

Midlife women's experiences of seeking help for psychological distress in rural Australia: an overview

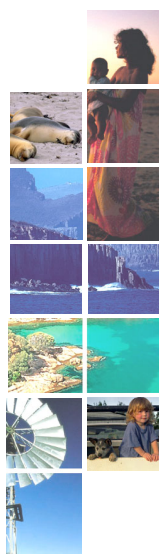
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Mental health problems cause a substantial burden of morbidity, disability and mortality (Judd 1996). While many studies have concentrated on the social and economic costs of severe mental illness such as schizophrenia, others have emphasised the costs resulting from affective disorders (Croft-Jeffreys and Wilkinson 1989; Johnson, Weissman et al. 1992). Prevalence rates vary, but it has been estimated that one in five Australians will suffer from a significant mental disorder in their lifetime, with anxiety and depression being the most common. The Australian National Mental Health Survey (SMHWB) found an overall 12 month prevalence rate of mental disorders of eighteen per cent in the adult population (McLennan 1998).

This paper examines the broad area of psychological distress rather than any one specific mental disorder. High self-reported six-month prevalence rates of stress (56.6%), anxiety (53.1%), and depression (45%) have been reported in Australian women (Redman, Hennrikus et al. 1988). Community mental health surveys have shown 2:1, sometimes even 3:1, female to male ratio of depression and anxiety (Blazer, Kessler et al. 1994) and women in midlife have been found in some studies to have higher prevalence rates than in other age groups (Royal College of General Practitioners 1986; McLennan 1998). There are widely held beliefs by both professionals and women that women in midlife have high rates of psychological distress, attributed either to the biological changes of menopause (Avis and McKinley 1991), or life-stage changes such as "empty nest syndrome" and caring for elderly parents (Bozic, Hermann et al. 1993).

While the relationships between mental health and the broader social and demographic factors are important, it is also important that knowledge about mental health problems is informed by the people who are most acutely involved: those who have experienced these problems. It has been noted that the voices of these people are almost entirely absent in the published scientific literature, except in anecdotal form (Walters 1993; Small, Brown et al. 1994; Karp 1996). We know little about what women expect of professional help. This research set out to fill this important gap, especially in relation to rural women.

This paper is part of a larger project, my doctoral thesis. In this thesis I also reported sociodemographic and health related variables on the 14,000 midlife women in the baseline survey of the Women's Health Australia (WHA) project. For this paper I will be concentrating on the interview data of a smaller number of women.



METHODS

Data collection

The data used in this paper comes from three sources:

- a cross sectional study of 14,000 midlife Australian women (aged 50–55)
- semi-structured telephone interviews with a random sample (400) of women in the above study who had low mental health scores on the mental health index of the SF36 and who lived in NSW
- follow-up (after 4 years) in-depth interviews with 3 women from different backgrounds, chosen because they illustrated common themes in the study.

The semi-structured telephone interviews, conducted 4–8 months after the main survey, explored the perceptions of a smaller group of women: their descriptions of their feelings, their perceived causes for their distress, their perceived reasons for feeling better, their strengths in adversity, what they did to help themselves, who they spoke with in the informal and professional arena and their perception of the effectiveness of that help. Most of the questions related to the most distressing episode in the past 12 months. Qualitative and quantitative data were collected and analysed. The quantitative data mainly related to experiences in the past year, however in telling their stories women talked about their experiences over many years and the qualitative data reflects this. I concentrate here on the experiences of rural women seeking professional help.

Analysis

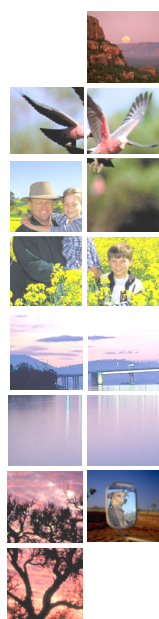
Quantitative data from the semi-structured interviews and cross-sectional survey described above were coded and entered into a computer data base and then analysed using the SAS Software program (SAS Institute Inc c1990).

Qualitative data. The comments made by the women in the context of the interview were written down as they occurred. Seven domains were chosen in which to organise the comments: help from partners, help from friends, help from relatives, doctors and psychological distress, seeking professional help for personal and mental health problems, medicines and psychological distress, and other help women would have liked. The data were typed and entered into a Word database within each domain. The comments were read and re-read and analysed to generate themes in each domain, using the “constant comparison method” (Strauss and Corbin 1991).

