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Help Seeking Among Male Farmers and their Female Partners: A Qualitative Exploration

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ABSTRACT

This study explored help-seeking among male farmers and their female partners, using data collected via 16 face-to-face semi-structured interviews. Eight male farmers and eight female partners aged 26-56 years were recruited. Data were analysed using thematic analysis. Seven main themes were identified, healthcare, self-protection, costs, support, roles, accessibility, and community. Both partners valued healthcare but identified barriers to enacting help seeking. Stigma and fear of embarrassment and disclosure led to self-protection through avoidance of help seeking. A community culture of masculinity mitigated against disclosure and help seeking though females were more open to change. Males were more reluctant to discuss mental health and focused mainly on physical healthcare. Time and cost were also restrictive but support enabled help seeking. It is suggested that a social ecological model should be applied and there is a need to provide a more farming friendly primary care.

What is known:

- Males are reluctant to talk about mental health.
- Males are reluctant to seek help.
- There are high levels of suicide among farmers.

What this paper adds:

- Male farmers and their female partners value help-seeking
- Male farmers and their female partners avoid help-seeking for reasons on self-protection. The farming community culture mitigates against help-seeking.

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Introduction

Agricultural workers play a significant role in global economic life and face significant stress from isolation and economic uncertainty as well as the unpredictability of both weather and politics [1-5]. A significant public health concern is the elevated levels of suicide among farmers [1,6-8]. Of particular concern is the reluctance among farmers, particularly males, to seek help, particularly for emotional problems [9-12].

Among salient barriers to help-seeking among male farmers are; the social stigma attached to mental health issues, a desire to appear stoic and resilient, low levels of health literacy, as well as financial and restrictive lifestyle factors [11,13-16]. Help-seeking reluctance is particularly prevalent among younger adults males [17-21], and since the majority of farmers are still males this is a substantive issue [22-24]. Social support from a significant other has been recognised as a salient facilitator to help-seeking [3,25]. Exploring help-seeking among partners of farmers may provide an understanding of their readiness to seek help for themselves and their role in facilitating their partners engagement in help-seeking behaviour. While suicide

rates may apply mainly to male farmers, stress affects all the farming family [26]. Economic stress is particularly consistent for all farming families and not only impacts individuals but may also impact on the relationships within the unit [27]. Since social support is largely drawn for other family members, anything that damages those relationships increases the psychological risk of disorder [26]. Values and expectations in rural communities additionally impact particularly on women to maintain and keep secret any relationship problems they experience [28]. Farming communities are diverse and form a major part of the population of any country, yet they experience complex sets of demands that make them unique and as an occupational group they have been less researched. These unique stressors, the high levels of suicide, and the reluctance to seek help among male farmers, justifies further research. Equally, the partners of male farmers have been neglected in the research literature and arguably should be included in any study of stress in the farming community.

This study aims to explore the lived experience of help-seeking in male farmers and their female partners.

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Methods

Design

The study was approved by the University Research Ethics committee. A qualitative research design incorporating 16 in-depth face-to-face semi-structured interviews were utilised to directly explore the participants lived experience and in particular their help-seeking.

Participants

Male farmers (N=8) and their female partners/ wives (N=8) aged between 26-56 years (mean = 46) were recruited using snowball sampling [29] with the assistance of Farmer Organisations. Inclusion criteria were full time or part time operational farmers or a partner of a farmer and between the ages of 18-69 years. The target sample was voluntary and included 8 male farmers and their female wives. Type of farm ranged from mixed (50%), dairy (31.2%), beef (12.5%), and poultry (6.2%).

Procedure

Interviews were conducted at a location (eg. home, farm or local coffee shop) and time convenient to the participant. Written informed consent was provided by participants. Interviews were audiotaped and began by asking closed demographic questions followed by semi-structured open questions. Probing questions were utilised throughout to gain rich responses [30]. The interviewer transcribed verbatim immediately after each interview [31].

