

# **Rural Men Getting Through Adversity: Stories of Resilience**

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## **Acknowledgements:**

**The study was funded by the University of Southern Queensland.**

**The research team particularly wishes to thank all the participants for their support for this project. Without their assistance, the study could not have been conducted.**

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Rural men getting through adversity: stories of resilience.

ISBN 0 909756 72 4

1. Rural men – Mental health – Australia. I. Hegney, Desley.

Published by the Centre for Rural and Remote Area Health, University of Southern Queensland, Toowoomba, Queensland, Australia.

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## EXECUTIVE SUMMARY

The overall aim of this study was to identify the factors that have helped rural men to move through adversity. A total of ten men from Queensland took part in the study. Participants shared their experiences through in-depth, unstructured interviews. The transcripts of these interviews formed the basis for the construction of their 'stories'. The ten men spoke about the difficult times they had found themselves in and the resources they harnessed in order to get their lives back on track.

The participants shared a diverse range of difficulties in their lives, but on analysis it became apparent that there were similarities in how the participants overcame those difficult times. The major themes identified for this study were:

- The individual and inner strength
- Support and strategies

The individual and inner strength theme highlights the personal qualities the men in this study possessed that enabled them to regain control following difficult episodes. Qualities discussed included positive thinking, appreciation and hope, self awareness, taking control and seeking meaning in life and religion. Support and strategies were the ways these men utilised external sources for strength and direction. Most men were able to move through adversity by combining internal and external resources. The issues raised by the men which were important to getting through adversity included access to information, seeking help, treatment, talking about it, support of family and friends, being needed, lifestyle changes, taking a break and a change of focus.

The data clearly shows that the rural men in this study have the ability to deal with difficult times in their lives. Their stories will be used and shared with other rural men to give hope and understanding of how other men dealt with adversity in their lives.



# 1. INTRODUCTION AND OVERVIEW OF THE STUDY

## 1.1 Introduction

The National Survey of Mental Health and Wellbeing (McLennan 1998) identifies that almost one in five Australians will experience mental health problems within a 12 month period. Rural people, who already have poorer health than metropolitan people (Australian Health Minister's Conference [AHMC] 1999), are identified as being significantly at risk for poor mental health. For example, *Healthy Horizons* (AHMC 1999, p. 8) states: 'individual and family distress and long term care needs arising from mental health problems are a growing concern'. Additionally, the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health (Commonwealth Department of Health and Aged Care, 2000a) also identifies rural and remote communities as a priority group in need of mental health services.

When considering health in rural and remote areas, it is important to recognise that each rural and remote community is unique. It is therefore essential that promotion, prevention and early intervention initiatives are community-driven and owned in order to address individual community needs. Enhancing the capacity of communities to identify and respond to their own needs is fundamental to strengthening the capacity of rural and remote communities to be resilient to adversity.

An important group within the rural and remote community is men. According to the National Health and Medical Research Council (NHMRC) (1996), economic problems within rural and remote communities have impacted on men's mental health, with suicide and depression of particular concern.

## 1.2 Background to the study

### 1.2.1 Mental Illness and Stress within Rural Communities

According to Wainer and Chesters (2000), mental health risk factors found in rural areas include the relative poverty due to economic conditions, negative life experiences and lack of control over work, and life in general. The stigma of mental illness within small and often ill-informed groups and the introspection of small communities, can negatively effect an individual's capacity to cope when they are unwell, and perhaps more so, if affected by mental health problems (Judd & Humphreys, 2001).

A study to understand how rural and remote peoples' identification and response to mental illness influenced help seeking was conducted by Fuller, Edwards, Procter and Moss (2000). One important finding of this study was that often people did not equate individual distress with mental health problems. Problems such as financial difficulties, alcoholism or relationship issues were perceived as problems of everyday living, rather than ones which would impact upon mental health (Fuller, Edwards, Procter & Moss 2000).

These findings may also reflect a degree of stoicism and self reliance which continues to be part of the rural culture (Elliott-Schmidt & Strong 1997). The

combination of misperception of what constitutes mental health problems coupled with the tradition of stoicism and self-reliance may well increase the distress felt by some rural people when dealing with adversity. The feeling of having nowhere to turn or having to deal with the situation on their own can lead to the exacerbation of the initial stressor.

Stress as a precursor of mental illness is acknowledged in the literature, particularly as it applies to rural populations during extreme times (Kane, Blank & Hundley 1999). There are many factors that can promote stress and test the resilience of rural communities. Gillies (1995) describes three major areas of stressors and those include issues relating to the farm (drought, new legislation); issues relating to finance (high debt and uncertainty in commodity prices); and issues concerning the individual and the family (marriage difficulties, workload or physical illness). All of these variables, however, will have a different impact on rural people as not only is each rural community unique, but so are rural people.

### **1.2.2 Rural Men and Mental Health**

In general the health of men living in rural and remote areas is worse than those living in metropolitan areas (Strong, Trickett, Titulaer & Bhatia 1998). Some of these differences can be attributed to poorer health related behaviours such as smoking and alcohol consumption, as well as risk taking behaviours such as reckless driving (Strong et al. 1998). With regard to issues of men and mental health, the notion that women are more likely to suffer from mental disorder than men is disputed by the National Health and Medical Research Council in a report on men and mental health (1996). The report outlines that faced with stressful events, women tend to show more anxiety and depression and men more substance abuse and antisocial behaviour, thus the symptoms displayed by women are more likely to be conceptualised as mental illness, leading to misinterpretation about gender differences (NHMRC 1996). Another factor influencing the perception of mental health issues in men is the reluctance of men to seek out professional help. As a result of their health-seeking behaviour, men come to the attention of health services less often than women (NHMRC 1996). The evidence suggests, therefore, that there is little gender difference in the overall prevalence of mental illness in the Australian population.

