COMMENTARY

Mental health problems in rural contexts: A broader perspective

Response to Jackson et al. (2007) Mental health problems in rural contexts: What are the barriers to seeking help from professional providers?

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Abstract

The objectives of this article are to expand and comment upon a recent review in *Australian Psychologist* of the literature in relation to mental health problems in rural contexts by Jackson et al. (2007). In the present article we review recently published qualitative research on the help seeking attitudes and experiences of rural Australian adolescents. While we agree on the utility of the Macintyre, Ellaway, and Cummins (2002) conceptual framework based on notions of health and place, we note that this framework specifically emphasises the importance of the collective dimension. We present a broader perspective on health and place than Jackson et al. (2007) by incorporating social geographic research. We argue that rural mental health research has been hampered by a simplistic view of social stigma of mental illness and that a more thorough conceptualisation of the phenomenon is needed. Finally, we make some further recommendations based on a broader perspective of mental health in rural contexts: one that incorporates an in depth understanding of the help seeking attitudes and experiences of rural adolescents as well as an appreciation of the collective social functioning of rural communities.

In a previous edition of *Australian Psychologist* Jackson et al. (2007) reviewed literature on mental health problem in rural contexts. Based on their review, Jackson et al. noted that while several studies had investigated the predictive value of ''compositional'' factors as gender, age, marital status, and illness-related factors, psychological or attitudinal factors have been poorly investigated. They proposed that a framework based on notions of health and place could inform further research on help-seeking in mental health contexts and suggested that future research go beyond ''the somewhat crude geographical label of ''rural'' and include contextual and social network components'' (p. 154). They made a series of recommendations for improving the mental health of rural Australians based on recent gains in public mental health literacy and suggested that more quantitative and qualitative research be conducted to increase understanding of the influence of context on help-seeking behaviour.

The purpose of our article is threefold. We bring to the attention of the Journal's readership findings of several qualitative investigations involving rural Australian adolescents. These findings extend our knowledge in this area by providing insight into the influence of rural contextual factors on the help-seeking process. We also present a brief review of the literature on the social geography of rural mental health and argue that this literature has great potential to inform our understanding of the collective social functioning of rural communities. Consistent with this collective understanding, we argue that the phenomenon of social stigma of mental illness serves various social functions and that these functions need to be taken into account in devising or implementing interventions to address

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stigma. Finally, based on a broader perspective of mental health in rural contexts, we recommend more cooperative strategies for involving rural communities in mental health promotion.

Qualitative studies of help-seeking involving rural Australian adolescents

Several decades of mental health research have found that adolescence is the stage in which most mental disorders first manifest (Patel, Flisher, Hetrick, & McGorry, 2007). Studies have also indicated that delays in seeking help for mental health problems lead to poorer treatment outcomes (Conus & McGorry, 2002; Steinhausen, Rauss-Mason, & Serdel, 1991; Stephensen, 2000). Taken together, this emphasises the need for a young person with a mental health problem to seek and receive professional help early. However, this also provides a strong rationale for why mental health professionals would seek to understand the barriers to help-seeking that young people with mental health problems experience. Rural adolescents face additional barriers to professional help due to poor availability and accessibility of services in rural areas as well as the characteristics of rural communities that limit anonymity (see Boyd et al, 2006 for review). For these reasons, rural mental health researchers (including ourselves) have attempted to gain insight into the help-seeking attitudes and experiences of rural youth through the use of qualitative research methods.

In one of several qualitative studies on rural adolescent help-seeking, Quine et al. (2003) discovered some notable differences between rural and urban adolescents in their health concerns and issues in accessing services by utilising a focus group methodology. They found that contrary to the concerns of adolescents from urban areas, rural adolescents were most concerned about youth suicide and teenage pregnancy. Rural adolescents were also associated with structural differences in service provision such as cost and lengthy waiting periods, the limited choice of health professionals, and poor public transport. They also identified limited educational and employment opportunities along with limited recreational opportunities as impacting on their health.

Francis, Boyd, Aisbett, Newnham, and Newnham (2006) presented focus groups consisting of students from rural secondary schools in Victoria, Australia with hypothetical scenarios of an adolescent living in a rural area affected by a mental disorder. These adolescents identified several barriers to help-seeking that could be considered unique to rural contexts. They perceived a lack of specialist local services and the consequent need to travel to gain access to professional help. They identified the need to reveal mental health problems to another person in order to obtain transport in the absence of local public transport options. They expressed fear of social stigma and exclusion as the result of revealing a mental health problem and identified rural gossip networks as limiting anonymity. Mental health problems were perceived as a sign of weakness. A range of professionals were considered as potential providers of help by these young people, but general practitioners (GPs) were not positively viewed as a source of help for mental health problems.

