

**Factors associated with accessing professional help for psychological distress in midlife
Australian women**

Sue Outram PhD, Lecturer
Barbara Murphy PhD, Conjoint Senior Lecturer
Jill Cockburn PhD, Professor

Discipline of Health Behaviour Sciences
School of Medical Practice and Population Health
Faculty of Health
University of Newcastle, NSW, Australia

All correspondence to:

Dr Sue Outram
Lecturer
Discipline of Health Behaviour Sciences
Faculty of Health
Locked Bag 10
Wallsend NSW 2287
AUSTRALIA

Ph: (02) 4924 6430

Fax: (02) 4924 6208

Email: Sue.Outram@newcastle.edu.au

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ABSTRACT

Background: Given the high prevalence of mental health problems in midlife women it is important to understand the factors that motivate and inhibit seeking professional help.

Objective: To identify factors associated with and barriers to seeking professional help for psychological distress amongst a sample of 322 midlife Australian women.

Method: Qualitative and quantitative data were gathered using semi-structured telephone interviews in NSW Australia.

Results: Seeking help from a GP was associated with poorer mental ($p=0.002$) and physical health scores ($p=0.005$). Seeking help from a mental health professional was associated with being out of paid employment ($p=0.035$), being mostly able to talk about one's deepest problems as opposed to sometimes or hardly ever ($p=0.015$), being dissatisfied with family relationships ($p=0.008$), and feeling understood by family/friends sometimes as opposed to mostly ($p=0.002$). Women's major barriers to seeking help were thinking they should cope alone (64%); thinking the problem would get better by itself (43%); embarrassment (35%); believing no help available (34%); not knowing where to go for help (30%); and fear of what others might think (28%). Qualitative data also highlighted attitudinal barriers to help-seeking.

Conclusions: Attitudinal barriers need to be addressed to enable midlife women to more easily seek and access mental health care when needed.

There are no known conflicts of interest.

INTRODUCTION

Identification of the factors that influence professional help-seeking was originally stimulated by the desire to increase equity in the use of health services and health outcomes. The recent focus on cost-containment in a cash strapped publicly-funded health system has renewed interest in this issue. Several models have been proposed to describe the process of seeking help for psychological and physical illness (Anderson, 1995; Goldberg & Huxley, 1980).

Recent research suggests that need is the key predictor of mental health help-seeking, consistent with the linear model of help-seeking (Goldberg & Huxley, 1980). In the Mental Health and Wellbeing Survey of Australian Adults (SMHWB), the predictors of use of mental health services were having a diagnosed affective, anxiety or substance abuse disorder, or self-identifying as having depression or anxiety (Parslow & Jorm, 2000). For those found to have a mental disorder in the SMHWB, seeking professional help increased with the extent of the disability (McLennan, 1998). Other studies of people with depression or neurotic disorders have similarly demonstrated that help-seeking increases with illness severity (Henderson et al., 1992; Bucholz & Dinwiddie, 1989; Bebbington et al., 2000).

However, sociodemographic and attitudinal factors have also been shown to impact on help-seeking and service use, consistent with a model in which predisposing, enabling and need factors interact (Anderson, 1995). Women are more likely than men to seek help (McLennan, 1998; Verhaak, 1995; Parslow & Jorm, 2000; Bebbington et al., 2000), partly due to higher rates of anxiety and depression amongst women (Blazer et al., 1994; McLennan 1998). Mental health help-seeking has also been found to be associated with metropolitan living, higher education, being unmarried, and being out of the paid workforce (Jorm 1994; Parslow & Jorm, 2000; Taylor

et al., 2000; Bebbington et al., 2000). However, some studies have found no demographic differences between help seekers and non-seekers of mental health services (Bucholz & Dinwiddie, 1989; Henderson et al., 1992; Verhaak, 1995), and others have found minimal differences (Wells et al., 1994).