In the main, Australian rural males have a higher risk of self-harm or suicide associated with mental illness. Additionally, the lack of access to treatment and follow up by specialist mental health professionals increases this risk (Brooks 2001). This phenomenon is not unique to Australia. Malmberg, Hawton and Simkin (1997) describe a similar range of circumstances in farmers in England and Wales. The spectrum of stress and its relationship to self-harm or suicide is noted. The high rate of suicide in this group is compounded by the easy availability and access to lethal methods to self harm. Again it is noted that stress related to financial difficulties and fluctuating commodity prices are a common factor causing stress. The impact on families is also noted when a variety of factors increase difficulties within the domestic environment, and at the same time, negatively affect their capacity to cope.

### **1.2.3 Depressive Illness**

Beautrais (1998, in DHAC 2000b) defines depression as 'the most common mental illness associated with suicide'. Approximately six percent of the Australian population experiences depression within a year and it is the tenth most common illness amongst men (DHAC 2001). The causes for depression are a complex combination between biological, psychological and social factors, contributing to the onset and course of the depressive illness (DHAC 2001). In Australia, the public in general knows little about depression and it is often stigmatised as a condition which the individual has total control, often leading to discrimination and social isolation (DHAC 2001).

Depression can result in a reduction in the capacity of individuals to cope in difficult times and to seek out the treatment required. Unresolved or untreated depression compounds, and is often the precursor to a range of somatic illnesses, and disintegration within the domestic environment. Other mental disorders such as anxiety disorder are experienced by almost half the people suffering from depression (DHAC 2001). The amotivation associated with the condition when untreated, impacts negatively on an individual's capacity to manage in difficult times, and to seek out professional help. The morbid thinking processes can contribute to suicidal ideation and self-harm attempts. Further, morbid preoccupation, rumination and its associated pessimism are difficult to manage in a small society where professional treatment and support may be scarce (Rohland & Rohrer 1998).

Coping with a depressive illness can affect not only individuals but also families. The breadwinner, if suffering depression, often imposes a strain on the rest of the family making it difficult for the family to be a cohesive group and thus manage difficult times. In many cases, with advances in the treatment of mental illness at all levels, many conditions can be successfully treated or managed. This management, which not only promotes better mental health outcomes for individuals, can also have a positive effect on their immediate families (Judd, Jackson, Davis, Cockram, Komiti, Allen, Murray, Kyrios & Hodgins 2001).

### **1.2.4 Suicide in the rural environment**

One tragic reality of rural living is an increased risk for suicide in men. According to Strong et al. (1998) suicide is one of the major causes of injury-related death in Australian males, with much higher rates compared to females. The cause of suicide is also different in men, with men tending to use more lethal methods such as hanging, carbon monoxide poisoning and firearms. Men from 'Large Rural Centres' and 'Other Remote Areas' have the highest suicide rates, often attributable to high unemployment, limited access to mental health services, and easier access to firearms (Strong et al. 1998). Overall suicide rates in Australia for middle aged and elderly people are declining, whereas the 15 to 34 year age group are increasing (DeLeo, Hickey, Neulinger & Cantor 2001). This trend is also seen in Queensland men (DeLeo et al. 2001).

Reasons why rural men commit suicide cannot easily be explained as 'the evidence strongly suggests that suicidal behaviour is not simply a response to single stress but related to complex and compounding vulnerabilities' (DHAC 2000b, p.4). Many factors are implicated with the increased risk for an individual to commit suicide, however the most important is the presence of mental illness, in particularly

depression (DHAC 2000b). People who have previously attempted suicide are also at greater risk of re-attempt. Often there are a number of precipitating factors or events prior to suicidal behaviour and these include relationship breakdown, a trauma in the family, financial problems, military service, marital separation or divorce, legal problems, imprisonment, interpersonal problems and disputes, sexual difficulties, moving house, school or job, or personal illness (DHAC 2000b, p.29). In relation to rural men it becomes apparent that the increase in stresses relating to their current situation such as drought and economic downturn can expand into wider problems such as family distress and personal losses.

### **1.2.5 Resilience factors**

Resilience can be defined as the capacity to move through and beyond adversity (Rogers-Clark 2002) and there are many positive influences to rural life that may contribute to mental health and enhance resilience of rural men to stresses. For example, farmers traditionally identified strongly with their land and the concept of productivity and they have enduring ties with their community.

A study by McLaren and Hopes (2002) identified that people from less populated rural areas reported having more reasons to stay alive, thus putting them at an advantage during crisis situations. The study also suggests that this finding contrasts the increase in rural suicides, but concludes that the use of high lethality methods such as firearms might also be an impulsive act (McLaren & Hopes 2002). The authors found that suicide prevention should focus on the individual's consideration for living, thus enhancing a resilient factor that already exists in rural communities.

McLaren and Hopes (2002) when comparing the rural and urban situation and its impact on an individual's inclination to suicide stated that the negative factors such as fear of suicide, fear of social disapproval and moral objection were factors that influenced this decision in terms of self-perception, and the perception of the family and the community with regard to the suicide outcome. The positive influences of survival and coping beliefs, responsibility to family and child-related concerns were seen to influence the outcome in term of the suicide intent. A shift in these dynamics is important, again in terms of outcome, when noting the availability of treatment and support services in rural communities.

### **1.2.6 The impact of rurality on treatment of mental illness**

Parslow and Jorm (2001) note a range of socio-demographic factors that influence the mode of care and treatment for persons affected by mental illness. The isolation of the rural Australian population brings with it the paucity or difficulty in 'obtaining information, medication, psychological therapy, practical help for self care as influencing the treatment and progress of mental illness' (Parslow & Jorm 2001, p.187). These authors also note that treatment of mental illness varies depending upon the age of the person with younger persons receiving predominately information and non-medication management of their illness, whilst older persons were more likely to be offered management by medication alone (Parslow & Jorm 2001).

