Rural mental health and social geographies of caring

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This paper contributes to an emerging geographical literature on the social geographies of caring. Drawing on recently undertaken empirical work in the Scottish Highlands, personal accounts about the provision of both formal and informal care for people with mental health problems are evaluated. The notion of ‘community care’ is critiqued, as too are claims about how rural and remote rural locations engender particular configurations of caring roles, practices and relations. It is shown that geographical distance, social proximity, stoic cultures and rural gossip networks all have a part to play in how caring occurs in such places. The paper concludes by suggesting areas of future research.

Key words: mental health, caring practice, roles, relations, formal and informal care.

Introduction

To ‘care’ for someone is a complicated social act. Geographers have recently become increasingly interested in the politics and practices of caring, and in thinking through how care is a spatially differentiated activity which spans both formal and informal realms of public and private life (Cloutier-Fisher and Joseph 2000; Gesler and Kearns 2002; Gleeson and Kearns 2001; Gould and Moon 2000; Halseth and Williams 1999; Kearns 1991, 1997, 1998; Kearns and Joseph 1997; Milligan 1998, 1999, 2000; Mohan 1995; Robson 2000; Robson and Ansell 2000; Williams 1999a, 1999b). Geographers of health, in particular, are active in re-examining spaces of caring in ways that build upon, but certainly differ from, the traditional ‘health care’ foci of an older medical geography. There is a move away from research and analysis that constructs mapped spatial distributions of formal health care resources and access patterns, towards theorizing care and caring relations in ways that highlight diverse political and economic processes involved in care restructuring. At the same time, community empowerment and social organization around declining care services start to attract attention, as well as the experience of receiving care in its many different forms. These recent developments also dovetail with other work which has interrogated the notion
of ‘therapeutic landscapes’ (Gesler 1991, 1998; Williams 1999b), environments fostering senses of well-being and ones that, in the most widest of senses, can be considered to be places and spaces which involve caring relations of various sorts. These developments are facilitating a nuanced (if not all that sustained) appreciation of ‘care’ as a concept, although there is perhaps a lack of attention to important empirical details about caring roles, practices, knowledges and relationships, as they are negotiated and played out within and through space (but see Dyck and Kearns 1995; Robson and Ansell 2000). This paper explicitly focuses on these elements in telling the story of particular ‘geographies of caring’ and as such seeks to build on the above in order to expand our understanding of this important fact of social life. In particular, we want to explore further the idea that care and caring are thoroughly social activities and always constituted by aspects of the places in which they occur. By using case study material from a project on rural geographies of mental health, we hope to elaborate this notion.

Kearns (1998: 227) is one geographer who has highlighted social and cultural dimensions of care by using the ‘example of health care in a remote region of New Zealand [which] provides a “lens” through which more general relationships between place, health and social processes can be examined’. That Kearns’s work has focused on the diverse relations, related to matters of ethnicity, history and culture, that surround ‘care’ (albeit formal care services in this case) in a remote rural region is of significance to us. We intentionally want to develop research that highlights how care in specifically rural places can be argued to be more than just ‘a medical interaction’ (Kearns 1998: 236; see also Robson and Ansell 2000; Williams 1999b). Other research has highlighted how ‘medically under-serviced rural places are usually without the resources needed to address their services needs ... and [this] forms an important motivational force behind self-help community organisation’ (Halseth and Williams 1999: 41). The suggestion here is that for rural places in particular, care (health care services, community care and care in the form of self-help) is configured in specific ways as a result of the particular economic, political and social geographies of such locations. By highlighting rural dimensions to social geographies of care, we are deliberately developing ‘situated understandings’ (Cloutier-Fisher and Joseph 2000) of the relationships between health, care and place. Through the materials below, however, we seek primarily to interrogate how aspects of the sociality of rural places contribute to particular configurations of ‘care and caring’ activities, asking about what this might involve in terms of roles, relations, practices and negotiations at individual and community scales. Here, both formal and informal provisions of care are critically highlighted in ways that elaborate the above research agendas.

This paper interrogates the notion of ‘community care’ as an umbrella term that includes wide-ranging practices of formal and informal caring related to people with mental health problems in rural areas. The materials discussed have emerged from a project based in the Scottish Highlands called ‘rural geographies of mental health: experiences of inclusion and exclusion’. This project seeks primarily to understand the ‘place’ of people with mental health problems in different types of Highland community. We have sought to understand this ‘placing’ through an appreciation of the social and cultural milieux that frame experiences of everyday social life, primarily through the verbal accounts of the people themselves: namely people diagnosed with mental health problems. However, it is the carers of such individuals upon whom we are concentrating here. Follow-
ing a brief explanation of methods and data selection, the paper draws on this project’s findings to outline contextual aspects of the social and spatial relationships characterizing rural and remote areas of the Scottish Highlands. We critically consider accounts of formal care providers that highlight how formal caring work in particular rural geographies involves culturally sensitive caring practices, negotiations of community membership and roles, and attempts to balance individual and collective experiences of care. Interview materials from informal carers of people with mental health problems are then privileged in order to elaborate further how caring in these localities is a contested social practice with difficult relationships and negotiations occurring on an individual, family and community scale. The paper will conclude by offering thoughts on how the social relations that characterize formal and informal caring are often uniquely intertwined in rural communities, as well as briefly outlining possibilities for future research on social geographies of care and caring.

**Methodology and data selection**

We have interviewed over 100 users of psychiatric care in four Highland locations—Inverness and surrounds, Easter Ross, North-West Sutherland (NWS) and the Isle of Skye—cover-
ing a number of issues, including the perception and experience of care in its various forms (see Figure 1).