Several studies have demonstrated the impact of attitudes and beliefs on help-seeking. A recent Australian study of 142 general practice patients reported that confidence in mental health professionals and a belief that others would approve were the key factors encouraging help-seeking (Bayer & Peay, 1997). In concurrent studies in New Zealand (NZ) and the United States of America (USA), a belief in coping alone was a key barrier to mental-health help-seeking (Wells et al., 1994), as was the case in an Australian study of women with post-natal depression (Small et al., 1994). Shame and embarrassment, fears of painful self-discovery and of hospitalisation, beliefs that no-one could help, and lack of information about services have also been reported as barriers (Belle, 1982; Wells et al., 1994; Small et al., 1994; Meltzer et al., 2000). With the exception of cost (Wells et al., 1994), structural barriers such as transport and opening times have rarely been cited as reasons for not accessing help.

Help-seeking for psychological distress is particularly relevant for midlife women. Both UK and Australian evidence suggests that the prevalence of psychological disorders, particularly affective and anxiety disorders, is higher in women than in men (Jenkins et al. 1997; McLennan, 1998), peaking in midlife between ages 45-54 (Kane 1991; McLennan 1998). Correspondingly, women also have higher rates of help-seeking for psychological distress than do men (Verhaak 1995; Parslow & Jorm 2000; Bebbington et al. 2000), again particularly in the 45-54 age group (Bebbington et al., 2000). Understanding of the factors that motivate and inhibit midlife women in their help-seeking is therefore needed.

While quantitative surveys are important in identifying the characteristics of those who do not seek help, thereby highlighting disadvantaged groups, qualitative methods more effectively elucidate the attitudes and beliefs that operate to inhibit access for any individual. Therefore, the present study used a combination of qualitative and quantitative methods to investigate the factors that encourage and inhibit mental-health help-seeking. Specifically, the aims of this study were to:

1. identify the sociodemographic and health-related factors associated with seeking help for psychological distress from (a) general practitioners (GPs) and (b) mental health professionals;
2. explore the attitudes and beliefs that act as barriers to inhibit mental health help-seeking amongst midlife Australian women.

METHOD

Design

Follow-up survey of a random sample of women who had poor mental health status (as defined) from a population-based cross-sectional survey of Australian women age 45-50.

Sample and Procedure

Baseline data for this study were collected as part of Women's Health Australia (WHA). WHA is a federally funded interdisciplinary longitudinal research project designed to track the health of three cohorts of women over at least twenty years. Random samples of women aged 18-23, 45-

50 and 70-75 years in 1996 were selected from the database of the Australian Health Insurance Commission (Medicare), the most up-to-date sampling frame available. This paper concerns only the mid-aged cohort, of whom 13,961 responded to the baseline survey.

From the mid-aged cohort of WHA, a random sample of 400 was drawn from those women living in NSW who scored ≤ 52 on the Mental Health Index (MHI-5; Ware & Sherbourne, 1992) of the SF-36 in the baseline survey. Trained interviewers administered a comprehensive semi-structured telephone interview. Questions about the experience of seeking help with a recent episode (within the past 12 months) of psychological distress were included in a wide ranging interview that explored women's perceptions of causes and treatment of psychological distress.

Measures

Recent period of distress. In the telephone interview, respondents were asked whether they had had a period of distress in the past 12 months: *Have there been periods of time in the past year when you have been very distressed, upset or worried?*

Help-seeking: Respondents who had had a recent period of distress were asked who they had talked to about their difficulties. They were prompted from a list of health professionals, namely GPs, psychiatrists, psychologists, counsellors, social workers, welfare workers, complementary therapists and self-help groups.

A range of sociodemographic and health related variables was assessed in the baseline survey. Health-related variables included: mental health status (measured by the 5-item Mental Health Index MHI-5; Ware & Sherbourne, 1992); physical health status (Physical Component Summary scores of the MOS SF-36; Ware & Sherbourne, 1992); satisfaction with partner, family and

friendships (adapted from the Spanier Dyadic Adjustment scale; Spanier, 1976); feeling understood by family or friends (hardly ever, some of the time, most of the time; Koenig et al., 1993); and ability to talk about deepest problems (hardly ever, some of the time, most of the time; Koenig et al., 1993).

Barriers to help-seeking: A pre-coded question asked *If you needed help, but had difficulties talking to someone outside your family and friends about how you were feeling, what were the main reasons?* Following the procedure used by Wells et al. (1994), up to three non-prompted responses were recorded before the interviewer read from a list of possible reasons for not seeking help. In addition, relevant comments made throughout the interviews were recorded verbatim.