It is challenging to provide support in a health care system that experiences difficulty bringing generalist and specialist health services to communities outside the metropolitan and large provincial centres. Those difficulties often revolve around

issues of recruiting and retaining generalist and specialist staff in rural outreach centres, particularly specialist services (Wolfenden, Blanchard & Probst 1996). Wolfenden et al. (1996) have identified the top 10 detractors to rural health professionals when leaving or considering employment in Rural Mental Health Services. These include a heavy workload; limited resources; a perception of not being valued by the organisation; lack of continuing professional development opportunities; diminishing job prospects; lack of career development; a remoteness from the decision making process; lack of access to professional support; and financial disadvantage (Wolfenden et al. 1996). The capacity of small communities to establish and maintain generalist and specialist health services is therefore, compounded by the above. This lack of health professionals may then have a negative impact on health outcomes.

### **1.2.7 Local Influencing Factors to Access of Health Services**

Adding to the lack of access to generalist and specialist health professionals are issues of privacy in small communities where people have a chance to observe each other more closely. The issue of privacy has been discussed by Roberts, Battaglia and Epstein (1999, p.500), who liken rural communities to a fishbowl, as 'comings and goings at the mental health clinic are observed, and people listen carefully to comments of clinic staff members'. A study by Buckley and Lower (2002) regarding factors that influence the utilisation of health services by rural men made similar observations. They found that men who were not overly concerned about privacy issues regarding visits to health services were 2.57 times more likely to visit those services (Buckley & Lower 2002). Thus, some rural people may delay seeking help from health clinics because of the fear of the lack of privacy and confidentiality inherent in living in a small and closed environment.

### **1.2.8 Preventative strategies.**

Barry, Doherty, Hope, Sixsmith and Kelleher (2000) describe the positive effects of community education, with regard to mental health needs. Community perceptions of mental illness at all levels is often formed on myths surrounding the illness, and not on objective fact which can be promoted through a range of education processes. This negative perception of mental illness often forms a barrier not only for individuals receiving treatment, but on developing and adopting a healthy community attitude. Sufferers of mental illness describe this perception as difficult to cope with, and adding to the strain and stresses associated with treatment.

Given this situation, what are the factors that influence resilience, or lack of it in rural males, when confronted or attempting to manage a debilitating illness and their social, domestic and community responsibilities?

## **1.3 Research Questions**

This project, through the use of narratives, aimed to address the following research questions:

1. What are the factors that participants believe are current stressors related to rural living.
2. What are the factors that participants believe enhance their resilience to mental illness.

## 2. METHOD

A qualitative methodology was chosen for this study, as a way of developing a detailed understanding of a particular phenomena occurring in a particular group of people. Schneider, Elliot, LoBiondo and Haber (2003, p.60) explain that the key benefits of such an approach is that the phenomenon in question are studied as a whole and within the context in which they arise. A qualitative approach, then, helps to collect data that is meaningful to the participants and allows for detailed expression. The research team in turn have gained a better understanding of men's resilience in the face of adversity.

After committing to a qualitative project, and whilst understanding the importance of being true to the underlying philosophical and theoretical perspective, many questions remained about the methods of this inquiry along the way. The result is an emergent design which is common in qualitative research (Lincoln & Guba 1985) and reflects the need for qualitative researchers to make research designs which honour the realities and perspectives of the participants. Decisions about the best ways to obtain data, from whom, how to organise interviews and other methods of data collection were made as the project progressed.

### 2.1 Selection and recruitment of participants

The original study aimed to recruit men from the following two groups:

**Group 1:** Rural men from Queensland, 18 years of age plus, who were clients of the Toowoomba Health Service District Mental Health Outreach Service and had been treated for depression or other mental illnesses and who had expressed suicidal thoughts.

**Group 2:** Rural men from Queensland, 18 years of age plus, not utilising the Toowoomba Health Service District Mental Health Outreach Service, who have lived through difficult times at some stage in their lives and may have considered suicide at some stage of their lives.

Exclusion criteria for this study were men who did not speak English or were unable to give informed consent to participate in the study (for example, suffering from severe mental illness and therefore not capable of giving informed consent).

It was anticipated that Group 1 participants would be recruited through the staff from the Toowoomba Hospital Mental Health Outreach team. However, despite the best efforts by these staff, the research team were unable to recruit any participants through this service.

To attract men who met the group 2 criteria, a wide variety of sources including newspapers, support groups and government organisations were utilised. Several media releases appeared in *The Rural Weekly*, which has a circulation of 60,054 and is circulated to Toowoomba, Dalby, Chinchilla, Roma, Emerald, South and North Burnett, Biloela, Goondiwindi, St George, Rockhampton, Ipswich country, Moranbah and Longreach. Media releases were also placed in the *Central Telegraph*, *Bush*

*Telegraph* and the *Crow's Nest Advertiser*. Talk-back radio presentations were held on ABC Radio. A large number of welfare and community groups were contacted, such as Lifeline and neighbourhood centres, as well as the Department of Primary Industries, the Department of Veterans Affairs and parent groups in local private schools. Responses were poor and difficulties with participant recruitment continued throughout the entire recruitment process. Most participants were recruited via the newspaper and radio announcements. A number of respondents contacted the Centre for Rural and Remote Area Health wanting to take part in the study to be of help to other men, following their experience of losing a friend or someone known to them through suicide in recent times.

As a result of these activities a total of ten men were recruited into the study.

## **2.2 Ethical Considerations**

Ethical approval for this study was obtained from the Human Research and Ethics Committees at the University of Southern Queensland and Toowoomba Health Service District.