RESULTS AND DISCUSSION

Respondents

The characteristics of the respondents in the national survey have been described elsewhere. For the substudy, data were analysed on 322 completed interviews, giving a response rate of 81%. The women in this study were not a homogenous group. They came from a wide range of different backgrounds and living situations. For instance,



one respondent had been earning over \$100,000 per year as a senior executive in a government department, while another was working as an Aboriginal health worker (a low paid position) having been married and given birth to her first child at 14 years of age. One of the most important characteristics of this sample is that over half (57%) came from rural or remote areas, over twice as many as in the Australian population (27%). This was not because the women in rural areas have poorer mental health than women in urban areas (there was no significant difference in mental health scores) but because women in rural areas were deliberately oversampled in the initial WHA base line study so there would be adequate data to make recommendations about rural women. This group which has been overlooked in previous studies about women's health.

Proportion of women talking to professionals

Two-thirds of women interviewed (n=215) had talked to a professional helper about their difficulties in this recent episode of psychological distress. GPs were the single most common person seen (52%), while 32.5% of women (n=106) had sought help from a mental health professional (psychiatrist, counsellor, psychologist or social worker). A summary of the professionals women talked to shown in the table below.

Table 1 Type of professional help *

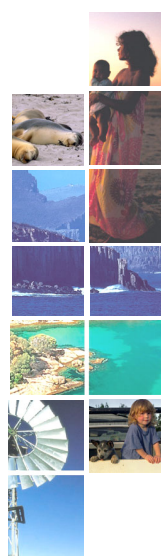
Professional help (n=215)	N	%	(95% CI)
General practitioner	159	52.0	46.4–57.6
Counsellor	53	17.3	13.1–21.5
Complementary therapist	47	15.3	11.0–19.0
Psychologist	34	11.1	7.6–14.6
Other doctor	27	8.8	5.6–12.0
Psychiatrist	27	8.8	5.6–12.0
Minister of religion	25	8.3	4.9–10.9
Self-help, support group	2	7.2	4.0–9.6
Welfare, social worker	17	5.6	2.7–7.7
Other eg hospital outpatients	40	13.0	

*Relates to help sought for an episode in past year.

Rural women seeking help

Difficulties in accessing professional help

Although the quantitative analysis indicated geographical status was not a significant predictor of the use of general practitioners or specialist mental health professionals women living in rural areas consistently talked about the difficulties of getting help. They complained more than urban women about their GP encounters – lack of GPs, long waiting times and closed books. In the WHA Survey 1, rural women in this age group were less satisfied with health care than urban women (Young, Byles et al. 1998), but there were additional complaints about getting specialty mental health care. The obvious one is the lack of local services and having to travel hours to get help. While few women said transport was a difficulty in answer to a specific question on barriers, having to travel long distances – two or more hours one way in some circumstances – was a difficulty for some women. Most had access to private transport as they were probably in the age group most likely to be able to afford a car and able to drive. Transport could be of greater concern for the less affluent or much



younger or older age groups. Some services such as specialist psychiatric care come to a town only once per month. These inequalities in health resources have been increasingly documented, particularly for serious mental disorders (Australian Institute of Health and Welfare 1998; Sidoti 1998).

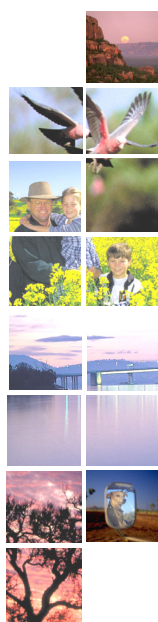
The more common aspect of rural life commented upon was the lack of privacy and the fear of lack of confidentiality in seeking help in small towns where *"everyone knows everyone else's business"*. It is perhaps obvious, but still important to emphasise, that it is the stigma of psychological ill-health that makes this situation such a problem. The doctor's children may go to the same school as your children, the receptionist of the only GP in town may be your neighbour, the nurse may be the local policeman's wife – all situations women complained of when talking about seeking help in country towns. The implication was that if these people were to know about the woman's emotional or psychological difficulties she would feel judged and found wanting. The situation seemed to be exacerbated, not relieved, by mental health services being offered through community health centres (CHCs). Although some women complained that counselling services were not available through CHCs or that they had too long a wait, many women were constrained to use them because of these fears about lack of confidentiality. The many people involved in a CHC increased the possibility of others *"knowing your business"* and it was obvious when one has an appointment with a psychologist, psychiatrist or counsellor that the reason is in the psychological or mental health rather than physical illness category.