Analysis

Factors associated with help-seeking: Two dichotomous dependent variables were used: having consulted a GP (yes/no) and having consulted a mental health professional, namely a psychiatrist, psychologist, counsellor, social worker, and/or welfare worker (yes/no). For each dependent variable, univariate associations with sociodemographic and health-related variables were explored using chi-square for categorical variables and t-test for continuous variables. Fisher's exact test was used when chi-square was not valid. Backward stepwise logistic regression was used to identify characteristics associated with each of the two dependent variables, while controlling for other variables. Variables that had univariate associations at $p=0.25$ were entered into regression analyses. Odds ratios and 95 per cent confidence intervals were calculated for variables in the final model, and the significance level was set at $p<0.05$. Quantitative data were analysed using the SAS software program.

Barriers to help-seeking: Frequencies for each barrier to seeking help, both volunteered and prompted, were calculated. Qualitative data were categorised thematically using constant comparison methods (Strauss & Corbin, 1991).

RESULTS

Respondents

From the women randomly selected to participate in WHA, 13,961 women participated in the baseline survey giving a response rate of 53.5%. Details of respondents are available elsewhere (Brown et al., 1999). Respondents were similar to the Australian population of 45-50 year old women (ABS, 1996) in marital status, parity, and aspects of employment (except for unemployment). However, they had higher educational levels and fewer were unemployed, suggesting that women of higher socioeconomic level are over-represented in the WHA sample.

For the follow-up survey reported in this paper, data were analysed on 322 completed interviews giving a response rate of 81%. Significantly more non-responders than responders worked at home or were retired, were of non-English speaking background, did not have ancillary or private health insurance, took medication for 'nerves' and to sleep, and reported that, apart from family, they did not have anyone close by whom they could depend on.

Factors associated with help-seeking

In total, 309 (96%) women indicated having had a period of distress in the past 12 months. Of these, 159 (52%) had talked with a GP about their difficulties while 100 (32%) had talked with a mental health professional. In total, 204 (66%) had talked with a health professional about their difficulties.

Talking with a GP was found to be independently and significantly associated with both mental health scores and physical health scores. In both cases, the higher the score (indicating better mental or physical health) the less likely the woman was to seek help from a GP (OR=0.96, 95% CI 0.94-0.98, $p=0.002$ for mental health; OR=0.97, 95% CI 0.95-0.99, $p=0.005$ for physical health). Notably, these odds ratios are based on non-dichotomous independent variables.

Only one demographic factor - paid employment - was found to be independently and significantly associated with talking with a mental health professional. Women in paid employment (either fulltime, parttime or casual) were less likely than those not in paid employment to seek help from a mental health professional (OR=0.52, 95% CI 0.30-0.90, $p=0.035$). Further, three attitudinal variables - satisfaction with family relationships, ability to talk about deepest problems, and feeling understood by family and friends - were found to be independently and significantly associated with seeking help from a mental health professional. Women who were satisfied with their family relationships were less likely to have consulted a mental health professional than women who were dissatisfied (OR= 0.45, 95% CI 0.25-0.81; $p=0.008$). Compared with women who said they could mostly talk about their deepest problems, women who said they could do so only sometimes (OR=0.33, 95% CI 0.15-0.70; $p=0.015$) or hardly ever (OR 0.37, 95% CI 0.14-0.97; $p=0.015$) were less likely to seek help from a mental health professional. Women who reported that they were only sometimes understood by family/friends were over three times more likely to have consulted a mental health professional than those who said that family/friends mostly understood them (OR=3.33, 95% CI 1.58-7.03; $p=0.002$). However those who said that family/friends hardly ever understood them were no more likely to have consulted a mental health professional than those who indicated they were mostly understood (OR=1.4, 95% CI 0.4-4.52).

Perceived barriers to seeking help

Barriers to seeking professional help are shown in table 1.