Consent was obtained from each participant by the posting of an Information Sheet and Plain Language Statement and Consent Form (appendix 1) to potential participants following their indication of willingness to undertake an interview. The Information Sheet and Plain Language Statement contained details of the study, contact addresses and telephone numbers for the research team. Once the consent form was returned, an appointment for an interview was made. The offer of conducting the interviews either at the Centre for Rural and Remote Area Health or at any other location nominated by the participant was made in order to provide flexibility.

Due to the sensitivity of this type of research, at least one of the researchers conducting each interview (interviews were performed with one or two researchers) had specialist mental health nursing or psychology qualifications and were highly experienced in working with people with mental health problems. All participants were informed that participation was voluntary and that no identifying data would be published that would identify them, their place of residence, any health professional or any health facility.

Referral mechanisms had been set in place in case any participant became distressed or expressed thoughts of self harm during the interview, however this situation did not occur.

Confidentiality was maintained at all times during the study and any identifying features such as names or locations have been removed in the construction of the narratives. A pseudonym was chosen for all participants and was used in all of the tapes, transcripts, narratives and data analysis. Tapes were only accessible to the research team. Tapes and transcribed data are stored in the Centre for Rural and Remote Area Health at USQ in a locked filing cabinet. Any computerised data analysis and information has been stored on the 'H' drive at USQ. Access to this drive is password protected. On completion of the project, all data on the 'H' drive were written onto a CD-ROM and removed from the 'H' drive. All material will be

stored for five years in accordance with the NHMRC guidelines for Human Research and will then be treated as confidential waste.

### **2.3 Data Collection**

Data were collected by face-to-face, in-depth interviews, which ranged from one to three hours in duration. No time limit was set for the interview and this allowed participants to express themselves as extensively as they wished. The interviews were unstructured in order to allow for breadth and richness of expression. Some questioning was used to further explore and clarify particular issues pertinent to the study. All interviews were audio taped and transcribed by a professional transcription service.

Participants were asked if telephone contact could be made to clarify any issues regarding the data and ask further questions if necessary. Once the narratives had been constructed from the interview data, they were returned to each participant for checking. This process provided participants with the opportunity to confirm the accurate representation of their interviews in the narratives. A further telephone interview took place to discuss any changes the participants wished to make to their narrative. No participant expressed the wish to withdraw from the study.

### **2.4 Data Analysis**

This study used a multi-case, comparative narrative approach. Polkinghorne (1988, p.11) defined a narrative as a 'scheme by means by which human beings give meaning to their experiences of temporality and personal actions'. A narrative is a collective wisdom, involving shared meanings among a group of people about a life experience. Within a narrative, people not only relate their actual experiences, but also their reconstructed memories. It is acknowledged that these will not completely resemble the actual experiences, but indeed are 'true' to the storytellers who have lived through this experience. The narrator is a creator of her or his world and experiences, rather than a dispassionate observer (Hare-Mustin & Marecek 1994).

In the telling, individuals are able to share their own representations and explanations of their experience. In these ways, narratives help to extend and widen knowledge, since there are always many stories to tell about a particular situation. Naturally, the ways of knowing between narratives and reasoned argument are different. As Bruner noted, 'arguments convince one of their truth, stories of their lifelikeness' (1986, p.11). Whatever the structure of the story, its strength lies in the memorable, often provocative way in which the experience is drawn out by the researcher and the meaning conveyed by the participant. The meaning of these stories to the participant and their centrality to the human experience is also explored; thus the meaning of concepts such as resilience and suicidal thoughts in this project will be defined and explored by the participants as they have experienced them (Frank 1995).

The construction of the narratives from the transcribed interviews was done following Emden's guidelines for conducting narrative analysis (1998). Emden suggests repeated reading of the interview transcript over several weeks. Following this process all interviewer questions and comments are removed as well as any irrelevant words or comments. The next step is to arrange the contents so related themes are grouped together and the story is coherent and ordered. Upon

completion of the constructed narratives they are returned to the participants to check for accuracy and any additional changes (Emden 1998).

The process of narrative construction also made it possible to identify a number of themes emerging from the data. To achieve this, a thematic analysis was undertaken, using the computer software NVIVO which allows transcripts to be reviewed, themes to be identified and the transcripts to then be compared for common themes. While common themes were identified, as this was a qualitative study it was not necessary for a theme to be mentioned by more than one participant for it to be considered significant. Once all the themes were identified, the relationships to each other were explored and they were grouped accordingly. This resulted in two major categories of themes: those considered to relate to the individual and their inner strength; and support and strategies.

## **2.5 *Limitations of the study***

This study presents the stories of ten men at the time they were interviewed in 2002. Each story is unique to each of the participants in this study. It is possible that other rural men may associate with the experiences of the participants in this study. However, the study does not claim that these stories are representative of all rural men.

It is recognised that there are several limitations to this study. One relates to the small sample size and how the findings of this cohort may be representative of any other rural men who have gone through adversity. Additionally, the findings of this study will not be able to be generalised to other areas, for example, metropolitan communities or other dissimilar rural communities. It is not the intention of the study to generalise the findings, but to understand the variety of experiences of the individuals.

### **3. FINDINGS**

A total of 10 men participated in the study. Their places of residence were in various rural locations throughout Queensland.

An analysis of the stories told by the 10 men revealed a number of factors that the participants considered helpful in coping during difficult times. These factors can be broadly categorised into two major themes: 1. The individual and their inner strength and 2. Support and strategies. The issues discussed by participants in the areas of the individual and their inner strength include positive thinking, self awareness, self control, the meaning of life, as well as appreciation and hope. Support and strategies relates to factors with regard to access to information, seeking help, treatment, talking about problems, support from family and friends, being needed, life changes, taking a break and having other interests. The data have been categorised into themes and sub themes merely for clarity, as they do not necessarily occur as a single identity, but frequently interconnect and overlap.