Analysis

Qualitative thematic analysis was applied to analyse and describe the data. During the first stage, data reduction, transcripts were read repeatedly, and recordings were listened to several times to ensure the accuracy of the transcription. This repeated reading and the use of the recordings to listen to the data, results in data immersion and ensures the researcher’s deeper relationship with the data [32]. During the second stage coding categories were formed which identified aspects of the data that were pertinent to the research question. The third stage involved identifying themes, which combined relevant codes into descriptors of larger portions of the data which were presented in a Table as shown in Table 1. All relevant codes were included and themes that seemed less supported at this stage were revisited in the data to ensure that no relevant codes had been missed. The next stage involved naming the themes by reviewing the underlying codes to ensure relevance to the research aims. The final stage in the process involved identifying examples from the transcript that evidenced the theme. Triangulation was used in that coding was reviewed by two researchers working independently to ensure codes were reliably identified. Resulting themes and quotes were discussed by both researchers, and all discrepancies were identified and resolved, which improved the reliability of the analysis process.

Table 1: Themes and Sub-themes from the discourse.

Main Theme	Sub-themes
Healthcare	Being cured
	Trusting experts
	Peace of mind
	Taking responsibility
Self-protection	Prevention
	Stigma with mental health
	Fear of appearing weak
	Fear of embarrassment
	Fear of disclosure
Costs	Need for privacy
	Fear of negative diagnosis
	Time pressure
	Wasting own time
	Wasting others time
Support	Economic cost
	Putting it off
	Friend’s advice
	Family support
Roles	General support
	Community
	Church
	Wife’s role
Accessibility	Not telling partner
	Self-reliance
	Multitasking
Community	Familiarity
	Bedside manner
	Time
	On a different page
	Macho culture
	Lack of contact
	Need for change
	Suicide

Results and Discussion

The analysis of transcripts identified seven main themes, healthcare, self-protection, costs, accessibility, roles, support, and community, and a series of sub-themes as shown in Table 1. The theme of healthcare reflected a generally positive set of attitudes and expectations around seeking out help from health professionals when necessary and was endorsed equally by male farmers and female wives. This included an expectation that cures (*being cured*) were available and good health could be restored.

“Well::: hopefully there’s a cure somewhere. If you go and look help, hopefully it’s a cure. Whether it be the doctor that fixed you, you know (.) physically or somebody fixes you mentally ... Well you’d like to think you’d get normality back wouldn’t you?” (P2, male farmer).

“you’re getting the right diagnosis or whatever (.) for (.) for your ailment. So, you know, you’re dealing with it properly (.) when you seek the appropriate help, you know. So, I feel (.) it’s the best way to try and (.) help or cure the problem”. (P3, female partner / wife).

Related to this was a sense of *trusting experts*.

“... they [health professionals] would have seen.hhh a variety of different types of health problems (.) so you’d like to think they’d have a wee bit maybe more experience in it and maybe a better way to help you, you know?” (P9, male farmer).

“They’re more qualified to deal with (.) whatever is wrong with you than you are yourself”. (P14, female partner / wife)

This confidence in cure and trusting in expertise brought *peace of mind*, though mainly for wives.

‘You automatically feel a little bit calmer because you think that (.) things are now working, and you know whether it was (.) what you think it was or it’s not. So (.) you just feel a bit more peace of mind.’ (P4, female partner/wife).

This was not a theme much endorsed for male farmers who seemed much more focused on physical outcomes and physical health and *prevention*.

“if you don’t go and sort yourself out, .. that could lead to something else, and (.) before you know it you have a whole flipping backlog of problems. So (.) the way I look at it is (..) get that sorted out and get on top of it ...” (P13, male farmer).

Prevention was also endorsed by farmer’s wives.

“sometimes if you let a thing (.) fester on, you know, you work at it yourself and you can’t get it healed- maybe if you’d went straight away it would have been quicker”. (P14, female partner / wife)

For farmers *taking responsibility* for own health was seen as a driver towards seeking help.