Despite the key purpose of this research being focused on the views of users, we have also interviewed sixty-two providers of mental health care in the same locations, and these providers include General Practitioners (GPs), Community Psychiatric Nurses (CPNs), social workers, psychiatrists and informal carers (family, friends, neighbours). Recruitment of users and formal care providers occurred through mental health teams, GP practices and rural mental health drop-in centres. Recruitment of informal carers was more difficult, and occurred through the latter strategies and spaces, but also through snowballing and formal carer support organizations. That there were difficulties in the recruitment of self-identified informal carers speaks to the issue of ‘invisibility’ that surrounds this group, as we outline further below. Interviews with formal care providers, informal carers and users were carried out by both authors and a research assistant, and roughly the same numbers of people in these categories were interviewed in each location. In a deliberate attempt to achieve a more situated understanding of the interviewees’ lives in rural and remote places, up to two months were spent in each location carrying out interview work, but also engaging in ethnographic research, primarily, but not solely, focused around rural drop-ins for people with mental health problems. All interviews were analysed through the software package NVIVO and anonymized for the purposes of report and academic writing. It is the views of formal and informal carers that we are mainly discussing in this piece, although some more general claims about Highland social geographies are supported with references to interviews with users. For the purposes of this paper, we are not fully drawing out the differences in caring relations and practices between each of our four study areas, but rather we present key themes that traverse narratives from the remoter rural parts of each. However, in doing this we draw most heavily on data from NWS and Skye, these being the most remote rural locations. That such areas are not well resourced in terms of a diversity of formal care providers also explains why only specific providers are represented in these areas, meaning that their narratives are drawn out disproportionately to those of other types of providers in other areas. In some ways, then, the narratives selected and represented here point to localized concerns, localized to the remoter rural parts of the Western Coast of Highland Scotland, but we also feel that many of the issues raised here are applicable to other types of rural areas, to greater or lesser degrees.

‘Community care’ and social geographies of the rural and remote Highlands

When discussing mental health in rural areas there is an interesting conceptual need to start thinking rather differently about that phrase commonly associated with contemporary mental health issues: namely ‘community care’. Often, it could be argued, when policy makers, journalists and even academics envisage community care, they are thinking very much about an ‘imagined geography’ of community care: an imagined ‘moral landscape’, as has recently been discussed by Gleeson and Kearns (2001), of communities who are supposed to be able to care. These could be interpreted as rather unrealistic imaginings, given the realities of discharging psychiatric patients into rather ‘uncaring’ inner-city locations and suburban neighbourhoods. Inner-city locations are often made up of fragmented individuals and groups, all leading disparate lives, and as such they are
places which might be characterized as physically proximate but socially distant. In this context, the term ‘community care’ often has a particular meaning, really referring to the deinstitutionalization and fragmentation of large-scale psychiatric care facilities into small-scale centres, located in different neighbourhoods, rather than to any real approximation of a ‘caring community’ wherein neighbours truly look after each other and support local people with mental health problems who come to reside in their street.

By contrast, community care is rarely envisaged in the context of rural locations, even less in the context of remote rural locations (but see Milligan 1999). Yet, questions of ‘community’, let alone of community care, are here highly pertinent. In some rural places, exactly the opposite social–geographical relationships to those in urban locations can arguably be found in that people are physically distant from neighbours (particularly in crofting communities) but more socially proximate. This social proximity means that neighbours five miles apart might know intimately each other’s personal histories and biographies, family relationships and so on. The genealogy of an individual and their family is something collectively known, placed, remembered and narrated by other community members, especially those who have long links with the area and residents in question. This may have particular implications for people who have experienced emotional and psychological disruption. Crucially, though, we cannot assume that this social proximity will always lead to more caring communities, especially with respect to mental health issues. It is in such a social geographical context of remoter rural places and communities, therefore, that we begin to consider what ‘community care’ might mean for people with mental health problems.

As discussed above, we are interested in the considered reflections of those people who in some way, shape or form—as practitioners or informal carers—have an input into constructing the meaning of mental health, illness and care in different rural places. It is also possible to appreciate how carers understand their care work as being mediated by or adapted to local conditions: the local geographies, the social and spatial proximities of crofting communities, the local understandings and attitudes towards mental health and illness, and so on. In this sense we are concerned with how formal care and its delivery is infused by the social and cultural conditions within which it exists, as we shall see below. But it is also important to understand how care operates beyond the formal service, and here we are not just talking about informal caring as it is conventionally acknowledged—although this is a concern—but rather are also seeking to understand how and if communities, especially small and remote rural communities, can care for their vulnerable members through different forms of individual and collective actions. Conversely, we are also concerned about occasions when these caring practices do not exist, and when low-level expressions of support and inclusionary relationships break down or are never established because of more negative community attitudes and cultural beliefs about mental health and illness. The reality, of course, for many rural areas is unlikely to be one of an either/or: either caring or uncaring. The story is always more likely to be a messy fusion of the two, as the case studies below highlight.

The interview accounts below elucidate such themes, and are primarily drawn from research in the remote and rural Highland locations (North-West Sutherland, Skye and Easter Ross), although cross-referenced with some supporting comments from the rural surrounds of Inverness. In terms of formal mental health care, there is sparse provision in these areas:
for example, in NWS there is just the one CPN whose client list covers patients from five GP practices, and who is supported by a visiting consultant psychiatrist from Inverness (a vacant post in 2001). The clients are spread over an area of circa 100 square miles on single-track roads across hills, glens and around irregular coastlines, making service-access and client support difficult. From interviews with both the CPN and the five GPs, there is a palpable sense of a marginalized health service, poorly resourced and poorly understood by the relevant centre(s) of health care decision-making and resource allocation (Inverness and Edinburgh).\(^8\) The material reality which makes this particular geography of mental health care is paralleled by social–cultural geographies which help to shape a distinctive provision of care by both the CPN and informal carers in the area. The broad issues that colour this illustrative example are replicated in the other research areas in ways that convey complex rural spatial contexts to social geographies of care work.