#### **3.1 *The individual and inner strength***

##### **3.1.1 Positive Thinking**

Positive thinking was identified by a number of men as important particularly in relation to the positive aspects in life rather than the negatives. This did not mean denying the negative factors. Rather, they recognised the potential for the negative feelings to dominate and therefore exclude the positive feelings. When this happened, the negatives could become out of proportion and reduce the individual's ability to cope. Positive thinking was also an activity of looking for and valuing the individual's characteristics. The following three comments exemplify the notion of positive thinking:

*I mean it's not every day you're thinking it's beautiful, but that seemed to be what gets you through. I've always found if you're going through difficult times, what will often get you through is to have a fallback. ...Just say you had to lose your farm and your home, you've got to think 'well I suppose it's not so bad if I've got to live in a caravan or got to live in a tent, but at least I'm still alive.*

*You know and these challenges aren't going to last forever and that's, that's an important thing to me even when I tell my kids, you know what you're going through, whatever it might be you know, a relationship with a girlfriend gone wrong or whatever, it's not going to last forever.*

*There are a lot of farmers in the same position, it's just everywhere, it's not like I'm just hopeless. If the worst comes to worst, then the bank will come and sell me up, who cares I just do something else, it's not the end of the world, it's not that important.*

### **3.1.2 Appreciation and Hope**

Participants expressed that having an appreciation for life and the things they have in their life is important to them. This appreciation was often also coupled with a vision of hope that things will improve in the future. Several men explained:

*You know say I've got cold feet you know well, but some people haven't got, someone's got a foot missing, and, and so you've only got one foot and then someone, I've got cold legs, well some people haven't got legs. There is always someone worse off.*

*Being thankful for the things around you.*

*I don't think life's ever meant to be that easy, I think there'll always be something happening, like even though I feel as though I'm getting that little bit closer to God, you're going to still be growing and no matter what level you come to, there's still always something more to learn.*

*I'm frightened of giving up life because even though I've had some terrible downs, I've had some mighty big ups too, you know, and you pray about it and you think "well maybe this will be better this time".*

### **3.1.3 Self awareness**

The issue of self awareness and the importance of being aware of one's health, especially mental health is an area several participants discussed. This self-awareness allowed the individuals to take steps during particularly vulnerable times. It also meant that without self-awareness they could have been unaware of how depressed they were. Two men commented:

*I was just in a deep depression and didn't realise.*

*I think it's pretty important to keep an eye on yourself and how you are...and if you can notice changes about yourself that just weren't in your character a little while ago, talk to someone.*

### **3.1.4 Taking Control**

The issue of taking control of one's situation in life was raised by a number of participants. Taking control was seen as taking ownership of the problem or situation and to actively do something to improve it. Further to this, it was seen as a step of redirecting thoughts of feeling sorry for oneself and maintaining an inward focus, into a proactive and outward focus. This was seen as important in regaining some control over difficult situations. Comments included:

*... I was always thinking you know, why don't people care, but if you get strong then you can show the people direction. It's so strange, but when you can take control of your own life, you're actually helping other people as well, rather than the other way around.*

*But I've got to deal with my challenges; I can't walk away from them. Some things I can walk away from...but some things I can't. I am responsible for my account.*

*Well see that's the trouble with looking inwards, you know like it's a type of selfishness that you know all your problems are sort of, you're looking at what you can do for yourself and how I can help myself and all this sort of thing and poor me, that sort of attitude, and really that does keep you looking at yourself, like a selfish sort of self centred sort of life and...and it's hard to leave that, like I can still do that, so you've got to start looking outwards at just being there for other people, not necessarily running around and doing charity jobs, but just being there when your family needs you.*

*You've got to get off your ass and you've got to work things out. There is a purpose.*

Another aspect of control was maintaining a level of control by avoiding the use of illicit drugs or alcohol. This avoidance was seen as a valuable step to avoid destructive behaviours. Two participants noted:

*Then you've got to discipline yourself to it and that's where not drinking or smoking or hitting off on drugs or whatever that be, you've got to have a discipline within yourself. ... I didn't have to succumb to drink or smoking to get a kick. I got a kick out of the little things in life around me. Look at the beauty of life around ya. I mean it's not every day you're thinking it's beautiful, but that seemed to be what gets you through.*

*One thing you must never touch is alcohol, never. If your going to lean on alcohol, that's going to be the end of you.*

One participant described how he managed difficult situations via a system he devised. This system enabled him to be in control of what and when he wanted to deal with issues that needed his attention. He described:

*My most effective coping strategy was what I called my filing cabinet technique. It developed during the divorce proceedings. When a document came, or issue developed, that caused stress levels beyond what I could cope with; as soon as I was capable I would try to understand, to research the problem, and to do what I could do about it at that time. I would implement actions to correct the problem to the maximum I could at the time, often I had to make appointments so that might be as far as I could go, or I might seek advice. Then I would physically place in a filing cabinet the paperwork involved, and lock it.*

### **3.1.5 Seeking Meaning in Life and Religion**

Seeking meaning in life was a factor identified by some of the participants. This theme refers to the importance of having a sense of purpose, something to strive for. For some participants this sense of purpose was further reflected in participation in religion. Religion had been an important support for several men during times of

stress, as well as a way of exploring one's concept of the meaning of life. These are some of the comments:

*I think as long as we're looking for, as long as we're seeking out something in our life and know that there's something to look for, I think that's the main thing and as long as we keep seeking or looking, then we'll find whatever we're looking for.*

*Since God has been in my life I'm trying to use his strength now and I'm trying to do that more and more rather than my own and that's been a big help to me.*

*I guess you could say that relying on God has been the big help to me.*

## **3.2 Support and strategies**

Support and strategies refers to factors outside the individual that have helped them to cope with the stresses of life. The main sub-themes arising from the data were: seeking help and treatment; talking about it; life changes; being needed; support of family and friends and distractions.