Seeing a GP can potentially make it easier for women to access help for psychological problems without having to announce the state of their mental health. Concerns about the lack of privacy were not restricted to clients; one GP recommended a woman patient see a private, rather than public, psychologist *"because they are better able to maintain confidentiality in a small town."* One woman said that she had to travel 2.5 hours return to see someone, but this wasn't a barrier because she had her own car and enough money, but *"in a small town privacy and confidentiality are issues."* Confidentiality and privacy was one of the six main health-related concerns reported by women in rural communities in the Great Southern Region of Western Australia (Bishop, Pelligrini et al. 1993). Recommendations were made about increasing the training of health care workers in aspects of privacy and confidentiality that were particularly appropriate for rural women.

The words of this woman succinctly describe the situation.

I said "I'm stressed. I need something." We both sat there tapping our feet. We were embarrassed because I just couldn't talk to him. He was going to give me some relaxation tapes but didn't. Dr. Doolittle, I call him. ... (I) only went once. ... (In a) rural town, everyone knows everybody. Even when I went, everyone knew everyone else's business and I was embarrassed to talk to them in their rooms. Couldn't really talk to him, he's a friend. Even friends, you just can't sit and talk to friends in a small town.

Another group with particular difficulties identified in this study were health and welfare workers and others with a high community profile, especially those living in rural areas. They included nurses, psychologists, social workers, a prominent member of local government, a member of a religious order and a senior government bureaucrat. They often had the advantage of knowing what services existed, although even this was by no means universal. One woman pointed out how she worked in the (health) system and still did not know where to go, *"so it must be really hard for other people"*. People working with physical illness, as most nurses do, were often not aware



of mental health services. However, it was mainly the stigma, the fear of being seen as not coping, of needing psychological help which diminishes one's worth in a society that values independence and individual strength, that was related to the barriers. Examples from the following three women illustrate this.

Because I work at the hospital, I felt embarrassed with colleagues and in a small town people look on you as weak if you need counselling.

As a psychologist, it's hard to get help, people don't notice, they expect you to cope. It's not quite right for you to get help.

It's not that I think they'd break confidence, but because it's a small town and I work in Community Services, I know everyone professionally and socially.

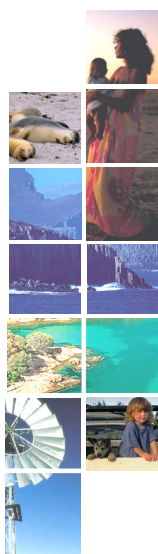
Beliefs and attitudes prohibiting professional help-seeking

A minority, but important number nonetheless, of women said they would never seek help, especially not mental health care. The main themes which emerged from the analysis of these comments were: you've got to solve your own problems; emotions are private and should be kept to oneself/in the family; no-one can understand unless they have been there themselves; don't believe in therapy; people will think badly of me. Some women expressed beliefs that incorporated more than one theme and a small number were ambivalent about seeking help

For some women privacy meant talking to no-one, others would talk only to their family, or sometimes friends. Many women alluded to the way they were brought up to explain why they would not seek professional help "I was brought up in the bush" as well as more personal explanations "I'm not the sort of person to talk about private things" and "I wouldn't like to talk to someone I don't know. Mostly, I've battled on by myself. It's been hard." There were also examples given of the pressure from significant others to keep problems within the family. Husbands and other members of the family worked to prevent women from accessing help. One rural woman said that her in-laws, particularly her father-in-law, would not hear of his son having marriage guidance counselling and as they were living on a family farm this made the necessary travelling almost impossible.

Dissatisfaction with general practitioners

Because of the pivotal role of the GP in the Australian health care system, the large number of women who consult GPs on a regular basis and the dominant place of biomedicine in the conceptualisation and treatment of mental health, it is important to consider the experiences of women and GPs. The broad themes which emerged in this study were: structural aspects of the encounter (time, access and money); caring and communication; GPs' lack of interest and lack of knowledge and skills in emotional areas; women's choices and actions in response. Several themes were often present in the one interview. Two hundred and forty-seven women talked about GPs and although there were some positive reports, most were negative. This was particularly true for rural women. Even though the respondents were approximately equally distributed between urban and rural areas, more women from rural areas (151:95) expressed dissatisfaction with GPs in all the above areas, supporting previous research (Sidoti 1998; Young, Byles et al. 1998). In the main survey, a higher proportion of rural and remote women rated their satisfaction with their last GP visit and the cost of the visit as fair or poor compared with urban women (Young, Byles et al. 1998). Rural women in this study had additional concerns about the difficulty of changing GPs if



unhappy with the service, the lack of confidentiality in small towns and the stigma associated with mental ill-health.