<Table 1 about here>

In response to the open question about reasons for not seeking help, 348 unprompted responses were made (216 respondents volunteered one reason, 57 gave two reasons and six gave three reasons). As shown in table 1, the three most frequent unprompted responses were: a desire for privacy; thinking or knowing they could cope alone; and thinking they should be able to cope alone. Once prompted, the most common barriers were: thinking they should be able to cope alone; thinking the problem would get better by itself; embarrassment; not having anyone to talk to; not knowing where to go for help; and fear of what others might think. Attitudinal factors were reported more often than structural factors such as lack of money, inconvenient hours, and distance or transport difficulties. Sixty women (18.6%) said that theirs was not the type of problem needing professional help. Fifty-two women (16%) reported having no barriers to seeking help.

Thematic analysis indicated that four main themes or beliefs underpinned the qualitative comments. Only one theme addresses positive feelings of power in solving one's own problems, whereas three address reluctance to self-disclose and distrust in the therapeutic process. Again structural barriers were rarely mentioned in the qualitative comments: for example, only a handful of women cited financial barriers: *"A private counsellor costs \$75 per hour; I can't afford that"*.

Belief in coping alone

Some women held this belief from a positive perception of their own coping abilities and power. Typically they indicated “*You’ve got to do it by yourself.*” Feelings of weakness in asking for and accepting help were also common: “*Talking about my problems makes me feel weak. I like to feel strong. I’m the sort of person who doesn’t like feeling weak, so I feel I can’t cope with feeling powerless. Going to the psychologist makes me feel weak, so I don’t feel good. That’s the same as when I take drugs. Being on tablets makes me feel weak, so I stopped taking them.*”.

Belief no-one can help

Linked with the belief in coping alone, many women believed that “*no-one can help you*”. Some commented that “*I just don’t see how you could get relief from talking to someone*”. This attitude was underscored by the belief that one’s problems are unique and, unless they had been there themselves, professionals are unable to understand. One woman, a teacher who reported that she was suffering from severe depression precipitated by work stress, said that the intake officer at the community health centre indicated that the staff didn’t know anything about teaching and stress: “*So I said if they can’t understand that, they can’t understand me. I went to the GP and said I wouldn’t do it. I am self-healing, but slowly. I feel very proud of myself.*”.

Shame and embarrassment

Feelings of shame and embarrassment and fears of judgement from others encouraged women to keep their problems private. Some women stated categorically that they were “*not the sort of person to talk about private things*”, and alluded to the way they were brought up to explain why they regarded problems as private: “*I’m not one to run to the doctors... no-one in our family*

does” and “*I was brought up in the bush!*”. Many were concerned about others’ disapproval, highlighting the shame and embarrassment associated with psychological distress and help-seeking: “*They’ll think I’m neurotic*” and “*I would not want anyone to know just how miserable my life really is.*” Family members who pressured women to keep problems within the family often reinforced these concerns. For one rural woman, resistance from her in-laws precluded her and her husband seeking marriage guidance counselling. Indeed, concerns about privacy were highlighted for women living in rural areas: “*Because it’s a small town, I know everyone professionally and socially. I couldn’t really talk to him (the doctor). He’s a friend*” and “*Because I work at the hospital, I felt embarrassed with colleagues... and in a small rural town, people look on you as weak if you need counselling*”.

Fear of painful self-discovery

Some women were afraid of opening up painful memories. Many women felt “*terrified where it would lead... would rather not open a Pandora’s box of the past.*” As one woman stated: “*Pain! If you talk to someone you have to experience this pain and in your adult life you need to keep going. Who wants to confront this pain? When you make yourself open, make yourself vulnerable... (I) couldn’t allow anyone to weaken me, take away my strength*”.

DISCUSSION

Strengths and limitations

The study has a number of limitations, which need to be acknowledged. First, psychological distress was determined on the basis of MHI score, but no formal diagnoses were used and

women's actual need for treatment is unknown. Therefore, the present findings regarding predictors of and barriers to help-seeking should be interpreted within this caveat. It is interesting to note that almost one-fifth of the women interviewed said that theirs were not the type of problem needing professional help. It is possible that some women were unaware of the type of help available. As pointed out by Buetow (1995) making a distinction between perceived and actual need can be reductionist and judgemental. In this study, want or need is used synonymously and given equal importance.

Second, the response rate of 53% potentially limits the generalisability of the study findings. Importantly though, it compares favorably with other similar longitudinal studies (Greenblatt-Ives et al., 1992; Kaldenberg et al., 1994).