### **3.2.1 Access to Information**

Participants emphasised the importance of finding out practical information about their condition and how that empowered them to cope. Often participants did not realise that what they were going through was common and that something could be done to help. Some participants were also unaware of the signs and symptoms of depression and did not relate the problems they were going through to a mental health issue. Several men explained:

*A turning point was when I read in a magazine the symptoms of men who've got really bad depression and I fitted the bill perfectly. I was just really aggressive and withdrawn from people and just didn't want to talk to people. When I'd go to the public things, like the races or socialise, I didn't want to talk to other people and I realised something was wrong. I was starting to get a bit better when I read that; but it did help a lot. I reckon that's sped up the healing process.*

*I think someone like my older brother, if he had known, he would of probably told me and I would've listened. I think some guys need to know what the symptoms of really bad depression are. I thought when you're depressed you'd sit at home and feel sorry for yourself, not be sort of aggressive and anti-social like I was. It happens so gradual. It doesn't sort of happen overnight.*

### **3.2.2 Seeking Help**

The majority of participants commented on the benefits of acknowledging the need for professional help and seeking it out. The participants in this study resorted to various forms of help, such as telephone support, face to face counselling as well as support from their General Practitioner. Three men described:

*I think [professional help is important] because they've got the training*

*behind them in the first place and there's things that you can say to them that they can interpret differently to what your mates, your wife whatever would. And because they can interpret it in a different way they can see that there's a problem underlying, so I guess it is important.*

*I forget how but I got the phone number of a group called Men's Line. It's based in Melbourne and I found them really helpful. They were pretty clued up on what they were talking about, I just found it very encouraging talking to them.*

*I went to see a doctor who'd studied psychology for a lot of years. There's quite a few times I've seen him, of course he tried to get to the root of the problem, so I sort of tried opening up then and admitting that there was a problem there. He had a great way of getting past that and getting me to talk about it even more, which was fantastic. He was of great help because he could, I suppose see through the answers I was giving and know there were more underlying problems there. I suppose he kept questioning around it, until he got back to where he was before and we'd work at it.*

The help that most participants received had a positive effect, but the most difficult part for some was to overcome the initial uneasiness with making contact. One participant in retrospect also acknowledged the negative effects of not doing so sooner. Comments included:

*I nearly called Lifeline one time, twice I think it was. I just couldn't bring meself [sic] to do it. I nearly rang another friend of mine that I knew went through a rough patch years ago, I nearly rang him but I didn't. Cause I was, I think I was too embarrassed to admit that I was that bad.*

*Just swallow your pride and talk to someone. You could hurt a lot more people other than yourself if you take that step further.*

*I wish I did get help when I needed it. I made a mistake there. Yeah I wish I had of rang Lifeline or something like that, it would've made it a lot easier. It's not a shame job to ask for help, but you need to admit you've got a problem and then you can do something about it. And realise that no matter how bad things are, you are worth something.*

### **3.2.3 Treatment**

Participants that chose, in consultation with their General Practitioner, to include pharmacological agents into their treatment regime spoke of the benefits of the treatment and how it helped them to cope with the symptoms of their illness. Two men said:

*He [the doctor] also put me on some antidepressants and I noticed a huge improvement. I didn't get upset over minor things at all, a lot of things that would happen I could just brush off, whereas before I would blow up. From early times on the medication, I could look at myself then and before, and I could see the difference and I really liked what I saw.*

*I ended up on Zoloft and I'm still on that, I've been on that for a couple of years now I tried to go off it and I ended up with panic attacks again. I suppose I tried that, but I might have to stay on it for a couple more years.*

### **3.2.4 Talking about it**

Talking about problems with others was very strongly supported by the majority of participants. The process of discussion and reflection allowed participants to unload some of their burdens, receive different points of view and reflect on their current position. The act of talking it out was experienced as therapeutic. Some typical examples included:

*I felt I started getting better straight away 'cause I talked to my wife a bit more and I bent over backwards with her to try and make her understand how I felt. I tried a lot better to explain things and then she started to realise.*

*It don't hurt to talk to other people you know, that's the trouble when you're sort of down you don't feel like talking to other people. I think you do need to discuss your problems a bit because otherwise they're just building up inside of you and if you don't get them out, that's all right for a start but you know you sort of, unless you can find someone to talk to...*

*I had to get through it and one of the things was, I talked to a lot of people. A bloke I knew whose wife had also left him and went through the same thing, he ended putting himself in hospital and all sorts of things. So he was a year ahead and so he had stuff to tell me.*

### **3.2.5 Support of Family and Friends**

Participants placed great importance on the support they received from their family and friends. Again the therapeutic benefit of talking to others surfaced, but the knowledge that there were people there that cared about them and fully supported them, increased the benefit of the support. Several men explained:

*But there was always a support from my wife and even like when we separated over it all...there was still always that support from her. It makes a huge difference if you've got something or someone there behind you to help you through it. The support that I had wasn't a nagging support it was a comforting support.*

*To me family's most important you know, having a strong family and having the family around and, it's really, really helped.*

*I have a good relationship with my mother and my brother so you know that's quite healthy. My mother is old and I really didn't know how she'd react. At first I thought maybe I shouldn't say anything to her, but she took it quite well and she didn't get distraught or emotionally upset, which I thought she would, so it was good just to have that support.*

*I talked to Dad a bit but not much really. Talked to mum a bit, but they were supportive in all other ways. Not the talking side but helping me and all that sort of thing so I had someone that was looking over me.*

In contrast, not having family or friends as a support system was seen as a negative factor. Comments included:

*I've never really felt the need for friends that most people seem to have, but you feel it more when you haven't got them. Omitting friends was a big mistake.*

*I guess that meant my wife and I drifted, when you don't have that sort of mutual support happening and you're each doing your own thing. I felt relatively isolated. I've never really felt that there was support, I think my wife just expected me to be able to cope with the stress on my own, I guess because she could with the things that affected her.*