“either accept responsibility and take time out (.) and save this [health] or (.) carry.....3 on and lose everything.” (P1, male farmer).

Overall, there was quite a strong sense of the importance of seeking help for health concerns though male discourse was predominantly focused on physical health with a tendency to ignore mental health. Females were much more ready to see help seeking as equally important for mental and physical health. This reflects the literature on male reluctance to openly admit to mental health problems seen as a sign of weakness and to present an outward face of masculine hardiness [17,20,23 24]. Health care seemed to be held in high esteem by farmers and their wives but making the transition from valuing it to actually enacting help-seeking was problematic. Both groups held a strong sense of *self-preservation*, which mitigated against help-seeking. A sense that seeking help exposed a vulnerability that might be exploited. *Self-preservation* came out as a global theme as evidenced by a set of sub-themes. These included *stigma with mental health*, which was most prominent among male farmers.

“There’s like a stigma to it (.) in society because if anybody mentions mental health issues it’s like, awk (..) pull yourself

together or (.) awk that boy there’s something wrong with him ...” (P13, male farmer).

“... I would probably be more inclined to go for a physical because it’s probably a bit more obvious (.) em:::: if it was mental health (.) em:::: (.) with mental illness I would feel a wee bit uncomfortable” (P12, male farmer)

Linked to this was a *fear of appearing weak*, which was mainly manifest among farmer’s wives.

“To be seen to ask for help about things it’s almost like you’re maybe not coping with your .hhh own (..) farm ... and (.) if you’re seen to be showing a weakness ...” (P4, female partner/wife).

“I would feel I had failed in some way or another that I have to (..) em seek help. I would be putting myself down as (.) a failure.” (P3, female partner/wife)

Again, this was linked to a *fear of embarrassment*, a theme mainly among male farmers.

“I.. don’t find it the easiest experience to go to the doctor (.)::: there might be a wee bit of, sort of eh:::: uncomfortableness or:::: a wee bit of maybe embarrassment ...” (P12, male farmer).

Perhaps a similar theme to embarrassment was the theme of *fear of disclosure*, among farmer’s wives.

“... if I had a mental health issue:::: and they started to ask me, well what’s wrong with you today?either tell lies or disclose something that I wouldn’t be willing to disclose ... You don’t want eh::: people talking about you like ...” (P5, female partner/wife).

Though this was compensated by trust that confidentiality would be protected by health professionals.

“it would be confidential with the doctor (.) so nobody would know what you’d went to the doctor ...” (P6, female partner/wife).

Also, an issue for the females was *fear of diagnosis*, a sense of not wanting to know if it was bad news, an important factor highlighted throughout the literature [33]. An extreme fear of disease is known as Nosophobia, and milder forms are associated with resistance to help-seeking.

“... the fear of being given- being told what was wrong. ... just the fear or the (.) having to come to terms with would be (.) be trying to put it to the one side and (.) and making yourself believe it’s not there or it’s not happening.” (P3, female partner/wife).

Overall, this theme of *self-protection*, of being wary of seeking help because of potential negative consequences, was common to both farmers and wives, but with some fundamental differences in focus. The perennial problem of social stigma which prevents many from seeking help for mental health problems is well known, as well as the fear of appearing weak and vulnerable [13]. The differences between farmers and wives in terms of self-protection may be linked to the adopted or ascribed roles of each partner and may be further explicated under the broad theme of *roles*. Male farmers seemed to abdicate the role of arranging healthcare to their wife, thus displacing the burden of responsibility. The burden of care-giving seems to be often ascribed to the role of the wife in a relationship [34,35].

"It's usually the wife that does the like of that (.) then books you in (.) and unless you're booked in you don't go." (P2, male farmer).

Wives seemed to accept or at least try to fulfil some unspoken responsibilities allotted to them, for example in *not telling their partner* about symptoms until after they had seen a health professional.

"I think I would go first of all (..) to the doctor and find out about it myself and (..) maybe get a few tests done before I even speak to [husband's name omitted] about it (.)" (P14, female partner/wife).