As briefly outlined, these localities are ones in which social proximity is the norm: people’s everyday lives and activities are highly visible, and, despite the physical distances involved between neighbours, it is hard to keep secrets. If something happens, the local gossip networks spring into action, and, as has often been said to us, ‘if they [community members] don’t know anything, they’ll make it up’. This is also a place in which people are accustomed to sparse services (of all kinds) and ‘getting by’ is normal: there is a strong underlying discourse about a regional Highland culture of self-reliance, something flagged by care practitioners and users alike. When it comes to emotional and psychological problems, there is a sense in which people ‘soldier on’, often not discussing such things with neighbours and even family, partly to avoid the perceived stigma that contact with formal services can bring, especially in a region which had as its only form of mental health service provision for many years a widely feared asylum based over 100 miles away.\(^9\) Undoubtedly, in sketching such a bold picture we have not conveyed the nuances and contradictions which are already apparent in our wider research results, but there is a sense in which these characteristics do contain a ‘truth’ for many of the people to whom we spoke. These social and cultural characteristics, coupled with the material realities of limited formal mental health care provision, are important contexts with which to frame the accounts of care-givers below.

**Formal caring**

In rural and remote localities the burden of formal care delivery for people with mental health problems falls mainly on GPs and CPNs. Whereas in urban locations people with emotional and psychological problems might be routinely referred on to a mental health team or a specialist consultant, in some remote areas this option is seen as the one least preferred, most obviously because of the distances involved for the users of specialist services (this could be a 200 mile round trip to Inverness for clients in NWS, for example), but also because of the risk of stigma associated with such a referral:

> From my point of view, I would try and cope, yes. Yes I would, I would refer as a last resort. (GP(a), NWS, 25 July 2001)

We’re taking more responsibility for ... their care. Obviously that’s relying on our experience and any mental health training ... And if we have any problems we try and find some psychiatrist in Inverness ...
who will give us some advice. (GP(b), NWS, 13 July 2001)

The consultant psychiatrist, who has just left the post ... wasn't really interested in coming to the remote areas ... so what we have to do is see people, diagnose people, medicate people, dispense drugs and when in terms of the psychological treatment it tends to be over to [the CPN]. (GP(c), NWS, 15 July 2001)

The lack of access to specialist services in rural and remote areas means that ‘primary’ care staff are disproportionally responsible for the care of ‘secondary’ health care needs. This raises concerns about adequate levels of expertise, training and treatment decisions, and some GPs acknowledge that a side-effect of GP-based formal care for mental health problems is occasionally a reliance on medication for dealing with emotional matters which in other geographical contexts might be dealt with by ‘talking treatments’:

We don’t have the time, we do spend lots of time ... but we don’t have the time and the counselling skills to deal with ‘I’m feeling a wee bit low Dr’ ... you know and there’s a temptation to say ‘right, try this and come back in a week’. There’s a huge underlying pool of people who could do with counselling if you like. Your traditional Highland culture ... you went to the minister, they don’t any more, they come to the Dr. (GP(d), NWS, 18 July 2001)

Whilst the rural GP is undoubtedly an important figure in the provision of formal mental health services in the Highlands (at least in terms of diagnosis and prescription), the rural CPN is the key provider of daily and weekly support for people with mental health problems. The CPN accounts indicate still more clearly how social dimensions of geographical location impact upon their provision of care. All providers of care have to tailor their services to the local communities that they serve. In a very real sense both GPs and the CPNs interviewed as part of this research project were conscious of the ‘local moral orders’ pertaining to social behaviour, recognizing how such orders infuse what is regarded as acceptable locally in terms of thinking about and responding to all manner of health and illness issues. This recognition linked in turn into the practices of care adopted by these formal providers themselves, practices which were, by and large, clearly attempting to be sensitive to locally constituted cultural meanings and social relations surrounding ill-health. One CPN talked of the importance of her being able to build the trust of her clients by guaranteeing anonymity in small communities where anonymity is such a fraught consideration, as already explained in our outline comments on social proximity and gossip. She would go to the lengths of leaving her car a mile away from a croft house in order that the recipient of care was not at risk of being associated with her (for in small places where it is not unknown for people to follow and to identify cars with binoculars, the CPN’s car would be instantly recognizable). By walking to her client’s home, and effectively trying to mask or at least to adjust her identity in her caring practice, she is taking seriously the weight of local feelings about psychiatric services and the associated fear of stigma. Whilst accessing a GP for medication may be fairly anonymous, the receipt of care from CPNs is clearly much more of a visible activity. In a region where cultural norms include stoicism and non-disclosure about health and emotional problems (especially for self-identified ‘indigenous’ people\(^\text{10}\)), this can be seen as a form of ‘risky’ care relation. This local knowledge informs the
CPN–client relationship, then, and the ways in which care is delivered and received.

The perceived risks associated with caring relationships in socially proximate rural areas link not only to the CPN as a known mental health practitioner, but also to the CPN as a community member. The community status of a formal care-giver can impact on whether or not a potential client will access a psychiatric service. For example, for those CPNs who are ‘indigenous’ to the places in which they practise their care, this can act as both an advantage or a disadvantage:

I think there are advantages and disadvantages, some people don’t want to see me because I am local, some people do want to see me because I am, because they don’t want to see someone who is English or they don’t want to see someone who is male. (CPN, Skye, 11 September 2001)

The notion that for some clients the ethnicity of the care practitioner is important relates to the significance of the rural Highland context: for some ‘indigenous’ people, this will be related to the presence of Gaelic language skills (being able to explain complicated emotions through familiar vocabularies); for others, it will simply be related to the implicit assumption that a Highland care practitioner will be more sensitive to the social and cultural relations surrounding illness, emotional problems and the common (non)disclosure of these. Whilst we will say more about the community membership of the CPNs later, we wish to elaborate the notion that such practitioners (whoever they are) have place-based knowledges enabling different and culturally sensitive practices of care.