Third, the use of stepwise logistic regression for identifying predictors of help-seeking has introduced the possibility of Type I error. However, given the exploratory nature of the study, our priority was to ensure the identification of all factors possibly associated with help-seeking and, thus, the minimisation of Type II error.

The strengths of this study lie in the initial random community sample used and the use of multiple methods of data collection. The combination of both quantitative and qualitative methods enables findings to be set in a broader context. For example, while relatively few women reported privacy and confidentiality as barriers using quantitative methods, women's comments highlighted the extent of these concerns and the way in which they interact with feelings of embarrassment and concerns about judgement to inhibit help-seeking. Use of a single method alone does not provide such a complete picture.

Factors associated with and barriers to seeking professional help

Just over half (52%) of women who had experienced psychological distress in the previous year had sought help from their GP. Seeking help from a GP was associated with both poorer mental and physical health. One previous study similarly found that physical illness was the key predictor in seeking mental health care from a GP (Vazquez-Barquero et al., 1990). No sociodemographic factors were associated with GP help-seeking in the present study, also consistent with previous research (Bayer & Peay, 1997; Henderson et al., 1992). In regard to GPs then, the present findings are consistent with the linear model where psychological distress and physical illness predict help-seeking (Goldenberg & Huxley, 1980), rather than the more complex model incorporating socioeconomic and attitudinal factors (Anderson, 1995).

A smaller 32% of women who had experienced psychological distress in the previous year had sought help from a mental health professional. Unlike GP help-seeking, seeking help from a mental health practitioner was associated with several factors apart from need, suggesting a more complex process and set of barriers.

First, seeking help from a mental health professional was associated with being out of paid employment, as has been found in previous studies (Jorm, 1994; Verhaak, 1995; Taylor et al., 2000; Bebbington et al., 2000). This might in part be related to the poorer mental health scores for these women (OR=2.15) although, contrary to the findings of the SHMWB (McLennan, 1998), mental health status was not an independent predictor of mental health help-seeking in the present study. Given the small number of psychologists in the public health system in Australia, and the disinclination of psychiatrists to charge the government directly for services, it is unlikely that increased consultation for unemployed women is due to being on a health care card, as has

been reported in other countries (Verhaak, 1995). It is possible that work commitments restricted employed women's ability to attend appointments, although structural barriers to help-seeking were rarely reported.

Second, help-seeking from a mental health professional was significantly associated with the ability to talk about one's deepest problems. Qualitative comments highlighted the way in which women's beliefs in coping alone, needs for privacy, feelings of embarrassment and fears of opening a 'Pandora's box' exacerbated their reluctance to self-disclose, thereby inhibiting help-seeking. To some extent, these beliefs are reinforced by Australian cultural values of individualism and stoicism, although a belief in coping alone was also the key barrier for both USA and NZ samples (Wells et al., 1994). Feelings of shame and embarrassment (Belle, 1982; Wells et al., 1994; Small et al., 1994; Meltzer et al., 2000), concerns about judgement from others (Bayer & Peay, 1997), concerns about privacy (Bishop et al., 1993) and fears of painful self-discovery (Belle, 1982) have also been reported as barriers in previous studies. The belief that no-one can help, also evidenced in previous studies (Wells et al., 1994; Small et al., 1994; Meltzer et al., 2000), suggests a lack of confidence in the therapeutic process which is likely to further encourage women to cope alone.

Third, women dissatisfied with their family relationships and those who had problems in feeling understood by their family and friends were more likely to seek mental health treatment. Indeed, problems with family relationships were commonly seen as the reason for distress. This supports the view that good relationships with family members can be a buffer against needing to access professional help (Brown, 1978). For some women though, family members actively inhibit help-seeking, evidenced in qualitative comments regarding fears of judgement and concerns about privacy. This is consistent with the view that family members can limit professional help-

seeking by their closed systems that keep outsiders from knowing and being part of what is happening (Horwitz, 1978).