It seems that wives feel they have no choice in the matter other than to be *self-reliant*.

"- nobody will help you- you can only really help yourself (.) when you get to a certain level you can only really help yourself!" (P11, female partner/wife).

It seems to be part of the role description to be effective in *multitasking*.

"... to be a farmer's wife (..) you're a mother (.) you're wearing a lot of different hats. You're trying to- help your partner (.), you're trying to run your house, you're working part-time. You know (.) there's- there's a lot of pressures." (P14, female partner/wife)

Health care seems to be the allotted role of the wife in this sample. While the traditional role distribution between couples in marriage are moving to a more equitable balance, wives still tend to take on a more caregiving role [34,35]. This brings with it an additional burden on wives to be more self-reliant as expressed here, and for women to be more adept at balancing many different roles [36]. The costs of seeking help for health issues was identified across a range of time and economic loss issues as another main theme. While wives were under pressure to multitask, farmers were preoccupied with the *time pressure* of a conveyor belt system that never stopped.

".. the hard facts of farmers: they have cattle to feed, they have cows to milk, they have (.) barley to spray and things. It's all sorta (..) .. is just like a conveyor belt. (.) That conveyor belt never stops (.)..." (P13, male farmer).

For some male farmers seeking help was seen as *wasting own time*.

"... sounds bad but a waste of time [laughter] ... if I go to - to seek help for physical health (.) I can't do (..) things that I need to do ... it's taking away from (.) time that I need to spend doing stuff that's all ..." (P9, male farmer)

While for females there was a concern about *wasting other's time*. *"You sort of think to yourself, (..) [tut] you know, (.) you look foolish going into the doctor...., you think you're wasting the doctor's time ..."* (P3, female partner/wife).

The underlying issue was a theme of *economic cost* to taking time away for health care.

"...you can't afford to be away from the farm for a week or two weeks or whatever it is (.) because that's the income coming

in to support the family and (.) you know (.) a week or two, or three days away from the farm can be a problem!" (P12, male farmer).

Another aspect of time was *putting it off* in the hope that it would not need medical care.

"... you'd just work away, you know, and (.) you think you're alright, ... another day it'll be alright, it'll sort it's self out." (P2, male farmer)

The notion that time is precious and costly and needs to be prioritised for farming rather than help seeking for health concerns comes across as more of a mechanism through which the fear expressed under self-preservation can be avoided. The fear of economic loss seems to be more related to the outcome of help-seeking rather than help-seeking per se. Seeing a health professional doesn't take up that much time but a period of testing and treatment that prevented working the farm could be costly. It was better to ignore and pretend there was no issue rather than seek out health care.

Relationship with and perception of health professionals was another broad theme which we called *accessibility*. This was evidenced by four subthemes the first of which was around *familiarity* with the health professional.

"... you don't always get the same doctor ... (.) depending on the doctor can be a wee bit off putting ... it's kind of like you're talking to a stranger ..." (P9, male farmer)

This was linked to the health professional's *bedside manner*, or how good or bad they were at putting one at ease.

"I don't cope very well in the doctors [nervous laughter] you know, eh::: they need to sort of make it (..) make you feel more at ease when you're in there to start with, that you're not so much of a number that they need to (.) get you in and get you out [nervous laughter]" (P11, female partner/wife).

Time was also an issue in that there was often not enough to be able to talk through the issue.

'you just can't talk to them (.) maybe (..) as much as you'd want to, (.) you know' (P14, female partner/wife).

Ultimately there was concern about being *on a different page*, where the health professional just didn't really understand the world of farming.

'.. some of them [health professionals], you know, are on a different page, she's a nurse [from a farming background] and (.) you know. (..) She'd talk to you the way I'd talk to anybody. That's more (.) farming talk (.) you know or::: rough talk ... somebody like that, you know, I can relate to better than::: somebody, you know, more professional.' (P2, male farmer).

