theoretical ideas (questions of affect, discursive formations, binaries, power) that 'shapes how data and transcripts are produced, how one intra-acts with data, and how one writes-up research' (Kuby et al., 2016, p. 142).

Our analysis has involved tracing the *affective intensities* that moved us in reading-listening relations with individuals and transcriptions (Ringrose & Renold, 2014). We write in relation to fragments of "data" from interview transcripts that "glow" as a means of analysing how depression is assembled through particular gendered knots and also disassembled through recovery practices (MacLure, 2013a). These affective moments moved and engaged us to think about how we could think creatively and generatively *through* women's different articulations of bodymind and natureculture relations. Braidotti (2010, p. 414) argues that attuning our reading to affective traces works to trouble any assumption of transparent meaning as we consider, "what is left over, what remains, what has somehow caught and stuck around, the drags and the sentiments of the reading and the cognitive process". In our analysis we have paid attention to what is said and how recovery is voiced through interviews (words, sound, affective qualities of anger, shame, sadness or joy), as well as the silences and impossibilities of language. The interviews were conducted by the first and second authors while the third author collaborated on the analysis for the book.

This collaboration is also a departure from previous analysis that has been produced from our 'data set' (for example, Fullagar & O'Brien, 2014) as we re-turned this project through new materialism to address our increasing unease with the tensions between poststructuralist theory and interpretative, humanist methodologies (St. Pierre 2014). We began to unlearn research practices and ways of thinking that prevented us from exploring the materiality of depression-recovery and questioning representationalism. We re-turned to the interviews, the transcripts, the encounters that disturbed our sense of being knowing researchers as we moved with the affective qualities of talk and text. We connect with the research challenges also described by Norman and Moola (2017) in their materialist analysis that seeks to undo dualistic assumptions about eating disorders and obesity. They de-emphasise the researcher as a self-contained, masterful subject by suggesting that "the world that we aim to capture is itself *on the move* and, as such has its own movements and rhythms that press back against our research decisions, categories, concepts, theories and, in this way, is intra-actively involved in shaping the knowledge produced" (Norman & Moola, 2017, p. 6, italics in original).

The interview intra-actions produced complex affects in the research process, often articulated by women in terms of - relief in sharing experiences previously kept private, shame in the realisation of injustices, sadness in recounting trauma and loss, as well as pleasure, confidence and anger fuelled energy that was bound up with the transformative effects of recovery. For us the interview invoked a feminist ethics of listening as we witnessed and affirmed women's stories that had been variously ignored, trivialised and for some respected by others as effecting change. Listening 'with' talk and text generated a sense of permeability in our embodied ways of knowing, we were opened up in different ways by complex affects as they intersected with our own lives and feminist desires to challenge injustice. It was painful, heartening, inspiring, riveting, horrifying and at times overwhelming to hear different women's stories of the gendered conditions of depression and the struggles of recovery (including many with mental health services and professionals). Our embodied listening as researchers became attuned to "how matter makes itself felt" (Barad, 2003, p. 128) as multiplicity – the voices of participants and feminist scholars - in a productive, (un)learning entanglement that continued for many years and beyond the interviews through our reading-writing collaborations. We draw upon Mazzei and Jackson's (2017, p. 1090) approach that (re)configures voice as more than human to "refuse the primacy of voice as simply spoken words emanating from a conscious subject and instead place voice within the material and discursive knots and intensities of the assemblage". In this sense, we do not consider women's voices as transparent articulations of unmediated truth that we can access nor do we presume that we can 'give' voice to some kind of authentic experience (see Jackson, 2003 on the complexities of voice in feminist research). Instead, we consider what voices do and how voices have material effects within human and nonhuman assemblages.

In the desire to produce research that contributes to world-making, MacLure (2013b, p. 658) has called for creative approaches to qualitative data analysis that involve "research practices capable of engaging the materiality of language itself" (see also, Chadwick, 2016 on embodied poetics). Working with a critical-creative analytic, we enact different kinds of inventive *writing through* the relations of depression-recovery to evoke biographical fragments, the embodied and remembered traces of gender power relations, tensions and contradictions, as well as the pleasurable and joyful moments when women recounted how things changed and what they had learnt. We continue the experimental ethos of new materialist research produced in some of our more recent work [articulating a rhizomatic enactment of "found poems" (Richardson, 1993)] to evoke the affective intensities and material relations of recovery (Fullagar, 2018). In this way we seek not to represent a

generalised truth of women's lives but rather to "mangle" our data analysis and work with theory in creative ways to evoke and write diverse ontologies (visual, affective, sensory etc) (Jackson & Mazzei, 2013).

The book pursues these questions through chapters that examine interrelated problematics, although they each 'cut' a particular perspective on the unfolding dynamics of depression and recovery. Chapter 2 works through theories of affect to consider the rhizomatic movements and gendered knots of 'bad feelings' that produce depression and entangle recovery practices. While chapter 3 examines how spacetime matters in models and experiences of recovery from depression in the desire to move beyond the limitations of linear trajectories of thought. We explore the gendering of women's movement through the 'life course' as an intersecting, normalised trajectory through which hormones, medication and other practices produce permeable bodyminds. Chapter 4 focuses more specifically on experiences of motherhood and how recovery is produced through affective arrangements of diagnosis, treatment and infrastructures of care that are gendered in particular ways. We pursue questions about the immaterial meanings that haunt the relationality of mothering and normative expectations of care. In chapter 5 and 6 we move into a deeper exploration of how embodiment movement (swimming to yoga) and creative practices are enacted in more-than-human worlds that enable transformative moments and gendered disruptions. Our final chapter 7 returns to questions about the gendered costs of depression, ways of enacting care-full recovery and the disruptive affects that feminist humour produces through pedagogic relations that traverse personal and public spheres. Each chapter draws upon different ways of enacting the stories that were co-constituted through the research intra-actions to mobilise a vital feminist politics of knowledge through the enlivening forces of theory, texts and bodies.