While geographic location was not a significant predictor of the use of mental health professionals, replicating epidemiological studies conducted overseas, qualitative findings suggest that some attitudinal barriers are particularly salient for rural women. In particular, feelings of embarrassment, the perceived stigma of using psychiatric services, and the subsequent desire to keep troubles private are highlighted in country towns “*where everyone knows everyone else’s business*”. Consistently, rural women in this age group in the WHA baseline study were less satisfied with health care than their urban counterparts (Young et al., 1998), perhaps partially due to these attitudinal barriers. In addition, inequalities in the availability of specialist mental health services in rural areas have been highlighted in the SMHWB (Parslow & Jorm, 2000) and other Australian reports (AIHW, 1998; Sidoti, 1998). Recommendations have previously been made about improving information access and increasing the training of health care workers in aspects of privacy and confidentiality in rural settings (Bishop et al., 1993).

Indeed, for women generally, inability to access needed help and lack of knowledge about where to go for help were commonly cited barriers (34% and 30% respectively), although neither emerged strongly in qualitative comments as reasons for not seeking help. Relatively fewer women have reported these barriers in previous studies: for example, lack of knowledge was reported by 26% women in USA and 19% in NZ (Wells et al., 1994). These findings suggests some limitations in mental health service availability for Australian women.

Few women volunteered cost of services as a barrier, although a higher 22% indicated financial barriers when prompted. This rate was similar to that recorded in NZ (6% and 21%), but much

lower than in the USA (16% and 47%) where social inequality in health care is well documented. The reason for this still high result in Australia might be that some respondents were not aware of public mental health services or, as evidenced for a handful of women, that they preferred to access a private psychologist rather than a counsellor based at a community health centre. It might also reflect the relative unwillingness to pay for psychological services previously reported amongst non-users of such services (Hopson & Cunningham, 1995). One of the main aims of the Australian health care system and the principle underpinning Medicare, is that universal access to health services should be ensured, particularly that people unable to pay for health care should not be disadvantaged. The results of this study suggest that inability to pay for help is not a major barrier to achieving mental health care in Australia.

CONCLUSION

The findings of the present study suggest that the linear model, where need predicts help-seeking, is most applicable in describing mental health help-seeking from GPs. In contrast, the more complex model whereby attitudinal and sociodemographic factors interact appears more applicable for help-seeking from mental health professionals. The perceived stigma of mental illness, and the associated embarrassment and fears of judgement, appear to be more salient in the decision to seek help from a mental health professional rather than a GP. Seeing a GP rather than a mental health professional can potentially make it easier for women to access help and avoid stigma. The challenge for service providers is therefore to offer mental health services in a way that empowers rather than weakens women. The question arises: should resources be marshalled to 'teach' people to overcome their fears and concerns, such as a program of community awareness that targets social values of individualism and stoicism? Or are there people for whom

self-reliance should be fostered? Clearly, increased information and encouragement, and normalising of mental illness, can be of benefit.

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Table 1**Barriers to seeking professional help**

Barriers	Volunteered		Prompted	
	N = 279 ²		N= 318	
	n ¹	%	n ¹	%
Pre-coded responses				
Believe I should cope alone	33	11.8	206	64.2
Thought it would get better by itself	3	1.1	138	42.8
Too embarrassed to talk to anyone	6	2.2	113	35.0
Wanted help but none there	15	5.4	109	34.4
Didn't know where to go	17	6.1	97	30.5
Afraid of what family, boss, friends think	4	1.4	92	28.1
No money	8	2.9	71	21.9
Not a problem needing this type of help	29	10.4	60	18.8
Had no trouble talking to anyone	30	10.8	52	16.3
Family objected	1	0.1	32	10.0
Afraid of treatment	0	0.0	32	10.0
Hours inconvenient	1	0.4	29	9.0
Afraid of being hospitalised	0	0.0	28	8.8
Problems with transport and/or distance	4	1.4	26	8.0
Post-coded responses				
I can cope alone	36	12.9	55	18.5
Desire for privacy	44	15.8	34	11.4
Confidentiality	13	4.7	14	4.7
Fear of being judged (by professionals)	19	6.8	16	5.4
No one can help me	24	8.6	26	8.7
Pride	8	2.9	7	2.3

Note. ¹ more than one response possible therefore total adds up to more than 100%. ² n=43 women were not able to spontaneously give any reason why they did not get help when needed.