All of this led to a reticence to seek help for both farmers and their wives. The role of communication in health care has been widely researched under doctor-patient communication and its role has been shown to be central both to seeking help and the delivery of care [37]. There is a growing evidence base on the need for improved communication skills in health care

delivery and the effectiveness of teaching these skills in the training of professionals [38]. An established relationship with a healthcare provider who sees the persons consistently seems to increase the likelihood of help seeking. Clearly primary care practitioners do not have the time or the required training to be able to provide the sort of service required to deal with mental health issues which suggests an investment in employing a range of specialists in counselling and psychology is indicated.

The global theme of support emerged as perhaps the strongest mechanism for bridging the gap between positive views of health care and seeking help. Subthemes related to *advice from friends, family support*, and for some, the *church*. For wives having a friend they could talk to in deciding to seek professional help was important. This along with the suggestion from wives that they would see a professional before telling their husband speaks volumes about wives seeking support outside the family.

'I would call a close friend and (.) they would .. have my best interests at heart and they were advising me to go to the doctor. I would start to query why I didn't (.) think (.) of it myself?' (P5, female partner/wife).

In contrast, *family support* was identified mainly by male farmers which accords with the issues discussed under roles where wives were seen as support givers rather than receivers. *'...because we're a family farm (.) my brother can look after my sheep, dad can look after the hens, and vice versa. I can look after my brother's flock (.) if he needed help. So::: that's a huge plus having a family farm.'* (P1, male farmer).

General support from unspecified sources was endorsed mainly by male farmers although for wives this was probably included under friends.

"... it's good to have support and someone there (.) to maybe help explain, because sometimes if you're feeling (.) maybe not yourself, it's difficult to (.) articulate how you're feeling..."(P1, male farmer).

The *Church* was also mentioned as part of the support network, interestingly mainly by male farmers.

" .. the church (.) I belong to the church down in [location omitted] and I suppose if I mentioned it to the minister (.) or some of the select vestry or something (.) you know," (P13, male farmer).

"my church group would support me". (P15, male farmer).

There seems to be quite a distinction between males and females here as males found their support mainly within the family while females sought support from friends or professionals before family. There is some evidence that friendships are more important for women [39], while family is more important for male mental health [40]. Alternatively, it could be that farmers see support as a wife's role in the relationship, just as they see their role in arranging healthcare. Further, as part of accepting their role wives may feel they cannot seek support within the family as part of their need to be self-reliant. One might expect support from the community would play a part but although the terms farming community are widely used, there was little

sense of community expressed in the discourse. We identified this issue of community as a separate key theme which in many ways was the opposite of support and operated as a barrier to help-seeking. In fact, there seemed to be a *macho culture* among farmers that mitigated against help seeking. As farming is still a male dominated profession this would accord with the masculine male norms which have been shown to restrict help-seeking and health care [41].

" .. men probably (..) don't talk (..) or don't (.) sort of think that they would need that sort of treatment (.) men- or farmers in general just kind of get on with things (.) and its probably a very last resort to actually go and get help like" (P10, male farmer).

There is an anecdotal notion of farming communities as tight knit, but this isn't supported here. In fact, there appears to be a *lack of contact* and communication with other farmers except about practical matters such as the price of livestock or the weather. In other words, contact and communication is at a very surface level and lacks the depth to be considered supportive.

"I'm never anywhere to see anything like that there, . . . first thing is the price of (.) what we're getting for our milk, what we're getting for our cattle, or (.) the weather. It wouldn't be well how's your mental health? Are you keeping rightly like? Have you been to the doctor lately?." (P13, male farmer).

That male dominated workplaces have high prevalence levels of mental health problems is well established [42,43], and this is generally attributed to masculine norms of reluctance to talk or seek help [41]. Public Health Agencies have advocated for change and this *need for change* was identified among farmer's wives who recognized the damage done by the tradition of not talking about issues around mental health. Not so among farmers who although recognizing that men don't talk about mental health did not articulate it as a problem.