Through interview and ethnographic materials, one CPN in NWS conveyed her conscious attempts to adjust her practice of care to local moral orders, particularly in relation to gender roles. She maintained that there are a lot of hidden problems, especially relating to depression in the district, among men in particular. A common and culturally acceptable way to cope with these feelings (one continually cited across the region by all respondents) was through the (ab)use of alcohol, instead of reaching out to the health services. For this CPN, one way around this has been to seek to involve (when appropriate) male partners in her community visits to female clients, not explicitly as part of a therapeutic discussion, but more through general conversation and other activities such as massage and aromatherapy. Through such practices, she can often make connections with other household members, who, in some cases, begin to gain an awareness of, and hear about solutions for, their own emotional and psychological distress.

This very informal practice is related in the following interview extracts with service users:

Hamish: In little places like this … people don’t speak about it … I was depressed myself for years … but I never went to the doctor about it.

Ishbel: Oh yeah and what was your medication? [sarcastic]

Hamish: I just tipped bottles down my throat for years and I was doing it to a serious extent … but people up here don’t want to accept that they have a problem like that … It took me a long long time to realize I was suffering from depression and in fact it was [the CPN] who eventually pointed it out, wasn’t it … You know, when I told her about how I was leading my life [laughs] she couldn’t understand how I could have gotten through it as what I did.

Ishbel: He still doesn’t take medication.

Hester: When [the CPN] comes to see you, do you talk mostly about medication?

Ishbel: No not really, not now.

Hamish: But when she was coming first of all … the first few times … she was dealing purely with you [Ishbel], the depression and the medication, but
then as she saw Ishbel coming out and getting better and her mood getting improved ... it’s now like a social visit ...

Ishbel: And it involves the two of us.

Hamish: As Ishbel improves, it has become more of an informal visit than the formal visit it was in the first place.

[discussion of being able to pick up the telephone]

Ishbel: And now she’s helping Hamish with his shoulders and back and everything, and you know she’s special.

Hamish: You know she was the first person to discover that I felt depressed from time to time.

Ishbel: And she’s very aware of his depression, which it is ...

Hamish: And the funny thing is, even though I know her now, ... I wouldn’t sit there and say ‘God I’ve been feeling really depressed for the last week’. If she started to ask me about it I might tell her, ... but I wouldn’t volunteer any information myself.

Ishbel: [laughs] It’s like drawing blood from a stone.

Hamish: But I don’t think I’m unique in that, I think that’s the way you’ll find most of the indigenous people to be I would think. (User and husband, NWS, 15 July 2001)

Although these are lengthy extracts, they show, through the italicized words of the clients, how the CPN has gradually engaged with the male member of the household with regards to his mental health issues. Through this extract, the CPN is shown to be trying to work within the cultural possibilities and constraints that she understands to exist around her practice of care. She has to be sensitive to these in order to be able to assist a man like Hamish, realizing that here perhaps more than in other places men and mental health problems are not supposed to have any relationship to one another, and also that a common male response to ‘emotional stuff’ in this part of the world is indeed to seek solace in the bottle.

This gender dimension to care practices in rural Scotland was highlighted by other (mostly female) workers, who also discussed the difficulties of caring for ‘indigenous’ male clients and the different ways in which they sought to address their needs. Interestingly, it is often the case that a female family member (in this case Ishbel) acts as an important bridge between the formal care worker and the male client (emphasizing how formal and informal care can mesh). However, some clients have also raised the possibility of the need for more ‘local’ male workers to deliver mental health care to men:

It almost needs like ‘a Hamish’ to go into these homes ... he understands the lifestyle ... he is indigenous to this part of the world ... he has lived and worked this part of the world and he would be more received ... women would be more open ... but there are a lot of men ... who suffer. (User, NWS, 15 July 2001)

Whilst the ethnicity, ‘localness’ and gender of care practitioners are clearly issues in rural mental health care delivery, there are other important dimensions to the caring role for rural CPNs. As mentioned above, issues of community membership and status impact upon care providers. In places where their working role may be very visible, formal carers are careful about their everyday interactions with other community members:

I know from my own professional point of view I keep a low profile. Most people they don’t know what I do. They know I’m a nurse and I am in the hospital. My close friends know. I don’t say I’m a psychiatric nurse, because tomorrow their mother could be referred to me ... Maybe that’s wrong but I feel I should be keeping a low profile. (CPN, Skye, 11 September 2001)

It’s about knowing your boundaries. I’m quite clear...
where my work starts and where it stops. I think you have to be absolutely clear, especially living in a rural area. It’s very easy to allow these roles to be blurred. That has happened. I’ve seen colleagues that has happened to—it’ll destroy you. It means you need to be able to say no to people, you need to be able to say to people if they stop you in the co-op … I have seen colleagues who are quite happy to hold a consultation in the co-op and I don’t think it’s at all appropriate. (CPN, Skye, 11 September 2001)