Women reported being quite active in response to their dissatisfaction with GPs. Some persevered, giving feedback to the doctor with one woman saying how she “trained him” after he did not respond appropriately to her problems. Others “shopped around”. Some women, dissatisfied with the lack of holistic care and the failure to find a sympathetic doctor turned to complementary therapists such as naturopaths. “I don’t talk to her (GP) because of past experience and have found alternative therapies better. Once I got away from the doctors, I’ve felt better.” This dissatisfaction is reflected in the high numbers of women who sought help from complementary practitioners,

Geographic location was not a significant predictor of using professional help

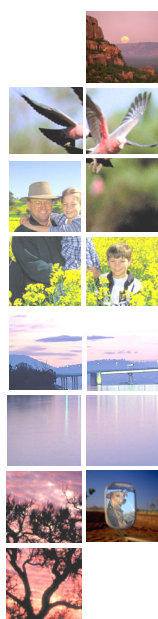
Interestingly, geographic location was not a significant predictor of the use of general practitioners or specialist mental health professionals in this study. While this replicates epidemiological studies conducted overseas, this result was unexpected in the light of the results of SMHWP (Parslow and Jorm 2000) and other Australian reports clearly showing inequalities in the availability of specialist mental health services in rural areas (Sidoti 1998), as well as dissatisfaction with health care by rural women (both in this study and others). This result may be due to the broad definition of rural and/or the possibility that although the woman did get to see a health professional, the outcome could have been that she only saw them once, or less often than would have been therapeutic. There is some support for this idea in that some women said that it was not so much getting any help that was a barrier, but finding the *right* person. The reasons for this could be in the lack of choice in finding a more suitable therapist, or the lack of availability of the service when needed. The qualitative data back up the reports of difficulties for rural women and without these data a much more complacent picture would have emerged.

Case studies

The themes in the stories of the three women reinterviewed after 4 years were generally the same as those found in the analysis of telephone interview data and in the supporting literature: multiple adverse life events; perceived negative attitudes toward people suffering psychological problems and psychiatric treatment; the perception that GPs are primarily there for physical illnesses; long waiting times and short consultations in busy country general practices; the shortage of psychiatrists in rural areas; the use of complementary health practitioners for holistic care. Of the three women one lived in a metropolitan area, one in a small regional centre and the other on a farm. It is the latter woman, Barbara, whose story I will now discuss.

Barbara

At the time of the initial interview Barbara was a 49 year old married woman with two “children” (aged 12 and 22 years) living and working a family farm with her husband and sons in western New South Wales (NSW), 270 kilometres away from the nearest regional centre. Barbara’s story is typical of that of many midlife women for whom their family (parents, husbands and children) are sources of stress. In this case there were multiple stresses, not least of which is life on a farm with increasing costs and falling commodity prices. Her mother had died two months before, her husband had



experienced a nervous breakdown in the past year, her 12 year old son was having behavioural problems and farm costs were high and income low, causing financial strain. She described her emotional state as “worried a lot of the time”, “stressed” and “tired a lot of the time”. Barbara’s main strategy to cope with her difficulties was to keep busy, working physically hard.

Because her husband had his own problems she did not discuss the way she felt with him. Friends were there, but she did not talk to them because “a lot of people don’t understand about a mother dying.” Barbara had not talked to any GPs or mental health professionals about how she was feeling. The one health professional she did see was a chiropractor for a wide variety of conditions, in whom she had great faith. This involved a round trip of 500 kilometres.

Oh, just mainly tried to cope on my own ... no one sort of understands. ...all my friends, most of my friends, are not on the land ...I’ve really only got a handful of really close friends... they don’t understand how you feel, they don’t. Because... they’re not going through what you’re ... Well I mean we’re watching the sky day and night in the summer time to get our crop off.

When Barbara was specifically asked whether she had consulted a counsellor or similar person for help for her problems she said

No. No, because there’s no one really out here that can do it, that I know of. I mean the doctors you can wait for three or four hours to see them in there anyway. So I mean by the time you get in there you’ve forgotten ...why you wanted to go and see them.

The closest GP was in a town 29 kilometres away, and the closest professional help for psychological or emotional problems was probably in the regional centre about 250 kilometres away.

We’ve got two (doctors)... we’re hoping, and I believe now we’ve got a third one. But ... it covers such a big area ... you can wait up to three or four hours there and think nothing of it... ...they’re so tired, poor things.