### **3.2.6 Being needed**

Being needed and knowing that other people depended on them helped some participants to gain additional strength during difficult times. The feeling of being needed also enhanced a sense of obligation/purpose and a boost to their self esteem. This also became particularly apparent when the feeling of being needed was combined with the altruistic experience of helping others. Several men explain:

*I knew that my parents needed me to keep going. ...With your family, it's a big focus point to realise you're worth something and you have to stick around for them.*

*What kept me going were primarily my children and my own family. I do make a contribution to my children's upbringing, not just financially but in many other ways as well and I just focus on those sorts of things.*

*I've got a responsibility to these children and I can't walk away from that responsibility.*

*Giving to other people is important.*

### **3.2.7 Life Changes**

For some participants making some conscious changes to their life helped them to deal with their situation. These changes primarily occurred once it was recognised that the situation they were currently in was not conducive to improvement, or the process of 'letting go' was underway. These are some of the comments:

*I had an alternative life starting to go, I started to move into a different church group, I got different friends, I got more support, more realistic support from various people who knew that I was under a lot of pressure.*

*Moving from the country to the city and everything is different but yeah it was a good change and it was time to get away from the farm.*

### **3.2.8 Taking a Break**

A large number of participants made reference to the importance of taking time out from their daily lives. Taking time out included getting away from familiar

surroundings and undertaking activities that would divert their focus from the difficult times they were going through. For most this meant literally going away for a time, but they also referred to not talking about their problems.

*Getting away from the farm, there was one stage there I was really bad and we didn't plant cause there's just no rain in winter and I was stressing out and my wife just said, "come on, let's just book a weekend in [town], and we went up there for four days and I felt like a new man. Yeah just get away from it, even for four or five days, it made a world of difference. Things like that really helped. You just forget about it for a few days. A lot of guys don't do that, they just stay there and there's always something to do, but it pays to walk away every now and then, just leave and not think about it.*

*I feel you can't live in the same environment all the time because the walls close in and you just need to get away and have a different outlook for a little while.*

*But I'm just reaching the stage now where I'm just saying, "well I'm just going away" you know like I could drop dead tomorrow with a heart attack, I'm probably in pretty good health, but theoretically you know and they'd have to go on the same then, they'd have to manage so now it's time.*

*A good thing is to be able to not just talk about what you're doing all the time. When you have conversation with your family and people around you, try and bring that conversation to something different besides your farming.*

### **3.2.9 Change of focus**

Creating distance from life's drudgery and taking a break is also reflected in the value of having things to do outside of the participants' daily lives. This sub-theme incorporated a range of different activities but the benefit came from the change from concentrating on their problems. Some examples include:

*Whenever I was in trouble I retreated to my photography. I did up a dark room at home. There's a creative sense then, the fact that you're actually creating something, achieved something. The achievement is a plus, it gives a strength I guess, I have achieved something and it looks okay.*

*Well sometimes when you feel that things are getting you down, you know you might have to go to a Lions meeting, or I might help at the gate at the show or at the car rally or fishing competition. That helps you because you get out and then you're talking to the others and you come home and you just feel different. You're meeting other people with likewise interests and...now sort of broadening your knowledge I think it's pretty important to be involved in something, a club or something.*

*I think I was lucky in a way because I had a job that I liked and I could get myself away in my job for eight hours and then after that eight hours I slipped back into where I was. That was a big plus, having a job that I really enjoyed.*

Sometimes just a simple thing such as 'having a laugh', was seen as a positive activity to feeling better. One participant referred to the importance of being able to maintain a sense of humour and to find fun and happy activities in life as a means of countering the negatives.

*Having a laugh, like being able to laugh at things, I mean things get us down at times, you don't feel like laughing but you've got to be able to sit down and watch favourite home videos and that sort of thing and have a good laugh. And if you can't laugh, well there's something wrong with ya. It's good medicine.*

## 4. DISCUSSION

The findings from this study indicate that a number of factors contribute to the strengthening of rural men's resilience in the face of adversity. Factors surrounding the individual and his inner strength, as well as support and strategies, were the major areas addressed by participants. It has to be noted that despite the relatively low number of participants, the men who did take part in the study were able to share their experiences in depth, thus providing valuable information to this study. An outstanding feature of the rural men in this study is their strength and ability to bounce back despite adversity, which had, in some cases, been with them all of their life.

The most significant finding of this study is that the resources men drew on were not specific to any one identified adversity but could be applied to any adversity. In other words, independent of the difficult situation men found themselves in, they used very similar strengths and strategies to overcome these situations. This finding is important in that it may also indicate that the resilience factors found in this cohort may firstly also be found in other resilient men and secondly may be a useful guide for men with less resilience. The data also indicate that utilising certain resources was not always a conscious decision, but more a process that occurred without the individual even being aware of it until they realised retrospectively that it was helpful to them. In some cases it was a process initiated by other people such as family and friends but the benefits were not recognised until after the event. This is important because it suggests that supportive strategies may not be consciously obvious to the individual and there is therefore the potential for others to benefit from the experiences of the participants of this study.

The findings of this study are supported by other studies reported in the literature. A study by McLaren and Hopes (2002, p 689) identified that rural residents reported more reasons to live than their counterparts in regional towns. This finding seems to contradict many other studies that show that there is an increase in suicide in rural areas. In this study, rural men expressed many reasons to feel positive, despite the difficult times they were going through. These reasons included being needed by family and friends, having a purpose in life and having a responsibility to themselves, their families and their communities. This sense of purpose and belonging may be more strongly found in rural communities, where families are more likely to live nearby and good social structures are in place.