The difficulties of maintaining other community roles apart from formal carer are hence pronounced in rural areas where mental health care practitioners may have to negotiate being customers, parents, committee members and neighbours to the people with whom they are involved in therapeutic relationships (see Philo, Parr and Burns 2003; Roberts, Battaglia and Epstein 1999; Williams 1999b). Not only do rural care workers have to practise culturally sensitive care, they also have to manage dual working and personal roles in ways that allow them to interact successfully with other community members on several different levels. At the same time, CPNs are realistic about the fact that ‘I think when you live in a rural area like this, I think you have to give a bit more’ (CPN interview, NWS, 29 July 2001), even discussing how they become attached to particular individuals, partly as their clients do not move on to other practitioners or parts of the service as such facilities do not exist. For some CPNs, the involvement of their selves in care relationships becomes more than just formal work, but also about friendship, pleasure and companionship:

I think you get nurses that think ‘oh they’re nice’ and so they … it’s easy to have someone like that—it’s comfortable and it’s maybe because they’ve been such a part of the nurses’ life for a long time. (CPN, Easter Ross, 28 November 2001)

In general, however, considerations such as maintaining confidentiality, being discrete and erecting boundaries around working roles means that ‘community care’ in rural areas is mostly about individuals receiving face-to-face services in isolation. This is the best way, favoured by clients it seems, for preventing any leakage of information about their condition from one domain to another.

There is little evidence from our research that particularly remote rural places are conducive to more collective experiences of care, such as are experienced through drop-in facilities, group therapy and self-help groups (although some do exist). Several CPNs spoke of the difficulties in establishing this kind of organization of care:

They wouldn’t go—there would be a stigma there. (CPN, NWS, 29 July 2001)

Y’know, I said ‘why don’t you meet in someone’s house, you know every couple of weeks’. I said I could come and do an evening—even theme it around aromatherapy—but no—it never happened … it’s perhaps different in [the village] but in the remote valleys, you know. (CPN, NWS, 15 July 1998)

Interestingly, because they find it difficult to group clients together, this means that care providers have less time to spend with individuals, especially when they are spread over a large geographical area. Here we can see that the sensitivity to the components of social proximity in the rural Highlands—namely gos-sip, fear of difference and cultural stoicism—perhaps mean that a more efficient organization of collective care experiences is not possible.

Despite these examples, this material should not be interpreted as arguing that care providers like CPNs are always battling against
local cultures and social relations in socially proximate places, as on occasions these processes do assist with the provision of care in the community. CPNs from all areas have told us of telephone calls that they would occasionally receive from concerned community members, who have seen someone behaving strangely or out of their normal routine:

[Pe]ople in the community would contact me if they were worried ... I mean nothing would be really discussed ... but someone might phone me and say ‘I saw so and so in the shop today and he didn’t look too well and he said some things’, you know ... and it’s like a safety valve. (CPN, NWS, 29 July 2001)

In this way the gossiping of small communities can act as an informal safety net for stretched formal services in remote geographical areas, especially if someone is going into crisis. The notion of a genuine ‘community care’ is not entirely dispensed with in this case, and it can be argued that community members assist and supplement formal care provision with informal caring practices:

I would have been lost on numerous occasions had it not been for the goodwill of neighbours going in to check if someone is alright or keeping an eye on them. (CPN, Skye, 11 September 2001)

For both rural Highland GPs and CPNs, it was found to be important for people to receive formal care within their own locality if at all possible. For the GPs especially, they are sometimes wary of sending people away to hospital in urban locations like Inverness partly because of the difficulties of individuals retaining and re-establishing community social relations on return. Although attitudes and referral patterns are changing in this part of the world, for some, the social sensitivity of local GPs to local gossip and stigma can sometimes cause problems when there is hesitation over diagnoses or over the need for hospitalization (and we will come back to this below). Overall, then, the provision of formal mental health care in remote and rural geographies is difficult, as there are quite distinctive social and cultural practices and discourses regarding mental health and illness, which means that services have to be delivered discreetly, sometimes very differently to what might be the case for a similar service in an urban locality.

Informal caring

Informal carers who support individuals with mental health problems are also greatly influenced by the localities in which they live. They too are aware of local moral orders in places where people rarely discuss mental health issues. Informal carers tend to suffer what might be termed a kind of ‘double invisibility’. If general mental health problems remain terra incognitae locally, any difficulties facing informal carers are thereby rendered even more obscure, unknown and unheeded. Sometimes ‘carers’ do not actually think of themselves in this role or use such language to describe themselves (and thus they contribute to ‘making’ their own invisibility). As Mark, a carer from a rural area outside of Inverness argues:

Carers don’t know they’re carers anyway. I didn’t know I was a carer. (Informal carer, Inverness, 10 May 2001)

I'm somebody's mother—it's very difficult to call yourself a carer—I'm just somebody's mother ... I'm sure Kate has difficulty thinking of me as her carer. (Informal carer, NWS, 24 July 2001)
One index of this reluctance to identify with the caring role is that we have found it incredibly hard to recruit informal carers to interview in our project. For a variety of reasons, they remain unwilling to come forward to talk about their lives in the remoter rural areas of Highland Scotland. Nonetheless, we have talked to a few people, and their remarks shed light on both their own caring practices and how these practices are contextualized in the wider cultures of caring within the places and communities where they reside. In this context we shall highlight a few brief points about how informal carers are supported by both local formal services and local communities.