"..it certainly wouldn't have been something that was talked about in my- in my home growing up (.) mental health or anything like that there. But certainly, things change, and I would- I would intend to talk to my children about it." (P5, female partner/wife).

There is a high risk of suicide among farmers [7], an effect which seems to be global [6]. There was an acknowledgement among farmer's wives that suicide was an issue and a recognition that such tragedy does help to bring about change.

" .. they have actually experienced a suicide in his own family. .. where he lives now its- its- its quite a (.) well known topic and prominent (.) and everybody is quite aware of what has happened and (.) I think it has kind of opened everybody's minds a bit more." (P4, female partner / wife).

The growing recognition of the harmful effects of a community culture which suppressed mental health issues among farmers provides a potential for public health intervention.

Conclusion

The aim of the study was to explore help-seeking among male farmers and their female partners, who in this sample were in

fact married partners, or wives. The themes and sub-themes which emerged from the discourse show that both farmers and their wives have positive attitudes towards help-seeking, and its importance, and have a generally positive view of health care professionals. However, for farmers it was quite clear that they preferred to discuss physical health issues and had a mindset that was resistant to discussing mental health issues. Wives were much more willing to consider both mental and physical health and see the importance of talking about issues. While wives were more open to discussing help-seeking for mental health problems, they were equally able to identify barriers to actually seeking help. Avoiding seeking help for mental health issues was expressed as self-preservation, of avoiding the consequences of perceived stigma and avoiding the many fears involved. There was a macho-culture of seeing mental health issues as signs of weakness and staying silent and carrying on as if there was no problem, as a sign of strength. This was more prevalent in males in line with quite an extensive previous literature [9,11,19], but seemed to translate to females through ascribed roles and a community culture of reluctance to expose mental health issues. Attached to this was the economic cost of having to take time out of farm work to deal with health problems generally. It seems accepted in both farmers and their wives that looking after one's health is a good thing, and something that should be done, but there are so many reasons that can be found to avoid actually doing it. The farmers in the sample seem to generally accept the inevitability of being reluctant to seek help for mental health problems, but wives on the other hand seem to be more open to the need for change and breaking with the silent tradition. The fact that it takes the tragedy of suicide to initiate change attests to the strength of hold that tradition and culture have over the behaviour of many.

While we cannot generalise from a qualitative study the themes have some implications which can inform public health initiative. The influence of community culture, friends, and family, point to the need for a multilevel approach. Bronfenbrenner's Ecological Systems Model [44,45], could provide such a framework. This model explains behaviour as influenced by a wide range of inter-dependent social systems, including family, friends, community, and society at large. The fact that healthcare is positively valued suggests that this is a hurdle already overcome and would mitigate against the simple educational messages often preferred by Governments in raising public awareness. Instead resources might be better placed in a) breaking the vicious circle of community culture, b) supporting and enabling wives or partners who are already motivated towards change to be able to better influence their male partners, c) focusing on health care delivery to ensure that knowledgeable professionals are available on a consistent basis. By the latter we refer to the issues raised under accessibility where there is a need for a familiar face and someone who has the time and knowledge of farming issues to be accessible. The expectation that local General Practitioners can be all things to all people is widely recognised as unworkable. There is a need to employ other health practitioners, particularly those who can deal more effectively with mental health concerns.

Further, fear of a serious diagnosis emerged as a salient belief inhibiting formal help-seeking among both groups, an

important factor highlighted throughout the literature [33]. However, fear of diagnosis was described by participants as creating anxiety concerning the stability of the business if given a serious diagnosis and thus participants preferred to suffer symptoms rather than seek a diagnosis [33]. Positive social support emerged as an important factor facilitating help-seeking among farmers and their partners/wives and is consistent with existing literature [11]. Of note, social support was found to facilitate help-seeking at a multitude of levels including prompting self-reflection on the need to seek formal help, sharing the farm workload, providing informal support at formal help-seeking and via the disclosure of symptoms to significant others.

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