Boyd et al. (2007) conducted in-depth interviews with a small number of first year university students at a regional university who in their adolescence had sought help for a mental health problem while residing in a rural town. The experiences of these young people involved a set of barriers to help-seeking in rural contexts that concurred with the Francis et al. (2006) findings. Concerns about lack of anonymity due to gossip, a culture of self-reliance whereby the acknowledgement of mental health problems is perceived as weak, and lack of knowledge about available help sources were raised by each participant. Participants who had managed to receive help discussed experiences in which their helpers had noticed their distress and had approached them to offer assistance. They expressed a clear preference for school-based help over medical help, due in part to the ability of school-based helpers to be readily available as well as a perception that the GP was not an appropriate source of help for mental health problems. Participants identified the characteristics possessed by these helpers that had made them approachable; these included being caring, non-judgemental, genuine, young, and able to maintain confidentiality.

Finally, Aisbett, Boyd, Francis, Newnham, and Newnham (2007) conducted a series of in-depth interviews with rural adolescents who had received mental health services within the context of a rural community. These young people described how lack of transport to and from the mental health service was a barrier to treatment. They also expressed frustration with long waiting lists and the remote after-hours service. Notably, they indicated that rural gossip networks and social visibility within rural communities compounded their experiences of stigma and social exclusion and explained how these experiences in particular affected their on-going utilisation of the mental health service.

In summary, the findings from recent Australian studies utilising qualitative methodology enhance our understanding of mental health problems in rural contexts in several important ways. Foremost, these studies show that the social phenomena arising from socially proximate communities create fear of social stigma, gossip, and social exclusion in help-seekers and that these factors can be seen to affect not only

the help-seeking but also on-going utilisation of mental health services (e.g., Aisbett et al., 2007). Second, access issues including poor availability of local services and lack of transport options specifically affect rural youth who are not licensed to drive. Third and contrary to the findings of rural mental health research involving adult populations, these studies suggest that GPs should not necessarily be seen as the first step in accessing mental health care and, in the case of young people, school-based counsellors need to be more fully recognised for their role in the help-seeking process.

Social geography of rural communities

We agree with Jackson et al. on the utility of the Macintyre, Ellaway, and Cummins (2002) conceptual framework for the study of health in relation to place. This framework separates compositional factors such as place of residence, age, sex, and socioeconomic status from contextual and other collective characteristics. We note that Macintyre et al. in their article proposed that:

> Since the collective properties of local residents are part of the context facing any individual living in that place, we no longer think it sensible to view collective explanations as being separate from contextual ones. However, we think drawing attention to features of collective social functioning and practice is timely in the current state of research on health and place. (Macintyre et al., 2002, p. 130)

Jackson et al. (2007) argued that the majority of research in rural mental health has focused on compositional factors, with scant attention being paid to contextual or collective characteristics of rural communities. While Jackson et al. (2007) suggested that the ideology of stoicism was an example of a collective characteristic, they gave little attention to the other, more fundamental, collective characteristics of rural communities. We would like to assert that a deeper understanding of the collective functioning of rural communities and the impact on these phenomena on help-seeking behaviour is possible through an appreciation of the work on the social geography of rural mental health (also see Boyd & Parr, in press). We have summarised this work below.

Parr, Philo, and Burns (2001) undertook a major study of the social geography of mental health in the rural Scottish highlands. That study critically deconstructed the narrative accounts of 160 users of mental health services, service providers, and carers. The work resulted in 16 finding papers (Parr et al., 2001) and several published articles (e.g., Parr & Philo, 2003; Parr, Philo, & Burns, 2004). While the findings from the work in the Scottish highlands are too numerous to mention in the present article, one of the main contributions of that study to rural mental health research is the authors' conceptualisation of rural communities in terms of social proximity and physical distance. They observed that in rural environments, community members may be separated by many kilometres yet they can be considered socially proximate in that they can have an intimate knowledge of each other's lives. In urban environments, the opposite sociospatial relationship usually exists whereby community members tend to be physically proximate yet socially distant. Parr et al. referred to this as the ''rural paradox of proximity and distance'' and described the ways in which this sociospatial relationship is responsible for both the silencing of mental health difficulties and the exclusion of people with mental illness in a way that is more pronounced than what occurs in urban areas.

Various social phenomena extend from social proximity – the fundamental collective characteristic of rural communities. In regards to help-seeking in rural contexts, a unique chain of effect exists whereby social visibility combined with the social proximity of a rural community sets into action local gossiping networks upon the event of a person being seen entering a mental health facility. Once enacted, these networks have the potential to cause the suffering individual to be a target of social stigma and exclusionary practices on the grounds of their suspected mental illness. This, in turn, leads to the person to withdraw from social contact due to fear of stigmatic reactions, potentially perpetuating stigmatic views regarding the person as different or abnormal and consequently reinforces societal practices of exclusion. Ultimately, social withdrawal compounds psychological distress and affects mental health service utilisation to the point where a poorer treatment outcome might be expected. These were precisely the observations documented by Parr et al. in their research as well as by Aisbett et al. (2007) in their study of the barriers to mental health service utilisation for adolescents in rural Australia.