One of the major problems facing informal carers in rural areas is the negotiation of support for themselves in light of issues such as social gossip and fear of stigma. Often for informal carers their caring role is hidden, partly because of pressure from those that they care for:

I mean the user goes into the surgery. Doesn’t pick up a leaflet … you can go in to accompany them and you can’t … You just sit there and you can’t pick up a carer leaflet [whispers, imitating the user] ‘Can’t pick up a carer leaflet, these people will know I’m being cared for’ … you just sit there in the surgery looking at all these leaflets and nobody says ‘Look have you got a carer? Take this to them’. (Informal carer, Inverness, 10 May 2001)

Whether a carer self-identifies as such or not, they nonetheless have important roles in negotiating relationships between those they care for, formal carers and the rest of the community. In the former case the relationship can be difficult in the sense that there are few alternatives should the carer feel that adequate levels of input are not being achieved. For example, given what we have already said about Highland medical practitioners often wishing to provide care in local communities, we have found from some carers a feeling that they have to battle to gain access to specialist medical expertise and alternative forms of care:

We had seven years of Betty’s illness—and we had most of these years knowing that Betty had some sort of a mental illness, but to have it diagnosed was horrendous, I could write a book on how difficult it was, looking back I hardly know how we survived it … the GPs were very good to her and they were very good to us, but they weren’t of the opinion that Betty should see a psychiatrist … I had to fight for that … They said it was teenage thing and that they would give her medication and that things would sort themselves out … I had to actually beg to get her to see a psychiatrist. (Informal carer, NWS, 24 July 2001)

This experience is replicated in other narratives, especially where a diagnosis is disputed. For another carer, Elsa, this has meant hours of research, trawling Internet sites, contacting researchers elsewhere in Britain, debating with the CPN and sceptical local doctors her ideas about her partner’s diagnosis. The phenomena encountered here by both carers may not be entirely specific to the Highlands, but the frustration for these people is perhaps intensified by isolation from sources of *alternative* expertise and information because relevant specialists are located miles away in Inverness.

It is not only the difficulties of accessing appropriate specialist services that confront informal carers, it is also the attitudes of other community members once such care is received. For some interviewees, this means meeting with significant levels of community disapproval:

I think initially when she went into Craig Dunain [the asylum] some of my husband’s family and other friends really turned against me for the fact that she had gone into Craig Dunain. They felt they had only
seen this very nice little old lady who presented when they visited, one day a week, one day a month, whatever and it upset them greatly that she went into Craig Dunain. But that was about them. They couldn’t handle her being in there. They obviously felt there was a stigma attached to it or whatever. (Informal carer from Coll, Inverness, 14 May 2001)

Given such experiences, and the strong perception of this sort of outcome, some carers attempt to mediate the relationships between the person they care for and the wider community in ways that ‘limit’ their difference, and perhaps keep them out of specialist services. Consider the following exchange between Elsa (carer) and Steve:

Elsa: He’s well known for doing weird things in public places. [laughs]
Steve: Not so much now, though.
Elsa: I’ve tamed him a bit, I mean there are some things that aren’t acceptable—you know what I mean ... You have got to learn to sort of fit in, blend in a bit. (User and carer, NWS, 11 July 2001)

The burden of care for the informal carer lies not just with meeting the needs of the person who they care for on a daily basis, but also involves complicated negotiations of (sometimes hiding) their own role, access to specialist services and the perceptions of the wider community.

There is clearly a need for carer support services in rural and remote parts of the Scottish Highlands (especially for incomers who cannot always be assured of family or community support), or at the very least an informal collectivity between carers who live in the same areas. Here there are perceived benefits as well as barriers to these sorts of activities, as witnessed by three different carers below:

I went to the support meetings and I would phone them up and I got a lot of help, practical help, basics of dealing with the system, knowing the ins and outs of it. I didn’t get personally involved with other carers but I needed a group to support me because I felt very isolated. You start to question yourself, am I making the right decisions, where am I in all this? (Informal carer, Inverness, 10 May 2001)

Well, it is very difficult here as they have them in Wick and mostly they have them in winter time so you’ve got the travelling ... I went to three probably and I did find that very good ... hearing the same problems. (Informal carer, NWS, 24 July 2001)

Steve: I’ve even contacted the Scottish Association for Mental Health, and there’s no help or support for partners or carers, their mental health, there’s absolutely no support for them at all.
Chris: There is actually a Carer’s Association ...
Elsa: Yeah, they’re not much good, though ... They’re not much good.
Chris: ... based in Inverness?
Elsa: They are, yeah, everything’s based in Inverness.
Chris: ... which is one of the problems, there’s not much here is there?
Elsa: Yeah, well ... the thing is, you couldn’t actually start anything here, because what is needed here is, like, a very revolutionary type of women’s group ... where women start to talk about these issues and demand what they need, yeah, and demand what I need when I’m in a position where I’ve got someone with a mental health problem who is attacking me. (User and carer, NWS, 11 July 2001)

Elsa’s suggestion of the need for ‘a very revolutionary type of women’s group’ is intriguing, and may point to the need for further reflection on gender and mental health in remote locations as indicated earlier. What this latter exchange also reveals, though, is the simple concern that there is basically nothing available locally formally to assist informal mental health carers such as Elsa, and there is a sense
from all carers that both regional and national carer organizations are failing those in remote areas. These difficulties with providing formal assistance to informal carers is inevitably tied up with the distinctive social and cultural norms that we have already highlighted. The absence in particular of carer collectives is linked to the relative absence of both client/user and carer ‘identities’ and ‘politics’, and this is a distinctive feature of the wider social and cultural geographies of caring in the remotest rural localities. The brute facts of ‘physical geography’ are obviously relevant here: namely the difficulties of getting together people who may live many miles apart along poor roads, treacherous ones in the winter, and whose mental states or caring commitments will often make it near impossible for them to leave their homes for any length of time. A full explanation, however, will also need to encompass certain cultural aspects of the local communities which render them actually quite weak as resources for caring, despite—or possibly precisely because—it is the case that these are close-knit communities where social familiarity exists alongside spatial fragmentation (to return to bigger themes introduced earlier).