Short extract from Chapter 3

Anti-depressant use in our study was rarely the single course of action that a woman employed in her recovery, rather medication and the affective investment of hope in its capacities to alleviate distress was impossible to separate from everyday practices, relationships and therapies. As Wilson (2015, p. 120) argues in her compelling analysis of the mutuality of the drug, placebo responses, scientific trials and the vicissitudes of everyday life provide a way of thinking *with* the multiple entanglements that reconfigure mind and body. The historical changes and increased rates of placebo responders in contemporary clinical

trials presents a problem for pharmaceutical companies in developing new drug treatments (if efficacy in trials is less than placebo, drugs are abandoned)(Wilson, 2015).

In scientific and popular biomedical accounts recovery experiences are largely attributed to either the agency of medication or the individual, "Depressive symptoms tend to spontaneously improve over time and this phenomenon contributes to the high percentage of placebo responders in antidepressant trials" (Cipriani et al's., 2018, p.10). What is erased in this 'spontaneous' formulation of recovery is the affective labour of self-care and help-seeking that women enact through biomedical assemblages, as well as the placebo as a material-discursive effect. The labour of seeking help, receiving support and providing support is entangled with complex ethics of care, prescribing practices and pressures of Big Pharma and state provision as well as professional imperatives to do no harm. Yet, women often spoke about the failures of care that impeded their recovery and intensified affective relations of distrust, isolation, anger, disconnection, shame, self-blame and inequitable access to support; captured in this short collective *not to do list* of professional intra-actions.

I was trying to desperately find a psychiatrist who didn't charge too much
One said to me 'if I saw people like you once a week
you'd have to scrape me off the wall'.
Another one I tried kept falling asleep every session
so he got crossed off the list.

There was no one who could help me in this town
I felt really lost, suicidal.
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.
I was scared of self-harm
I was just really living in fear and
she never, ever returned my calls.

My psychiatrist said 'why would you,
as a person who has a chemical imbalance in your brain,
stop taking the medication, because you now feel good?'
I said 'because you're not depressed anymore'.
And she goes 'yeah, but your chemical imbalance

hasn't gone though
you could be on it for life as maintenance'.

It was quite a shock when I wanted to go off medication
that's when I had terrible mood swings
I just kept crying and screaming.
The psychiatrist came and talked to me
but did nothing to help me with post-natal depression
I said 'I'm a single mum, I've just had a small child
I've got post-natal depression
I can't look after him
I don't want to give him up
I just need help'.

The doctor who first prescribed them for me
painted a pretty rosy picture,
which I think was misleading because I have suffered
significant side effects trying to withdraw
I also think it's a psychological thing
Am I dependent these drugs to be well, or not?
It will be interesting to see.

I don't have a lot of promise in anti-depressants,
I'm a bit disheartened
I'm thinking 'now medication doesn't work,
what is there? What else is there?'.
I've been on this medication almost 12 months
And they won't listen,
they say 'No, you're going to stay on the medication.'
Sedating me too much … I feel like an underclass.

Roberts and other feminist scholars offer a way of thinking about how women's bodyminds become enfolded through neurological, sensory, affective, imaginative relations, "Sociological and STS studies of pharmaceuticals have articulated medications as dense material-semiotic knots: actors that carry meanings and actively bring about physical changes in bodies and environments (see papers in Fraser et al, 2009)" (2014, p. 337). It was not only pharmacological products that were entangled in recovery, women in our study also

consumed various complementary medicines, vitamins, foods and herbal preparations; twenty-eight women sought help from natural therapists (naturopaths, homeopaths, herbalists). While some did, many others did not wish to tell their doctors about complementary treatment (such as the herbal treatment, St John's Wort), or when they decided it was time to reduce anti-depressant medication in the desire to avoid judgement. The adverse effects of withdrawing from (often multiple types of) antidepressant medication was a highly troubling aspect of treatment as women found it difficult to distinguish between the somatic effects (short and long term) and return of previous symptoms. Women were often given little warning by professionals about the risks of psychopharmacology in their recovery, despite scientific research that has identified the need for clinical advice and guidance about 'withdrawal syndrome' (Fava, Gatti, Belaise, Guidi, & Offidani, 2015).

Medication talk often produced a diffractive moment in our study through the interview intra-actions where ontologies of depression (biochemical, hereditary and life events/injustices) rubbed up against each other in ways that unsettled the biomedical sovereignty. McLeod (2017, p. 58) also identifies this through her study where, "the positions taken up in relation to anti-depressants do not always fit a temporally logical sequence", rather "remedy/pollutant discourses are moved across in different combinations in an ongoing way – even during the course of one conversation"…

Chapter 1 References

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