Social stigma of mental illness

The third objective of this article is to provide a broader conceptualisation of social stigma of mental illness in order to better understand how this phenomenon unfolds in a rural context. First, we consider stigma as a social distancing phenomenon; and second, we argue that stigma is an active form of discrimination dependent on power. Each of these considerations has important implications for work with rural communities to reduce fear of social stigma as a help-seeking barrier.

In the Link and Phelan (2001) paper on conceptualising stigma, the authors paid considerable

attention to the dependence of stigma on the exercising of power. They argued that for stigmatisation to occur the stigmatised must be socially, culturally, economically, or politically weaker than those who engage in stigma and that the motivation for stigma is the disempowerment of the stigmatised. This notion is nicely illustrated in the following quotation from a much earlier article by Rogers and Buffalo (1974):

> To negatively label a person or collectivity is an act of retaliation for alleged deviance and is under certain circumstances an unprovoked act of aggression. To label oneself or one's reference group negatively is tanta mount to self assault. Epithets such as hoodlum, fink, whore, chicken, freak, or terrorists, racists, pinkos, and pachucos are no mere figments of the sociological imagination. As weapons of the street, as ammunition in the hands of powerful groups, they are capable of inflicting injury, since they serve to define, demean, and even destroy. (Rogers & Buffalo, 1974, p. 102)

Furthermore, when stigma is exercised by the more powerful over those who are relatively weak, the weak experience a downgrade in their social status (Link & Phelan, 2001). Status loss and discrimination are central to stigma; that is, people who are labelled are not just set apart but they are excluded from full and equal participation in society.

Historically, there many examples of how stigma is used to separate ''us'' from ''them'' (Link & Phelan, 2001) and subsequently used to justify the inhumane treatment of the stigmatised. Mental health geographers have described imagined geographies of ''us and them'' whereby ''us'' here in ''our'' patch of the world demonise ''them'' ''there'' in ''their'' patch of the world (Wolch & Philo, 2000). In rural communities, the social distancing component of stigma enables community members to limit their obligations to the mentally ill. We would argue that it is for this reason alone that the motivation to stigmatise the mentally ill is stronger in communities where access to formal services is poor.

Link and Phelan (2001) characterised stigma as a persistent predicament and suggested that changes in stigma need to be multifaceted, while also addressing its causes. Based on these principles, we suggest quite different strategies to those put forward by Jackson et al. (2007). In acknowledging that stigma is discriminatory and reliant on power, we suggest that clinicians have an advocacy role in this regard. For stigma to be broken down, those who experience it need to become empowered to fight back. Many examples of this exist in modern history, for example, women, gay and lesbian people, African Americans, and HIV-sufferers. These groups have fought public stigma by asserting their identity in the public arena; that is, by displaying power through solidarity. In terms of stigma as a social distancing phenomenon, increasing access to professional services and alternative help sources will reduce the need for the phenomenon to occur. In this regard, mental health service providers need to be work more closely with communities to overcome challenges of delivering services to smaller populations. Integrated services, school-based services, the use of non-government agencies, telepsychiatry, internet-based services all have a role to play in meeting the mental health needs of rural communities. The burden of care cannot continue to fall on the GP.

Recommendations based on a broader perspective of mental health in rural contexts

With this article we have attempted to broaden the perspective of rural mental health in Australia to include qualitative research on adolescent help-seeking as well as a fuller understanding of the collective characteristics of rural communities.

Based on this broader perspective, we suggest the following as appropriate targets for future research and intervention with rural communities. We see a need to extend help-seeking studies beyond the GP and to explore the acceptability among rural populations for other sources of professional help. We also see the importance of understanding the nature and extent of informal support networks, for example, peer support, family support, or collective community acts of caring, in rural communities in the absence of locally based services. We see the interplay between formal and informal sources of support as also relevant, and suggest that further research be conducted on family- and peer-mediated pathways to care in rural contexts.

In terms of intervention, and quite apart from the need to improve access to services more generally, we see the need to develop and evaluate bottom-up rather than top-down approaches to working with rural communities. For example, rather than import football stars to speak to rural men about mental health problems (Jackson et al., 2007), we suggest that participatory action approaches that engage whole communities are likely to be more fruitful. In this way, each community's individuality can be considered and action can be sustained; the latter being essential given the persistent nature of stigma. With respect to rural adolescents, we believe that it makes sense to target interventions toward at-risk youth to increase their confidence, self-efficacy, and ability to make ''the smart decision'' in regards to their own mental health. We regard programs that link young people to social environments and increase their social connectedness as particularly effective. Finally, with respect to fighting social stigma of mental

illness, we think that there are lessons to be learned from parallel groups in society. Action against stigma, we believe, will require more than simple improvements in public mental health literacy or other such urban solutions to rural problems.

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