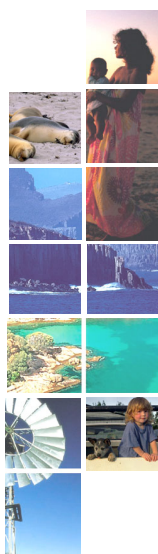
I asked Barbara what counselling or other sort of help there would be in the closest town.

I know the school’s got one. But I don’t know that we’ve got a, just a straight out counsellor.

Talking about counselling. Probably the best person I talked to was a chiropractor in __ (large town 250 kilometres way). He is a counsellor. And he is excellent. He says (that) I’m extremely stressed. I’ll often ring him up and say ... what am I suppose to do about this, this and this? And he says, “well hang on I can tell in your voice that something’s the matter.” ... And he is a proper counsellor, psychiatrist as well as a naturopath and a chiropractor. So ... he would be about the one I talk to most. ... I’ve a lot of confidence in him and I can talk to him about lots of things...

Women like Barbara do not expect mainstream health services to help them with their life problems. The low expectations of care by country GPs – shortage of doctors, long waiting times and lack of time for emotional health issues – would appear to be realistic (Consumers’ Health Forum of Australia 1998; Sidoti 1998). Like many women of this age in both rural and urban areas, complementary therapists, such as the chiropractor seen by Barbara, are an important part of the health care system (Lloyd, Lupton et al. 1993).

Barbara has experienced many adverse life events in a short period. While it may seem unusual for one person to have had so many, these were common problems experienced and appeared typical of many of the women in this study. Barbara shows



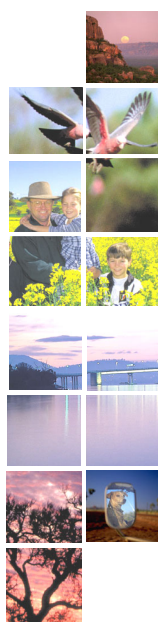
the qualities of many women in this study who said that their strengths to cope with adversity lay in their family, their sense of optimism, and knowing others were worse off. She said that they were lucky to have their sons to help them and she was really quite well off compared to women who were on really isolated farms. The relative isolation felt by rural women and their alienation from urban dwelling Australians was shown in her response to being asked if there was anything else she would like to say or ask. *"Thanks for caring about rural women. City people don't usually."* she answered. Her non-complaining acceptance of the distances to be travelled to large towns to access medical and other assistance was astounding to me, an urban dweller. I actually asked a couple of times to verify the name of the town where her chiropractor practised – a 500 kilometre round trip to her main health practitioner!

CONCLUSION

There are numerous contradictions both in the literature and in the results of this study in regard to mental health and rural women. The women themselves are reporting high stress levels, due to economic changes (Bishop, Pelligrini et al. 1993) but random community studies have failed to find differences between urban and rural women either on self-reported stress levels (Brown, Young et al. 1997), or mental health (Outram 2002). Although rural women consulted a variety of health practitioners the GP was the most frequently consulted and could provide a service that did not automatically stigmatise mental health problems. However improvements are needed in GP services at both an individual practitioner level (attitudes, knowledge and communication skills) and at a structural level (lack of access because of shortages of GPs). Some complaints of rural and remote women are difficult to address because of the perceived stigma and the lack of privacy.

RECOMMENDATIONS

1. Government rural initiatives should be supported and extended. For example, strategies to increase the number of GPs who stay in rural areas for longer periods and better access to specialist mental health services. Support services for people experiencing adverse events such as bereavement, divorce, cancer diagnosis and treatment and caring for chronically ill relatives should be available when needed.
2. Wide choice of strategies. If we accept that there are multiple causes for women's psychological distress in midlife, we need to ensure there are multiple strategies available to help them – pharmacological, welfare services, respite for carers, counselling from a range of therapists. There are many people who by their cultural or personality attributes will not benefit by self disclosure and talking therapy and they should be accommodated.
3. The effects on women's mental health as a consequence of the downturn in the economy of the Australian farming sector and associated rural towns should be monitored in future surveys by WHA and SMHWB.

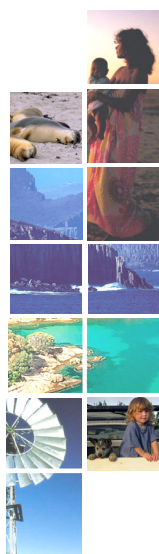


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PRESENTER

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