Despite the physical isolation of some people living in rural areas, a strong bond exists between the individuals and the community. Family bonds and social support appear to be important factors enhancing the resilience of the rural men in this study. This is supported by findings published in *Living is for everyone (LIFE): a framework for prevention of suicide and self-harm in Australia*, (Commonwealth Department of Health and Aged Care 2000, p. 35), which states that 'family connectedness or responsibilities also appear to provide some protection against suicide for adults and older people'. Further to this, social integration and community connectedness were also seen as significant protective factors in relation to mental health wellbeing (Commonwealth Department of Health and Aged Care 2000). The recognition of the importance of good social support is apparent in this study and the literature would

suggest that education needs to focus on developing good social structures at any stage, not only when men are going through difficult times. In fact the preventative potential of these supports is indicated by the finding that many of the participants in this study only realised how beneficial these supports had been when they reflected on their experiences. The effect of developing supports before periods of adversity would be twofold in that it could reduce the risk of men actually reaching the point where difficult situations appear unresolvable, as well as improving their resilience in dealing with difficult situations.

The difficulty recruiting men for this study has shown to be an indicator of the social stigma still connected to mental health matters. In times where rural suicides are still on the rise and the economic hardship is becoming increasingly apparent, one can assume that there could have been a much greater number of men taking part in this study. The issue of stigma, privacy and feeling of shame emerged clearly from the comments of the participants. A study by Barry et al (2000, p.300) supports this finding and found that men were found to be significantly more likely to conceal problems such as depression in comparison to women. Current health promotion strategies are focusing on the de-stigmatisation of mental illness, but acceptance of this is still a long way off. Continuing, ill informed attitudes in rural communities regarding mental health problems is one of the greatest barriers for rural men to seek out help during difficult times or even feel they can discuss the matter with family or friends. The culture of self reliance and the so called 'stiff upper lip' leaves little room for error or weakness (Fuller et al 2000), thus adding to the pressures already experienced by men during difficult times. Health education needs to continue to work towards changing prevailing misconceptions about mental illness and this study is one step towards this.

Despite the fact that stigma and privacy were important issues for some of the participants, being able to overcome these issues has enhanced their resilience to deal with adversity. Once men recognised the benefit of sharing their problems and feelings with people close to them, doctors or counsellors, they were able to refocus their situation and actively work on getting back in control. In fact some men commented how taking part in this study had been a healing process for them, an opportunity to consolidate their experiences and gain a better understanding about themselves. Being able to share the experience and showing rural men that what they are experiencing is not something only they feel, but many other rural men may experience during their lifetime, is a powerful message.

## **5. RECOMMENDATION**

It is the intention of this study to share the experience of the ten men who took part in this study, with other rural men. The stories are from rural men who have gone through difficult times, but were able to go beyond adversity. This project will utilise these stories and share them with other rural men in the hope they may find inspiration and help. It is envisaged that the stories will be published in a book and made widely available to rural communities and organisations dealing with rural people.

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# APPENDIX 1. PLAIN LANGUAGE CONSENT FORM

We are undertaking a research project investigating the factors that help rural men cope emotionally with difficult and stressful times. We are also interested in the personal strategies that rural men may have developed to overcome the current stresses of rural life. Our aim is to help rural men through these stresses by finding out what causes them, how they may be overcome, and by educating rural health professionals about how they can best support rural men through difficult times.

Your participation, which is completely voluntary, would involve:

1. reading and signing this consent form;
2. being interviewed by a member of our research team, to discuss the issues outlined above; and
3. reading a our summary of your interview, to check that we have been accurate in recording your experiences and ideas.

Your interview will be taped. To ensure absolute confidentiality, we will ask you to choose a pseudonym (fictitious name) for your interview and you will be referred to by that pseudonym throughout the interview and in the final report. Although we will have your name and contact details, these will only be used to contact you for making appointments for interviews with you or to send you the final report. Only the head of our research team at USQ will have access to your name, contact details and be able to link it to your pseudonym. All of the tapes and interview transcriptions will be kept in a locked filing cabinet at USQ for a period of five years, after which they will be shredded and disposed of as confidential waste.

**Please be assured that any health treatment you receive now or in the future will not be affected in any way should you wish not to participate or you wish to withdraw from the study at any time. However, if in our professional opinion it becomes obvious that your safety and well-being are at risk, we are obligated to contact a mental health care professional. You have the right to refuse to speak to this health professional.**

**If you do wish to withdraw from the study, you have the right to ask for and receive the original tape of the interview and be assured that is the only copy of the tape.**

If you have any questions with regard to this project please feel free to contact the project leader Professor Desley Hegney or Dr Andy Cumming, Director of Medical Services and Chair of the Human Research Ethics Committee at Toowoomba Health Services on the numbers listed below. If you wish to participate could you please sign and return the consent form. Please retain one copy of the consent form for your information.

## CONSENT FORM

I (please print) \_\_\_\_\_  
of(address) \_\_\_\_\_

have read the information above and agree to participate in the study. I am aware that I can withdraw from the study at any time by contacting Professor Desley Hegney or Dr. Andy Cumming and that my name will not be identifiable in the final report. I agree that the information from this study can be published as long as I cannot be identified in any way.

Signed \_\_\_\_\_

Witness \_\_\_\_\_

Date: \_\_\_\_\_

### **Any questions with regard to this project may be directed to:**

Professor Desley Hegney, Room 404 Q Block, University of Southern Queensland, Toowoomba, QLD, 4350. Telephone: 46315456; Fax: 464315453; Email: [hegney@usq.edu.au](mailto:hegney@usq.edu.au)

Dr Andy Cumming, Chair of the Research & Ethics Committee, Toowoomba Base Hospital  
Telephone: 07 4616 6154.

The following contacts will also be able to assist you if you feel distressed during or after the interview, or if you believe you require emergency assistance:

- Your general practitioner
- Lifeline (24 hour service): 131114
- Community Mental Health Service, Russell St, Toowoomba: 4638 5088
- Acute Psychiatric Unit (24 hour service), Toowoomba Base Hospital: 4616 6111