Conclusion

In trying to explain the complex issues involved in caring relationships in rural areas, many users and formal and informal carers return again and again to gossip networks and to the social proximity and visibility that characterizes social life in this part of the world. These factors are often evoked as part of an explanation for why both carers and users of mental health services would not seek care or support from the wider community in general (although this is not the case for all of our interviewees). In these interviews we were also told lots of local gossip about suicides, sexual abuse, rape and the mental health problems that accompany these tragic tales. And yet when asked, in several different ways, if any of these well-known events had produced any examples of community intervention or collective caring practices, the answer was usually a regretful and reflective ‘no’. The barriers to more collective practices of caring (through supportive groups, organized community networks) and more open care relations (for both formal and informal carers) hence seem to be structured in part by a geography of fear—a fear about what would be said or done by other community members if caring relationships or acts were more widely acknowledged and known. This material may also suggest that, while there is indeed a lot of social familiarity based upon gossip that spreads local knowledge of virtually everybody’s personal, social and emotional business in rural places, this gossip seems relatively empty of emotional resonance and care. For some of our interviewees, then, there was a perception that rural ‘community’ seemed not to coincide with an emotional openness to the substance of mental ill-health and care, and seemed devoid of collective forms of caring for those affected by mental health problems. As is highlighted above, this means further isolation for informal carers, as they are reticent about involving or utilizing wider community members by way of support. In various respects, Steve and Elsa illustrated the veracity of such a claim, both in general and with specific reference to mental health issues:

Elsa: [T]hey only look after people when they’re nearly dead or after they are dead up here … The nearer death you are, the more special you become …

Steve: They care more for you after you’ve died than they do before that … If you’re dead, everybody’s
'oh, what a nice person they were, and all the rest of it' ...
Chris: ... you wouldn’t say that the community around here was supportive of you, in any way, to help you to come to terms with having some sort of mental health difficulty?
Elsa: No, far from it.
Steve: Quite the opposite, quite the opposite. (User and carer, NWS, 11 July 2001)

We have clearly only begun to scratch the surface of the spatialities of caring in relation to mental health problems in regions like the Highlands, but the core of what we are arguing is that the rural geographies involved—very much interleaved physical, cultural and social geographies—engender particular caring practices seen in both formal and informal caring relationships. This squares with other research findings on rural health cultures where it has been noted that ‘peoples in rural areas construct unique cultural knowledge about health and health care which affects their linkages to the available mental health services’ (Hill 1995: 556). It is still debatable how ‘unique’ caring relationships are in the rural Highlands of Scotland, since they certainly share characteristics with ones found in, for example, rural Australia where ‘self-reliant and stoic ... rural and remote cultures’ (Fuller, Edwards, Proctor and Moss 2000: 149) help define access to and acceptance of mental health care practitioners. All of this means that, despite countless small acts of caring which can be identified in the Highland region, fostering ‘care in the community’ for people with mental health problems is proving really quite difficult. We already know that achieving good community care in urban and suburban areas is hard work, and that physically proximate people cannot easily be rendered socially proximate in their everyday treatment of neighbours with mental health problems. It might be assumed that the task would be easier in ‘idyllic’ rural places and communities, given supposedly Gemeinschaft-like characteristics which mean that there is a pre-existing nexus of social proximity and closeness. In practice, however, such social proximity appears not to be automatically productive of caring for people with mental health problems: indeed, it is perhaps that the very nature of this social proximity is itself militating against producing a more inclusive environment for people with poor mental health and the people who care for them.

In future geographical research on social geographies of caring in rural and remote places there are many questions which remain to be answered. It is clear from this short paper that there are gendered dimensions to caring in such locations (indeed most community nurses and informal carers were women) and as such this needs further interrogation, not only in respect to the gender of carers but also in respect to the gendering of caring acts which occur outside of established caring relationships. Much of this paper hints at the ‘care’ which operates within and between community members on an everyday basis—what Laurier, Whyte and Bucker (2002: 352) would call evidence of ‘good neighbour’ in which ‘rights and obligations are reflexively tied to ... settings’—and, although we have been largely negative about such wider caring relationships above, they undoubtedly do occur and need more consideration to understand fully what ‘community care’ can entail and can also be made to entail in small remote places.

Despite wanting to contribute to the building of a research agenda for ‘geographies of caring’ by drawing on the work of other researchers, it is clear that this paper is largely empirical, and as such there still a need to theorize care in rural geographies. We would like to suggest, via our contention that social proximity may itself be militating against more inclusive caring
relationships, that there is a place here for psychoanalytic thinking, where certain ideas concerning self–other relations (like, for example, Freudian notions of unheimlich as explicated recently by Wilton 1998) may help to explain why close neighbours seek to distance themselves from the full disturbing reality of mental health problems and the care which has to surround these. Wilton (1998) and Sibley (1995) suggest that a key dimension to geographies of difference is the fracturing of assured self-identities that in turn fuel spatial separations from threats that are perceived to destabilize those identities. Wilton’s adoption of the notion of unheimlich specifically points to the problem of social and spatial proximity (to illness, death and strange behaviour) which can cause ‘uncanny’ (familiar) human memories of times when self-identity was not assured and stable (if it could ever be). This proximity (in this case to people with mental health problems), and the instability it can provoke, could be argued to be a key explanatory feature of social geographies of inclusionary or exclusionary practices in rural places, and therefore this concept could be examined and extended in future research.

To return to some of the introductory comments to this paper, there is clearly a need in human-geographical research to spatialize notions and practices of caring in ways that go beyond mapping exercises. Geographers have begun this task, although they have perhaps so far neglected some aspects of the complex social relations of care-giving. In this paper we have attempted to redress this imbalance, but in doing so we have raised even more questions for future research agendas in rural and social geographies of caring: there are many more too, but we hope that this paper goes some way to setting the scene for why such questions should matter.

Notes

1 The majority of the empirical materials for this research were collected with the help of our research assistant Nicola Burns.
2 By ‘formal care’ we mean state and voluntary sector-funded care relationships and care that occurs in institutions like day care centres and drop-in facilities and so on. ‘Informal care’ refers to family, friends or neighbours who provide essential daily care support for other community members.
3 ‘Community care’ can be a term used to signify the dispersed organization of formal care services. The different but associated phrase ‘care in the community’ can be argued to encompass the informal ways through which families, friends and neighbours assist each other in daily life. With reference to informal mental health care, this can mean supporting people to take medication on time, helping to attend appointments, a commitment to ‘watch’ or ‘mind’ individuals on an hourly or daily basis, and a willingness to ‘look after’ them when they are feeling ill. These differing processes are implied in some of the quotes in the paper, and certainly should be differentiated in a theoretical exploration of ‘caring’, although we do not have space to fully elaborate them here.
4 ESRC-funded project: R000238453.
5 There are other individuals and agencies involved in the care provision for people with mental health problems in the rural Highlands including psychologists and voluntary-sector out-reach workers. However, these were rare in the study areas that constituted this project and hence do not feature in this discussion. Voluntary-sector provision was mostly centred in and around three drop-in centres in Skye, Inverness and NWS (the National Schizophrenia Fellowship Scotland being a key provider in this area). Religious and church-based networks for support in rural and remote parts of the Highlands are notably lacking, and this may be because of particularly strict versions of presbyterianism which discourage strong displays of emotion in some Highland places (hence contributing to the non-development of church-based support networks for psychological and emotional difficulties). For background details to support this claim, see our findings paper ‘Highland economy, culture and mental health problems’ on the project website: http://www.geog.gla.ac.uk/Projects/WebSite/main.htm.
6 Nicola Burns collected data for Skye, Easter Ross and Inverness with support from the authors.
Each area studied had one voluntary-sector mental-health drop-in, except for NWS which had no collective provision of this sort.

Edinburgh is the centre for national-level decision-making and policy frameworks, whereas Inverness is the centre for regional resource allocation decisions and health and community care planning.

The general claims that contribute to a ‘picturing’ of Highland social geographies are supported from in-depth analysis of interviews with users of services. For a series of findings papers that elaborate and substantiate these themes, please see http://www.geog.gla.ac.uk/Projects/WebSite/main.htm.

We use this term as it was one adopted in interviews by those people who had long connections with an area and were self-consciously part of family groupings which claimed links to past generations of Highland dwellers. The term ‘local’ was also used alongside ‘indigenous’, and this semantic device is one used to separate off an ‘authentic’ place-based identity that was seen as different from those people who have migrated to the area (and who are termed ‘incomers’, or ‘white settlers’). It should be noted that, even if migration to the Highlands occurred twenty to thirty years ago, some families might still be identified as ‘incomers’ and hence different from other ‘local’ parts of the community. See also Jedrej and Nuttall (1996).

Whilst these gendered dimensions of caring may be replicated in urban areas, there are specific issues which influence some aspects of gender relations and caring in Highlands places. These are partly related to the common use and abuse of alcohol amongst men as part of dealing with and covering up mental health issues. The strong masculinist norms that characterize social life in this region and contribute to excessive drinking cultures mean that women are routinely positioned as caring for men who drink. This ‘care’ may be constructed in multiple ways, ranging from ‘looking after’ men in inebriated states, to cleaning up the physical consequences of excessive drinking, to ‘mending’ damaged social relationships as a result of drinking and ‘watching’ men through phases of ‘drying out’. As a result, women in Highland places are often already routinely engaged in specific caring roles, ones unacknowledged by individuals and communities.

Steve has occasionally attacked Elsa when experiencing acute phases of his illness. Local police have attempted to charge Steve for such attacks, despite Elsa’s protestations that all she requires is protection at such times.

References


**Abstract translations**

*La santé mentale en région rurale et les géographies sociales du bien-être humanitaire*

Cet article se veut une contribution à la littérature émergente sur les géographies sociales du bien-être humanitaire. En s’inspirant d’un travail empirique récemment dans les Highlands en Écosse sur la procuration des soins de type formel ou informel, une évaluation de récits de gens souffrants de maladies mentales est effectuée. La notion du « bien-être communautaire » est critiquée de même que l’affirmation voulant que les régions rurales ou celles qui sont encore plus reculées engendrent des formes particulières de rôles d’entraide, de pratiques et de rapports sociaux. Il est démontré que la distance géographique, la proximité sociale, les cultures stoïques et les propos de commères retrouvés en région rurale contribuent tous au bien-être humanitaire dans ces milieux. Cet article se termine en suggérant des pistes de recherche à suivre.

**Mots-clés:** santé mentale, pratiques de bien-être humanitaire, rôles, rapports sociaux, soins de type formel et informel.

*Salud mental en sitios rurales y las geografías sociales del cuidado*

Este papel forma parte de una emergente literatura geográfica sobre las geografías sociales del cuidado. Hacemos uso de trabajos empíricos elaborados en las tierras altas de Escocia para evaluar relatos particulares sobre la provisión de cuidado, tanto formal como informal, para individuos con problemas de salud mental. Hacemos la crítica de la noción de ‘cuidado en la comunidad’ y también de afirmaciones sobre como sitios rurales y sitios remotos y rurales engendran configuraciones particulares de modelos de cuidado. Demostramos que tanto la distancia geográfica, como la proximidad social, culturas estoicas y redes de cotilleo rurales afectan el modo de cuidado en este tipo de lugar. Concluimos por sugerir temas para futuras investigaciones.

**Palabras claves:** salud mental, cuidado, papeles, relaciones, cuidado formal e informal.